Occupational Health: Working Better Consultation

Scottish Hazards Response

SCOTTISH HAZARDS

October 2023

Introduction

Scottish Hazards is an occupational health and safety charity, we provide support, advice, and representation to workers who, for whatever reason, are not in trade unions.

Our organisation supports universal access to occupational health services delivered by the NHS, free at the point of delivery and accessible to all. In our view the responsibility for delivery of occupational health services for workers made ill or injured by their work should always have been the role of the NHS.

There has been a steady decline in employer provision of in-house services, to be replaced by an occupational health free market economy, where some providers chase lucrative contracts for provision of a range of services decided by the employer. The nature of the services provided is always determined by the need for business efficiency as opposed to the health, safety, and wellbeing of the employer's workforce.

Occupational health is about far more than managing sickness absence, there must be a focus on prevention of occupational ill health and the functional capacity of workers to meet the demands of their role throughout their employment journey.

The foreword refers to 45% of the UK workforce having access to occupational health services, this is a figure we strongly dispute and plan to argue this point in the consultation response.

It also states that ***"expert-led impartial advice and interventions such as occupational health can help employers provide work-based support to manage their employee's health conditions,"*** we would not dispute this, but success must depend on the range of services offered and accessibility.

In our experience workers tend not to see occupational health advisors as impartial and, in many cases see referral as a sanction and not as a benefit. This is because they are referred when it suits the employer and not when it could be of most benefit to the sick or injured employee. This is normally when decisions are being taken on sickness absence management sanctions, cuts in sick pay or an opportunity to terminate employment on grounds of capability.

Scottish Hazards welcome the opportunity to respond to this consultation, although we are a Scottish organisation and health is a devolved matter this is an important consultation and, whatever the outcome, the response from the

UK Government can help inform public policy on future occupational health provision in Scotland.

Chapter 1: Opportunities for greater employer action, best practice sharing and voluntary health at work standards.

Question 1: What would you consider to be a robust and reliable source of evidence to establish a simple and clear baseline for quality OH provision?

- **Evidence based outcomes from an Expert Advisory Group.**
- **The Government guidance to support employee health outcomes in the workplace, including specifying a clear and simple baseline for minimum levels of OH support.**
- **Anything else? Give reasons for your views below.**

Scottish Hazards is of the view that access to quality occupational health provision is far lower than the 45% of the UK workforce quoted for the purposes of this consultation. If a simple and clear base line is to be established than a fair and accurate measurement of occupational health provision, and the services being provided, must be the starting point for any such exercise.

As far back as 2002, the HSE commissioned research from the Institute of Occupational Medicine on the Survey and Use of Occupational Health Support.[1] In this paper the IOM surveyed 4950 companies of varied sizes across the UK and from different sectors.

This work considers two definitions of occupational health support:
- a broad definition where occupational health provision focused on hazard identification risk management and provision of information, and
- a stringent definition consisting of all the components in the broad definition with the addition of what activity modification, training on health-related issues, measuring workplace hazards and monitoring trends in health

This study found that of the 4950 companies who participated in the study 44% provided occupational health support fitting the broad definition. When results were weighted to consider the size of the UKs 142957 companies in the UK at that time, then only 14.9% employers providing occupational health support met this definition.

[1] Survey and Use of Occupational Health Support, Contract Research Report 445/2002 [ARCHIVED CONTENT] CRR 445/2002 Survey of use of occupational health support (nationalarchives.gov.uk)

When the same model was applied to the more stringent definition only 3.3% of UK employers provided occupational health support.

In our view even the more stringent definition falls short in areas such as job retention and vocational rehabilitation, both extremely important components in comprehensive occupational health services, particularly for ensuring workers with disabilities and long-term health conditions have secure and fulfilling employment opportunities.

Scottish Hazards would support the formation of a tripartite expert advisory group, in our view it should have the same functions as the Industrial Injury Advisory Committee (IIAC), including scrutiny of any proposed legislation should the Government decide a statutory model is required, as well as commissioning research on occupational health systems in the UK and elsewhere. This would provide an independent and expert overview of the occupational health needs of the UK workforce.

Any expert advisory group should include workers representatives as well as employers, occupational health professionals and academics. As a Scottish organisation we are aware development of policy in this area stretches across reserved and devolved areas of competence, such as health and safety, social security, and national health services but there must be representation from all the devolved nations on any advisory group.

Occupational health services are in a crisis for many reasons going back to the formation of the NHS, when responsibility for health at work was seen to be the responsibility of employers. More recently, Government inaction and a series of short-term projects driven by a desire to reduce social security budgets has distracted from the reality, and for which the evidence is over whelming, delivery of occupational health support and interventions has gone terribly wrong.

The responsibility for this does not lie solely with the UK Government. In Scotland, up until recently, we had witnessed the development of occupational health support not matched elsewhere, culminating in Healthy Working Lives[2], providing occupational health support, mainly for SMEs and available online. Unfortunately, COVID saw the demise of Healthy Working Lives to a great extent.
Governments must end short termism in their commitment to occupational health public policy decisions and create services and interventions that are

[2] Healthy Working Lives, Home - Healthy Working Lives

world leading and support workers at every stage of their working lives.

This needs the setting of not just one baseline but many, each reflecting where we want to be at agreed points in time in the future, an initial baseline measurement and then one reflecting where we want to be in 5, 10, 15 years.

Our organisation questions just how effective guidance can be when we are trying to influence a change in behaviour in most UK employers. Scottish Hazards believes provision of occupational health should be a statutory responsibility with accompanying guidance and underpinned by an approved code of practice (ACOP).

During COVID, UK wide employers frequently ignored Scottish Government guidance on COVID emergency measures particularly when similar, but in our view less effective advice had been issued to apply in England. As health is reserved there is the possibility that the Scottish Government may wish to issue guidance relating to health at work in Scotland, a devolved matter, that would be similarly ignored by employers wishing to follow less stringent and less effective guidance.

Question 2: What best practice examples have you seen where workplaces are used to better support employee health outcomes that could be used instead to bolster greater take-up of OH provision? What kind of model would you prefer for sharing this good practice, particularly to support SMEs?

In our view good occupational health services will be found in workplaces where mechanisms are in place to ensure the views of workers are considered on matters affecting their health and safety. Research exists across the world that trade unionised workplaces are safer and healthier. This is no surprise to Scottish Hazards as trade unions provide an independent voice and representation to workers facing a wide range of issues at work including ill health, work related or otherwise.

COVID demonstrated that, where trade unions are not present and no effective employee voice exist, workers can be treated appallingly even during a pandemic, with little regard given to their health at work.

There are two sets of regulations placing obligations on employers to consult on how they manage health and safety in their workplaces.

They are:

1. the Safety Representatives and Safety Committees Regulations 1977[3] applying to trade unionised workplaces and
2. the Health and Safety (Consultation with Employees Regulations)[4] 1996, applying to workplaces with no trade union presence.

Both sets of regulations outline what employers need to do to ensure they meet these obligations and have effective arrangements in place to ensure the health, safety, and welfare of their workers.

There are more explicit regulation covering employers' obligations to protected workers welfare at work, the Workplace Health, Safety and Welfare Regulations 1992[5]

Finally, the Management of Health and Safety at Work Regulations 1999 places further obligations on employers to assess risk to employers' health and safety because of their business activities, this includes health risks at work. Section 3 refers specifically to the requirement to carry out suitable and sufficient risk assessments and put in place control measures to reduce the risk of harm.

Scottish Hazards believes these regulations must be considered by the Government when looking at delivery of occupational health support moving forward.

Points we would like considered as part of this consultation.

1. employers to be reminded of the legal obligations to consult on workplace health risks as well as safety.
2. any occupational health support packages recommended by the Government must be underpinned by the above and all relevant health and safety regulations.
3. it needs to be made clear to employers that the requirement to assess workplace risks applies to risks to health and safety, in equal measure.

If employers can be reminded of their legal obligations when designing and procuring occupational health support then the services have more chance

[3] The Safety Representatives and Safety Committees Regulations 1977 (legislation.gov.uk)
[4] The Health and Safety (Consultation with Employees) Regulations 1996 (legislation.gov.uk)
[5] The Workplace (Health, Safety and Welfare) Regulations 1992 (legislation.gov.uk)

of meeting their needs, identifying these needs can only be done by speaking to workers.

Our positive examples do not relate to best practice in individual workplaces but rather to projects we are aware of over the years that have sought to provide increased access to occupational health, particularly to workers in SMEs.

The Lothian Occupational Health Project (LOHP)[6] was launched over 30 years ago, in November 1995. This was a partnership between the Health Promotion and Primary Care Departments of Lothian Health Board, the Lothian Trade Union and Community Resource Centre and the Lothian Federation of Trades Union Councils. Occupational health advisors spent one day a week in each of seven GP surgeries across five primary care sites.

The most significant aspect of this project was patients were at the centre, their experiences in the workplace were listened to, drawing on their experiences of how situations arise and can be improved.

LOHP recognised the financial constraint small businesses faced and the impact on their capacity to engage occupational health services. It was also accepted that the links between a person's health and work was rarely discussed in the GP/patient relationship.

This project was truly tripartite, the Federation of Small Businesses, Health Education Board for Scotland and Public Health Sciences Department of Lothian Health Board were all represented on the steering group.

The project had two aims.

1. to improve identification and treatment of work-related ill health
2. to contribute to the prevention of work-related ill health by seeking to eliminate or reduce hazardous working conditions.

The LOHP evaluated very favourably but funding could not be secured to embed this non-clinical intervention to improve access to occupational health in primary care settings. This is indicative of the lack of progress and vision shown towards occupational health by successive UK Governments and, to a certain extent more recently, the Scottish Government as well.

[6] the-lothian-occupational-health-project.pdf (enwhp.org)

Sheffield Occupational Health Advisory Service (SOHAS)[7] was founded in 1980 and is now in its 44th year. It is a registered charity, and the Lothian Occupational Health Project was based on the same model, having a team of occupational health advisors based in GP surgeries across the city. They support approximately 1500 individuals a year and their focus is preventing occupational ill health through early intervention. They also provide non-medical assessments for employers and work with them and the worker to facilitate a return to work based on these assessments.

We have already referred to Healthy Working Lives, an example of good practice until the pandemic struck, Scottish Hazards is pushing for HWL to be resurrected as part of the ongoing Scottish Government Health and Work Review.

Working Health Services Scotland[8] encourages a positive approach to encouraging staff attendance aimed at employers and workers, this includes access to occupational health case managers and has numerous referral options including the capacity for the workers to self-refer.

Working Health Services Lothian[9] funded by NHS Lothian aims to prevent sickness absence and unemployment, support people to return to work from sickness absence quickly and support a managed return to work. This also signposts individuals to other services impacting on their health such as advice on benefits and debt management.

Scottish Hazards is strongly of the view that employees must be at centre of the occupational services their employers offer. Their views on the services they have access to, or interventions they have experienced have to be considered if they are to be seen to be independent and have the confidence of those who use them. Worker engagement applies, not only to the services offered by employers currently, but also to any occupational health services provided in the future.

This is not the case for occupational health, for many workers it is no more than a management tool to manage sickness absence, often with draconian consequences for those given access to them. Most occupational health services are not open to workers referring themselves/seeking advice

[7] Home - Sheffield Occupational Health Advisory Service (sohas.co.uk)
[8] Support for employees with health conditions - Healthy Working Lives
[9] Working Health Services – Lothian Work Support Services (nhslothian.scot)

themselves. They are only open to management referral. There is a saying in the disability movement "nothing about us without us," a strong message to include them in public policy decision impacting on them, and indeed every worker. The future of occupational service provision impacts on everyone in work, yet the consultation does not seem to seek views from workers.

The UK Government should map occupational health advisory services available through the third sector, such as SOHAS mentioned above and fund projects delivering similar non-medical interventions and advice to workers and employers. SOHAS has proved this model is sustainable.

Question 3: What benefits does, or could, access to OH services bring to your organisation?

Scottish Hazards is a charity specialising on providing support and advice to workers who are not in trade unions. In terms of staffing, we have one full time worker and two-part time. As an organisation we do not have financial resources to purchase occupational health services. Our organisation, due to the nature of our work, is fully aware of our responsibilities under health and safety legislation and how our people can access occupational health advice and information.

Question 4: Are there particular benefits these measures could bring for people with protected characteristics? In what ways could this be achieved?

Scottish Hazards is of the view far too many employers are ignorant of their responsibilities under equality legislation, including the obligation to make reasonable adjustments for those with protected characteristics. We believe individuals with protected characteristics could benefit from having access to comprehensive occupational health services and appropriate interventions.

This question is broadly based and occupational health needs for one group of workers with protected characteristics may not apply to others. However, having self-referral into occupational health support may help those suffering stigmatisation because of their protected characteristic. Workers with protection under the Equality Act 2010 are likely to suffer poor mental health because of their protected characteristic and more so if they have

more than one. Examples we have come across include ill-health resulting from sexual harassment, unfavourable treatment of disabled workers and failure to carry out reasonable adjustments, racial abuse of black and migrant workers, menopause in the workplace, pregnancy (particularly during COVID). We believe those with protected characteristics would benefit most from any occupational health support developed by the UK Government, or the devolved nations for that matter, if workers in these groups are actively involved in public policy decisions designed to make their workplaces healthier, safer, and fairer.

Question 5: What are, or could be, the costs of accessing OH services for your organisation?

Question 6: a) What should such a national health at work standard for employers, embedding a baseline for quality OH provision, include, especially given the requirement to accommodate different employer needs?

We would assume a national health at work standard only applies to England for the purposes of this consultation. In Scotland we would want to see provision of comprehensive occupational health services at the core of any comparable standard here, with guidance for employees and employers on how to access and make use of the OH resources available and at whom they are targeted. There needs to be a support services available to employees to access occupational health information, support and representation to workers who are not in trade unions. Scottish Hazards also believes any baseline should also include provision for workers to be consulted on occupational health support, including who provides it, the process for selecting a provider, performance of providers and provision for replacement/retendering.

b) What should the OH elements of that standard look like, particularly to ensure a simple and clear baseline for quality OH provision?

Scottish Hazards believes the baseline for occupational health elements of the standard should be the stringent definition of occupational health support in the HSE 2002 study Survey and Use of Occupational Health Support[10] . These are hazard identification, risk management, provision of information, modifying work activities, training on health-related issues, measuring workplace hazards and monitoring trends in health. It should also include arrangements employers have in place to consult workers on occupational health support.

Question 7: For an accreditation scheme, should the levels or tiers be based on business size and turnover? What other factors should we consider for the tiers? What incentives should be included in the higher tiers?

Scottish Hazards does not support accreditation schemes to recognise actions taken by employers to protect the health, safety, and wellbeing of their workers. Employers have legal obligations to do so, and we need to focus on the employers who are not doing what they need to.

Question 8: [To be answered if you are an SME or if you represent SMEs] As an SME with fewer than 250 employees or as a SME representative,

a) how useful and/or practical would such an accreditation scheme be for you? Give reasons.

None whatsoever

b) how useful and/or practical would benefits such as access to peer support be?

[10] [ARCHIVED CONTENT] CRR 445/2002 Survey of use of occupational health support (nationalarchives.gov.uk)

Given the nature of our business this would be of little use.

Question 9: How should such an accreditation scheme be monitored and assessed? What assessment or evidence should employers need to provide to achieve each level?

In our response to Q7 we outline our opposition to accreditation schemes although we recognise the business community will have a different view. Pre-COVID Healthy Working Lives operated a scheme based on gold, silver, and bronze awards but this has been discontinued. The criteria[11] for the award is still available on their website and this may be useful for the purpose of this consultation. This should not be seen as an endorsement of this, or any other award-based scheme aimed at preventing harm or injury to workers just an attempt to inform your consultation.

One of our criticisms of accreditation schemes is that employers sign up for awards such do not consult with workers or their representatives when seeking accreditation. Employers seeking a Healthy Working Lives Award had been known to bypass their legal obligations to consult with staff on matters affecting their health and safety, setting up separate consultative bodies to achieve the award but excluding trade union representatives.

Disability Confident was to make a real change for employees with disabilities. However, with a third of employers obtaining accreditation not employing a worker with a disability after signing up to the scheme there must be some doubts about the motivation for doing so.

Another concern is that, while employers work towards achieving awards, we are not aware of any employer having one taken away, suggesting monitoring of performance is not sufficiently robust or might not happen at all.

We would also be concerned an accreditation system would be burdensome for employers, especially SMEs and would not achieve sufficient take up in the target group in which we need to influence behavioural change.

[11] Award programme criteria - Healthy Working Lives

Our preference would be that local government were funded to ensure they could inspect workplaces to ensure employers were meeting their obligations to ensure their business activities do not adversely impact on the health, safety, and wellbeing of their workers. Accreditation schemes only reach those who want to do the right things and be rewarded for it.

Enforcement reaches employers who may be clueless (or worse criminal) about their obligations, provides opportunity and support to the clueless and sanctions the others. It is, however, another pilot funded by the DWP. We need to end short termism in occupational health support and develop permanent support drawing from the findings from the various pilots over the years.

Question 10: What Government support services would be most valuable for employers seeking to improve their support for health and disability in the workplace, including as they work by towards a baselined quality OH provision as set out in a national health at work standard for employers, embedding a baseline for quality OH provision, that the Government would develop?

Scottish Hazards believes the UK Government should also provide support services to workers as well as employers, SOHAS in Sheffield mentioned earlier does this and has done so for over 40 years. The consultation mentions the Mental Health and Productivity Pilot (MHPP) that is undoubtedly doing good work in the Midlands and there are likely to be many more.

Through the DWP, the UK Government, should provide financial resources to the regions in England and the devolved Governments to develop permanent regional occupational support and services, tailored to their needs and based on evidence from their own communities and health authorities. Other partners, such as local authorities and universities could provide financial and/or research support. Charities already working in occupational health and supporting workers with work related ill health or other health conditions/disabilities impacting on their work should be funded to develop their services.

Scottish Hazards would like to see occupational health support provided through primary care with occupational health advisers in GP practices. We understand some work is already taking place with specially trained job coaches engaging with patients, we are not aware of the level of occupational health training provided to the individuals.

Question 11: **Should access to a government-funded support package be conditional on accrediting to the proposed national health at work standard for employers, embedding a baseline for quality OH provision? Give reasons for your views.**

Any Government funding should be conditional on the proposed national health at work standard being implemented within their workplaces. This should include arrangements for monitoring employers in receipt of public funding to ensure employers work towards meeting the standard, but also embed occupational health support in their organisations, this should include having policies in place to prevent occupational ill-health and vocational rehabilitation. Employers receiving public money but failing to meet or adhere to the standard should have to repay sums received.

Chapter 2: Lessons from international comparators and successful UK-based employer models to drive OH take-up.

Question 12: Drawing on examples from international comparators, what could be effective in driving employer demand to enable a shift towards higher rates of access?

The extent to which provision of occupational health is provided to UK workers is determined by the decision by the UK on whether to make such provision a legal requirement. The difference in coverage between countries having the obligation enshrined in a single act (Type A) and those where it stretches across health and safety, employment law etc. (Type B) is stark.

In one of the examples quoted, the Netherlands, the duties to consult on health and safety are broadly like the UK, employers in the Netherlands with 50+ employees must have a Works Council, where the number of employees is under 50 employees the employer must consult with their workers individually on health, safety, and sickness absence. In the United Kingdom there are two pieces of regulation placing obligations on employers to consult with workers on matters affecting their health and safety, the Safety Representatives and Safety Committee Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996. The former apply to trade unionised workplaces and, should two union health and safety representatives request their employer set up a health and committee they are required to do so. In our view these statutory committees should provide the forum for all matters relating to occupational health to be discussed and appropriate action taken. This should include, among other things, examination of sickness absence, causes of absence and any developing trends, prevention of occupational ill health, appointment of occupational provider and monitoring their performance. The other regulations make provision for workers in non-trade unionised workplaces, the 1996 regulations are less prescriptive and there is no requirement to set up health and safety committees, they do place a legal obligation on employers, either individually or collectively.

In the last 10 years there has only been one enforcement notice issued under the 1996 regulations, one more than the earlier 1977 regulations covering trade unionised workplaces. Regulations exist to provide for consultation on occupational health, but enforcement is non-existent.

Another issue of concern is workplace ill health is not seen as health and safety matter, but a contractual issue and the focus is on managing absence under draconian capability procedures. Employers should have to ensure the focus is on job retention, vocational rehabilitation, and preventative measures.

In Japan[12] workplaces employing fifty or more employees must appoint a health and safety officer from among their employees, they ate licensed by the Government, in smaller companies a health promoter should be appointed. Both these roles involve taking responsibility for occupational health in the workplace as well as acting as acting as a co-ordinator between employers and occupational health physicians.

In trade unionised workplaces, safety representatives appointed by the trade union, or a shop steward would normally carry out this role. Sadly, this is too often representing members reacting to situations where the harm had already occurred. In these workplaces, where health and safety committees should exist, occupational health should be considered and discussed at every committee meeting.

In non-unionised workplaces, where the employer chooses to consult with employees collectively the responsibility for carrying out a similar function to a health and safety officer in Japan would fall to an "elected" Representative of Employee Safety. Our concern is that employers do not carry out elections, or worse hand pick those to represent the workforce on health and safety matters. We are also concerned that there is only weak protection for such reps if they raise and seek action on contentious issues.

Scottish Hazards believes all workers should have access to non-medical occupational health support from colleagues, either through their trade unions, an independent organisation, or trained colleagues to help facilitate resolutions to cases involving ill health at work.

The United Kingdom should be aspiring to delivering occupational health service models based on the countries listed in Group 2 in International Comparison of Occupational Health Systems and Provisions – A Comparative Case Study Review.[13]

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[13] International Comparison of Occupational Health Systems and Provisions – A Comparative Case Study Review - Search (bing.com) Grouping of national level OH systems by OH service models, Page 116

Occupational health provision in this group of countries is funded jointly by the employer and the state, Scottish Hazards wants more OH provision funded by the state to ensure wider access to services, greater transparency in the service and increased confidence in the workforce that occupational health services is independent and impartial. In Group 2 services can also be delivered through community health centres and the health care system. This would place occupational ill health on the same footing as any other medical condition and the Lothian Health Occupational Health Project and Sheffield Occupational Health Advisory Services were visionary in the approach they took all these years ago, taking occupational health into primary care.

Access to advice and support for those suffering occupational ill-health or any health condition preventing them for returning to, or retaining work, should not be at the behest of the employer. Employers should be allowed to engage their own providers, but workers need access to occupational health advice as part of the NHS commitment to deliver high quality health care to all. This should, and should always have included, occupational health services freely accessible, with no gatekeepers and delivered free at the point delivery, local primary care.

Question 13: What are the possible costs/benefits of legal measures to provide OH?

In November 2023, the HSE published its somebody statistics for Great Britain 2022[14], the estimated the annual cost of work-related injury and new cases of ill health to be £18.8 billion. Of this, £11.2 billion was the estimate of annual costs of ill health in 2019/20. The bulk of this cost falls on the individuals suffering the injury and ill health, then the government and finally the employers.

In our view the £2 billion pounds, while welcome is only scratching the surface of our occupational health crisis.

Scottish Hazards beliefs the major benefit of placing a legal obligation on

[14] Health and safety statistics 2022 (hse.gov.uk)

employers to provide occupational health services would be the only solution to increasing coverage. Offering tax incentives will only encourage employers who want to do the right thing, this will not encourage those who are oblivious to the benefits of healthy and safe work. We would never contemplate a voluntary approach to workplace safety, so we fail to see why this is the case for workplace health.

Making occupational health provision a statutory obligation would ensure consistency across all businesses and workplaces.

We would imagine the cost involved in the legislative route would relate to employers having to fund, to some extent, occupational health provision for their workers. Many studies[15] have looked at the return on investment occupational health with no one indicating any employer is likely to lose money by making such an investment.

In 2019 the Society of Occupational Medicine updated their paper, Occupational Health: the Value Proposition[16]. They point to the three key factors that motivates employers to provide occupational health services: to comply with their legal obligations, it is the right/ethical/ socially responsible thing to do and to reduce costs and add value to the business.

There may well be costs to businesses having to engage occupational health providers, they will be costs they should already be incurring to meet legal obligations under health and safety legislation. However, evidence is there to support investing in occupational is not only the right thing to do for workers, but there will also be economic benefits for the employer.

There will be costs on the UK Government to introduce legislation and enforcement arrangements. The introduction of the Health and Safety at Work Act 1974 as well as the formation of the HSE was because of unacceptably high rates of workplace deaths and severe injury. It is of little doubt that this played a part in driving down deaths and injuries at work. The same cannot be said for ill health and legislation is required to drive down ill-health at work in the same way, this should include the requirement to provide occupational health support.

[15] Price Waterhouse Coopers: Building the Case for Wellness Building the case for wellness (publishing.service.gov.uk)
[16] Occupational_Health_The_Value_Proposition_March_2022_0.pdf (som.org.uk)

Question 14: What lessons could be learned from self-reporting models and Automatic-Enrolment that could be applied to increase access to OH amongst employers? Please include which elements of these examples could be delivered for OH.

Scottish Hazards has never considered automatic enrolment as a method of increasing occupational health coverage. In2021 it was estimated 87% of workers were saving for a workplace pension, up from 55% in 2012. This would suggest automatic enrolment has been successful in relation to increasing coverage of pensions savings, whether it provides an adequate level of pension provision is another matter.

Whether the same level of success could be achieved for occupational health is another matter depending on the baseline level of services decided by the Government. If the baseline is based on the more stringent definition of services mentioned earlier enrolment may be lower, the less stringent may encourage greater coverage.

Scottish Hazards questions if automatic enrolment is required or makes financial sense. New primary legislation would be required as well as a body to monitor compliance, the latter would be an ongoing cost to the taxpayer.

Scottish Hazards suggests we look at existing legislation surrounding health and work and amend existing, or introduce new regulations to achieve the desired effect, healthier and fairer workplaces.

We already have health and safety legislation underpinning employers' obligations to protect the health and safety of their works and we have an enforcement body, the HSE.

Consideration should be given to making an addition to the six pack regulations

- The Management of Health and Safety at Work Regulations
- The Display Screen Equipment Regulations
- The Manual Handling Operations Regulations
- The Personal Protective Equipment at Work Regulations
- The Provision and Use of Work Equipment Regulations
- The Workplace Health, Safety and Welfare Regulations

This could be called the Workplace Occupational Health Regulations. Alongside new provisions within health and safety legislation, new regulations should be considered to make it more difficult for employers to dismiss employees on the grounds of capability. One suggestion would be to adopt the practice in the Netherlands, where employers must fund employment training schemes where it is not possible to find suitable alternative employment within the organisation.

Chapter 3: Developing the work and health workforce capacity, including the expert OH workforce, to build a sustainable model to meet future demand.

Question 15: What more can be done to build the multidisciplinary clinical and non-clinical workforce equipped with the skills needed to deliver occupational health and wider work and health services? Please include any examples of creative solutions.

The United Kingdom Government and those in Scotland and Wales must work together to address this crisis. In Finland they identified the same problems in their country and took measures to rebuild occupational health provision in their country.

In Dame Carol Black's 2008 review of the health of the working age population "Working for a Healthier Tomorrow"[17] she identified the need to develop an ***"integrated approach to working age health requires occupational health to be brought into the mainstream of healthcare provision".***

Sadly, this recommendation was ignored by the Governments at the time as was much and fifteen years later all we appear to have witnessed is more short termism, a few projects by the DWP but no positive action to build capacity to make Dame Carol Black's vision above a reality. It will be sad if, in another 15 years we have an occupational health crisis, potentially even worse than the one we are currently experiencing.

Scottish Hazards believes that, in addition to the Expert Advisory Group mentioned earlier the UK, Scottish and Welsh Governments should form a group to carry out the work witnessed in Finland and create a long-term strategy to rebuild occupational health and its delivery throughout the UK. The starting point would be Dame Carol Black's report.

Dane Carol Black also mentioned the role trade unions have in making our workplaces healthier and safer, and the need for them to be involved more in the health at work agenda. Trade unions have risen to that challenge,

[17] Working for a healthier tomorrow - Dame Carol Black's Review of the health of Britain's working age population (publishing.service.gov.uk)

mainly because of the impact that occupational ill health, particularly mental ill health has had on their members over the last 30 years.

More needs to be done to empower workers to be involved in health at work and to assert their rights to be involved in consultation on all matters impacting on their health and safety. In trade unionised workplaces this is done through the collective agreements in place between the union and the employer.

Scottish Hazards believes more emphasis need to be placed on prevention and the role trade union representatives and other non-clinicians could play in the health and work agenda. Trade unions representatives understand their workplace and the associated health risks as the HR representatives of the employer should. Both groups would be ideally placed to work with occupational health services to prevent and manage ill health at work as work as part of a multi-disciplinary approach and be trained and equipped to do so.

In non-unionised workplaces the workers have rights but are without a voice, they have no access to advice or representation when faced with action being taken against them under sickness absence management policies. Additionally, they have no one to act on their behalf to create the occupational health and safety structures within their workplaces, which would be to the employer's benefit through less absenteeism and presenteeism, increased productivity and healthier and safer workplaces. During COVID Scottish Hazards handled around 450 cases and, at times were astounded by the employer's behaviour especially during the biggest health crisis in living memory. At best this could be described as ignorance of their obligations under health and safety legislation, at worse a disregard of these obligations to exert control of a fearful workforce. In our view this extremely unhealthy culture in these workplaces was not solely caused by the pandemic, COVID only brought it to the surface.

Workers not represented by trade unions need independent advice to ensure their safety and health at work, organisations like ours are rare. If more workers have access to occupational health and, if interventions are to have the best chance of success, then all workers who are not in trade unions need non-medical support t to act on their behalf or to support them to act for themselves

Question 16: What would professionals find helpful to refer into wider work and health or employment support services?

(Please enter your response here)

Question 17: How can we promote OH as an attractive career to encourage a wide range of professionals to join and/or remain in the profession?

In the same way Dame Carol Black advocated occupational health being moved into mainstream healthcare, Scottish Hazards suggest the same applies for training of our future health care professionals.

Occupational medicine does not appear to feature much, if at all when training new doctors either at undergraduate level or in foundation programmes. However, as far back as 2005 it would appear there was limited opportunities to participate in foundation programmes offering specialties "previously less readily available to new senior house officers". East Kent Hospitals NHS Trust and the Kent, Sussex, and Surrey Deanery offered a foundation year 2 programme in occupational health and a review of the placement was featured in the BMJ [18] in May 2005.

In discussions with occupational health professional our understating is that one of the recruitment pools for occupational health physicians is through existing GPs retraining, some may continue to work as GP on part time basis. Scottish Hazards can appreciate how GPs might chose this option, better work balance and less pressure for example, but large scale recruitment from GPs would potentially resolve a severe shortage of occupational health doctors but create a new one in the GP community.

Scottish Hazards is also aware many occupational health nurses fund their own training. This could be for personal development or for the reasons above. Higher education institutions offering nursing degrees should include

[18] A foundation year 2 programme in occupational health | The BMJ

information to students on careers in occupational nursing and financial support to those wishing to pursue them

The United Kingdom Government should coordinate a mapping exercise of all occupational health training available in higher education in England, Scotland, and Wales.

Question 18. What are the optimum touchpoints to promote careers in OH at entry level e.g., studying different disciplines to those who have left the NHS or are considering a career change?

Scottish Hazards as outlined in our previous response believes occupational health training at every level needs to be mapped and steps taken to mainstream occupational health into the curriculum of undergraduate courses in medicine as well as in foundation years. Newly qualified doctors, nurses, physiotherapists, and allied health professionals must be encouraged and supported financially to specialise in occupational health and be part of a sustainable and growing occupational health workforce for the future. This will be the only way we can ensure the problems arising from having an ageing occupational health workforce as we have now is not repeated.

Question 19: What actions or mechanisms (including technology) can be used to ensure that the multidisciplinary OH workforce will be utilised by service providers in an effective way to respond to an increase in demand for quality expert and low intensity work and health support (OH)?

Healthy Working Lives[19] developed online support for employers, specifically aimed at SMEs. This was held up by best practice for many years until COVID necessitated workers being transferred to other areas of Public Health Scotland as part of the COVID response. That said, in 2021/22 434 businesses accessed HWL services[20], of which 262 were SMEs. Online courses were delivered including on alcohol and drugs and stress in the workplace, the latter being the highest performing course delivered on their virtual learning environment. The HWL web pages were accessed 797,693 times, an average of over two thousand times a day, the most hits were on the risk assessment

[19] Home - Healthy Working Lives

[20] Healthy Working Lives Performance executive summary 2021–2022, Healthy Working Lives

web page with 45,801 hits. This is not a surprise to Scottish Hazards as the pandemic taught us there appears to be a lack of understanding on employers' obligations to carry out suitable and sufficient risk assessments, or how to go about it.

Our understanding is work is being undertaken to redesign the website, although we believe it still offers valuable occupational health support to businesses. We are concerned, though, that there seems no plan to reinstitute phoneline and workplace based face to face advice and support.

Question 20: How do we encourage and support small and medium sized OH providers to adopt a multidisciplinary approach? What are the key enablers and what opportunities are there to incentivise collaboration within the sector?

Public sector procurement should offer an opportunity to ensure small and medium size occupational health service providers access public sector occupational health contracts and through this adopt a multi-disciplinary approach to provision. Although not around occupational health provision we have experience in one major public sector facilities management contract. Two large companies secured a public works contract of significant value. In their bid they proposed 85% of the work would be contracted out to small and medium size contractors, seen as an example of best practice in Scottish public procurement. The principal contractors may not have had the capacity to deliver a contract of this size using only directly employed labour. This results in the principal contractors losing control over the way work is carried out, including whether it is done in a safe and healthy manner.

Scottish Hazards would see collaboration of smaller occupational health providers as the only way they could compete with the large corporate, free market economy providers and hope to win public sector occupational health contracts. Scottish Hazards would not support any model for delivery of occupational health services involving the corporate providers employing small and medium occupational health companies to service large public sector contracts, doing little of the delivery but taking a fee for acting as a clearing house for occupational health services.

Local collaboration of SME occupational health providers may also provide a cost effective model for local delivery of services in the short term. Scottish Hazards is realistic enough to recognise there will continue to be a reliance

on private sector occupational health provision moving forward but we would want to see provision give its place in mainstream ha

Question 21: As part of the move to a more multidisciplinary workforce to deliver work and health conversations, should we consider further extension of the professionals who can sign fit notes?

And if yes, which professionals should we consider?

Scottish Hazards would not support any additions to the group of health professionals allowed to certify fit notes. We do not have positive experiences of current use of fit notes particularly around the circumstances under which a person may be fit for work or adaptations an employer may consider to facilitate a return to work. This is not a criticism of GPs, most of whom do not have any specialism in occupational health, do not understand the nature of the patients work or any internal issues in the workplace that may have an impact on their patients' health. GPs need a referral route into specialised occupational health services to obtain advice on adaptations and reasonable adjustments that are likely to result in the patient being able to have a sustainable return to work.

Question 22*:* What further action can the Government take to support multidisciplinary teams to deliver work and health conversations in other settings (for example NHS or community settings), to improve health outcomes and address health inequalities?

Occupational health services should be based in communities, in many locations communities are served by co-located GP practiced in health centres with access to services such as community physiotherapy. This kind of delivery of health services would lend itself to having, at least, some occupational health service provision. This could be a shared occupational health nurse or other occupational health support such as the services provided by the Sheffield Occupational Health Advisory Service.