The Future of the Occupational Health Workforce:

Supporting occupational health and wellbeing professionals

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This review was conducted by information gathering from individual discussions with relevant professionals and a multidisciplinary roundtable discussion organised by the Society of Occupational Medicine. Thanks for contributions to:

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Summary

Increasing Occupational Health (OH) professionals across the multidisciplinary workforce is necessary to meet the demand of providing OH services to all those who work.

This requires:

- **An overarching strategy to sustain and develop the OH workforce** with clear **leadership** to bring together the various professions to collaborate and develop initiatives such as new models of care to provide innovative ways of working together to meet growing demand
- **Funding to expand training to front load adequate numbers into the profession** and subsequently once they graduate from their undergraduate studies to acquire further relevant skills.
- **Incorporating OH into undergraduate course curriculums**
- **Clarity required regarding which professions OH encompasses** and ensuring the breadth of skills these professionals can contribute is valued to strengthen multidisciplinary team (MDT) working
- **Formalising pathways and accreditation in postgraduate courses** – to standardise the multidisciplinary workforce and clarify their roles and experiences.
- **Strengthened NHS commitment to OH** and clarity around how the government will assist businesses in meeting their vision of OH for all will be required.
- **Collection of OH workforce data** to formulate evidence based strategies on how to provide OH to all those who work.

Introduction

There is increasing awareness around work and how it contributes to our health. Waddell and Burton's independent review, commissioned by the Department of Work and Pensions, on work and health found a clear correlation between positive physical and mental health and work, and the association between worklessness and negative physical and mental health and wellbeing[1]. As well as personal benefits to the individual in work there are wider benefits to the economy and business growth and development in the UK of keeping employment rates high. In addition, there are cost savings to the NHS with an average reduction of 33% in GP consultations and medical service use when individuals move from unemployed to employed[2].

The *Taylor Review of Modern Working Practices* emphasised the need of high-quality jobs to ensure participation and engagement, with the term quality being subjective to each worker but broadly including factors such as wages, work life balance and working conditions[3]. To achieve and sustain quality of employment and workplaces that effectively manage employees' physical and mental health to retain them, employers need to have access to OH services.

The scope of impact of well-structured OH services is significant when we consider that 30.7 million working days were lost in 2017/18 due to work related ill health and non-fatal workplace injuries and the £9.7 billion annual cost in 2016/17 of new cases of work related ill health (not including long latency conditions such as cancer)[5]. Statistics such as these combined with the momentum behind the wellbeing agenda and its link to quality work, strengthen the need for a robust OH workforce.

OH's remit includes assessing fitness for work, workplace-based adjustment recommendations, promoting preventative health issues, providing or directing to specific treatments and health surveillance for certain environments exposed to specific hazards. An additional important branch of OH services is advising employers of what good OH is and how they can work in partnership to improve the overall health and wellbeing of their organisation. These skills and services are provided by a multidisciplinary profession comprised of a wide and varied workforce encompassing doctors, nurses, physiotherapists, occupational therapists, psychologists, occupational hygienists, ergonomists and those in human factors, vocational rehabilitation/case management workers and technicians. This list is not exhaustive and many allied health professionals will have to consider their client's or patient's work when formulating treatment and advisory plans.

The government's recent consultation *Health is everyone's business: Proposals to reduce ill health related job loss* calls for the extension of provision of good quality OH services for all those who work. There is currently varied provision of OH, for example a survey of just under 2400 representative employees in Great Britain commissioned by the Department for Work and Pensions showed those in small organisations of 1-50 employees having 21% OH access, whilst this rises to 65% for those working in organisations of 250 or more staff[6]. A key theme is ensuring employers take responsibility for the health and wellbeing of their staff, whilst acknowledging the variability in resources particularly for small and medium sized businesses. A suggestion in the consultation is for the government to subsidise the purchase of OH services in some way for employers, and whether and how this comes to fruition will be interesting in terms of impact it could create for accessing OH. As well as these supportive measures further consultation recommendations include strengthening the legal requirements on employers to ensure they support their staff adequately, for example through a right to request workplace adaptions not already covered by the current duty (Equality Act, 2010[7]).

The consultation also highlights the urgency of needing an OH workforce to assist in delivering these proposals, in a climate where the Faculty of Occupational Medicine (FOM) has described the recruitment and current numbers of doctors in OH in "crisis"[8]. This is supported by research showing 44% of providers of OH services struggle to fill their nurse and doctor vacancies[9]. The issue of the OH workforce seemingly declining in the landscape of government proposals to ultimately recruit and keep those of working age in work to ensure their good physical and mental health, and business and nationwide prosperity, poses a stark contradiction.

During the summer of 2019 on behalf of the SOM I spoke with or had written communication via email with several stakeholders. This was followed by a roundtable discussion with representation from the various relevant professions. This has allowed me to collate opinions from the various professional groups within OH on workforce issues and assist in reaching some broad conclusions on the workforce crisis.

Physicians

In 2018, a GMC report showed 571 specialists at consultant level working in the UK[10.] Within OH there are generally three types of physicians. Those who:

- Are Members of the Faculty of Occupational Medicine (MFOM) or Fellows of the Faculty of Occupational Medicine (FFOM) by having undergone speciality training and are Consultant grade (or working towards it).
- Are Associates of the Faculty of Occupational Medicine (AFOM) who have taken further training and examination to extend their scope of competency beyond the Diploma in Occupational Medicine (DOccMED) level.
- Hold the DOccMED who are registered medical practitioners often in another field such as General Practice.

In 2002 there were a total of 216 speciality training registrar (StR) posts available, 79 in the NHS and 137 within industry[11]. A trend of under-recruitment to StR posts then continued for some years with only 26 new StRs appointed in 2007[12] and only 14 in 2009 and 2010[13]. In 2016 the Faculty of Occupational Medicine's *Annual Report and Accounts* described training numbers as static and there being over subscription to StR posts - in the context of drastically less NHS training posts available and very few industry offered posts. The 2018 round of recruitment had 26 applicants for 11 posts in the UK[14].

Dr Anne De Bono, Occupational Medicine Consultant and President of the FOM, explained that the current number of speciality trainees is inadequate to meet future demand for OH Consultants. There are many factors for this including the ageing Consultant workforce[8], the lack of provision of training in the private sector and current commissioning models for OH services. Dr De Bono also touched on the underutilisation of GPs with the DOccMED and the potential of formalising the roles for those with an interest in OH to become GPs with an extended role (GPwER).

Dr Ali Hashtroudi, Occupational Medicine Consultant and Head of the National School of Occupational Health (NSOH), also spoke of DOccMED holders having the potential to contribute significantly to the OH workforce and the development of alternative models of care across the MDT being the likely way the profession will evolve and match demand. On discussion of numbers of StR training posts, Dr Hashtroudi expressed the main concern being the lack of training opportunities, particularly since the industry posts had been cut down but the roles being oversubscribed had benefits in that it retains the quality of those entering the profession. Dr Hashtroudi echoed the difficulties of predicting whether current training numbers for future Consultants would suffice, given demand for OH services. Dr Hashtroudi also discussed the greater emphasis OH required in the undergraduate medical school curriculum to raise awareness of work and health issues.

Dr Rob Hampton is a GP, Occupational Physician (DOccMED), Public Health England (PHE) Health and Work Clinical Champion and founder of the SOM's GP Specialist Interest Group (GPSIG). Dr Hampton spoke of the difficulty in tracking the number of GPs who have completed the DOccMED, and their current use of the training in practice. He also discussed the value of accrediting GP roles in OH to create GPwER, like the GPwER in Dermatology[15] who benefit from mentorship, competency maintenance and recognition via their appraisals, whilst expertise can be standardised. Dr Hampton discussed alternative care models involving OH multidisciplinary integration to deliver comprehensive assessment. He also recommended GPwERs working more on a population level rather than seeing individual cases, requiring less of them. This would provide a service whereby other GPs could contact the GPwER for advice on OH issues. The GPwERs would work with a team of social prescribers, physiotherapists, counsellors, case managers etc. This working at scale model

could be part of the solution to the proposals of widespread extension of OH services in *Health is everyone's business: Proposals to reduce ill health related job loss,* again it would need commitment from NHS commissioning to fund OH for the public.

Nurses

The training pathway for nurses in OH is less clear than physicians. Professor Anne Harris, President Elect of the SOM and former Course Director of Occupational Health Nursing at London South Bank University, explained that some nurses working in OH are registered with the Nursing and Midwifery Council (NMC) as Specialist Community Public Health Nurses [SCPHN(OH)], others have taken non NMC approved diplomas/undergraduate/postgraduate courses and others have no OH qualifications. Professor Harris expressed that the biggest challenges to development of the OH nurse workforce were insufficient institutions offering OH nursing courses and a lack of understanding about what the speciality encompasses, largely due to the absence of work as a health outcome in pre-registration nursing training.

Ms Christina Butterworth, Chief Operating Officer of the Faculty of Occupational Health Nursing, echoed this sentiment of the lack of OH in the curriculum for pre-registration nurses. According to the Council for Work and Health, in 2015 there were 3200 accredited occupational health nurses[16]. Ms Butterworth provided the figure of there being over 6000 nurses who have indicated to the Nursing and Midwifery Council that they work/have worked in OH in the last three years. This shows that there are likely to be approximately over 2500 nurses without specialist OH nurse training and therefore there is a need to ensure that they are working to evidence based practice and on a programme of professional development that meets the needs of the UK workforce. Ms Butterworth mentioned the unknown of the specifics of how the future OH workforce will be constructed making postulating on adequate numbers of OH nurses challenging, she also highlighted the issue of the impending retirement of many OH nurses in the next 5 years and the gap in mentoring future generations this would leave.

Physiotherapists

Mr Miles Atkinson, Occupational Health Physiotherapist and Head of MSK Corporate Services at Vita Health Group, discussed the lack of a formal accredited training pathway for physiotherapists in OH. Registered membership of the special interest group, the Association of Occupational Health Physiotherapists in Occupational Health and Ergonomics (ACPOHE) is the closest to formal training available. Registered members will either be qualified to master's level in a relevant OH discipline or show evidence of competency achievement, set by ACPOHE, via course work and assessment. Mr Atkinson provided figures of approximately 60,000 physiotherapists in practice in the UK and of these roughly 350 are members of ACPOHE, with 70 being registered members.

Mr Atkinson spoke of challenges in physiotherapy of numbers matching future OH demand including the lack of undergraduate places, the sparsity of OH on the undergraduate curriculum and many physiotherapists not practicing for their full career, opting to pursue management roles or alternatives as there is little opportunity for career progression. In terms of the future workforce an additional substantial consideration is the requirements of the NHS going forward, and the need for this to be explicit to plan. For example, the introduction of First Contact Practitioners (FCP) working in NHS primary care would have the potential to create a significant impact on the physiotherapy OH caseload, further clarity regarding numbers required around the country is needed however as it is currently in the pilot stage. *The NHS Long Term Plan* commits to increasing the number of physiotherapists in primary care via FCPs[17], however the need for frontloading the profession with more undergraduate places would need to be addressed for this to be practically achieved.

The drive behind the introduction of the FCP, is to ensure patients see the correct professional in a primary care environment and within an appropriate time scale[18]. The Chartered Society of Physiotherapy (CSP) estimates that physiotherapists working as FCPs could see half of

MSK presentations in primary care[18]. Mr Atkinson discussed the greatest future physiotherapy OH contribution within the NHS coming from FCPs and how the curriculum for FCPs was currently being developed to ensure it included the relevant competencies. He also talked of the specific advantage the FCPs will bring in being able to make workplace recommendations for MSK conditions and the potential of them providing some form of report for employers following the consultation to avoid then seeing the GP for a fit note, this has massive implications for GP workload. Mr Atkinson also mentioned models of providing care and how OH physiotherapy could be delivered at scale with the increase in FCP numbers dealing with the bulk of the workload keeping requirements for specialised OH accredited physiotherapists seeing referrals of a more complex nature at a more manageable figure.

Psychologists

Dr Roxane Gervais, Occupational Psychologist, described the significant challenge within Occupational Psychology being the lack of understanding employers have over the individuals working within this field. Whilst the term "Occupational Psychologist" is protected, meaning a robust evidence-based psychology degree would have been achieved before relevant postgraduate qualifications, anyone can market themselves as an Organisational or Business Psychologist by attending the relevant course without any prior psychology degree. This makes collating figures on those working in this area problematic. The 2015 figures for practitioner psychologists with accreditation in occupational health was 300 according to the Council for Work and Health[16].

An unpublished survey conducted by the Division of Occupational Psychology has shown that the bulk of those practicing are in the private sector. Dr Gervais spoke of the very few occupational psychologists employed in the NHS and the perceived difficulties of the NHS seeing the true value of occupational psychology from an organisational, motivational and wellbeing perspective. The current lack of occupational psychologist presence in the NHS, and no apparent commitment to increase numbers leaves the future workforce question in limbo.

Occupational Therapists

Ms Genevieve Smyth, Professional Advisor at the Royal College of Occupational Therapists, provided the information of there being 34,799 Occupational Therapists in the UK registered with the Health and Care Professions Council (HCPC), and approximately 200 of these specialising in OH according to 2016 figures from the Council for Work and Health. However, Ms Smyth explained all occupational therapists can offer interventions to working age adults and keeping them in work or rehabilitating them back is an important focus.

Ms Smyth described the challenge to the future workforce being more professionals needed within it, evidenced in the Migration Advisory Committee advising that occupational therapy should be added to the Immigration Shortage Occupation List. Further difficulties exist in accessing suitable postgraduate training in OH such as ergonomics, case management and vocational rehabilitation, with only four out of thirty-two higher education institutes training occupational therapists offering these courses.

Vocational Rehabilitation

Ms Deborah Edwards, Chair of the Vocational Rehabilitation Association (VRA), described the role of those working in vocational rehabilitation or case management as identifying those individuals with a physical or psychological problem preventing them from accessing or recommencing work, and trying to make them as functional as possible. It involves a holistic approach to view the person as a whole and attracts a broad range of individuals wishing to practice it, or elements of it in their scope of work, such as physiotherapists, occupational therapists, nurses, ergonomists, NHS managers and those within human resources.

Ms Edwards detailed the value of those in vocational rehabilitation to OH by explaining a current project she was involved in. The Link Service, a pilot vocational rehabilitation service integrated into primary care, funded by the Work and Health Unit's (WHU) Challenge Fund, is running in three GP surgeries in Newcastle and five in Leicester. Through the integration of allied health professionals and vocational rehabilitation it hopes to provide better support to patients with mental health and musculoskeletal problems and rehabilitate them back to work successfully by communicating with employers over adjustments and return to work plans. This project also intends to support the fit note service provided by GPs, adding the dimension of vocational rehabilitation necessary for successful rehabilitation back to work. The pilot will run for a year and so far, has received 150 referrals, the outcomes are eagerly awaited.

In terms of future workforce planning, Ms Edwards mentioned there had been some senior managerial interest from the NHS, but this would need to grow and become cohesive with an understanding of vocational rehabilitation's place in any future models of OH care before numbers can be predicted.

Occupational Hygienists

Mr Simon Festing, Chief Executive Officer of the British Occupational Hygiene Society (BOHS), explained the nature of occupational hygiene being a multifaceted discipline with some working full time and others incorporating it into their scope of work, for example those in health and safety. Occupational hygiene involves preventative advice on exposure and controlling substances that may be hazardous to employees at work and therefore those assessing, surveying and advising in OH may all be including elements of occupational hygiene in their work. Therefore, numbers spanning the spectrum in this field are difficult to pinpoint, Mr Festing provided the figure of 1000 members of BOHS who are working full time in occupational hygiene. The 2015 figures for those with occupational health accreditation working in occupational hygiene was 152[16].

Workforce planning for occupational hygiene faces challenges in that there is no clear pathway for the career and no accreditation, so anyone can title themselves an occupational hygienist. BOHS do provide education and training modules, and certain scientific undergraduate courses may offer occupational hygiene as a module option within their degrees. Mr Festing described how the workforce is very much demand led by industry and it tends to be the smaller businesses, such as independent motor garages who are perhaps not compliant with regulations as exposure led illnesses are still occurring, for example work related respiratory problems, emphasising the place for occupational hygiene. Mr Festing also explained the need for closer communication with other members of the OH workforce, such as physicians, to refer to occupational hygienists and involve them when needed, this would strengthen their place in the workforce and future demand.

Ergonomists/Human Factors Professionals

Mr Stephen Barraclough, Chief Executive Officer for the Chartered Institute of Ergonomics and Human Factors (CIEHF), provided the figures of the Institute having 1800 members, 800 being qualified and 400 chartered, with the remaining 1000 being in education or interested in the field. The number of those practising ergonomics is relatively small and these are spread out amongst the various sectors within the field including the workplace, energy, healthcare, transport, manufacturing and defence.

Those ergonomists working within the workplace are either employed directly within businesses including NHS OH departments, or deliver work as self-employed consultants. Only 1 ergonomist is believed to be currently employed in the NHS on a full-time titled basis (many do operate on a consultancy basis in less than fulltime roles), compared to an example of over 20 fulltime roles in the national air traffic control service.

Mr Barraclough noted there was currently significant competition from other sectors for human factors skills and in a limited supply market this would limit the number of qualified human factors people locating within OH roles. More recognition is required for the field in general and CIEHF is committed to raising the visibility of the profession. Mr Barraclough discussed that whilst the Institute was keen to raise the profile of ergonomists working within OH specifically, this sector will be competing for resources with the other sectors described above.

Policy Makers

The Work and Health Unit (WHU) is a cross government unit sponsored by the Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC). The WHU's *Improving Lives: the future of work, health and disability* paper describes how government will generate change in the workplace, health service and welfare system to see one million more disabled people in work by 2027[19]. Part of this paper describes the need to extend OH services to include everyone, including the self-employed and those in small businesses.

Conclusion

There is a need for a cohesive strategy of working across the OH professions. Several common themes came out in discussions:

- **Limited funding and resources** - predominantly in the context of the need to expand undergraduate, postgraduate, specialty and training places. Issues vary from lack of places to the effect of removing NHS bursaries from undergraduate courses including occupational therapy, physiotherapy and nursing.
- **Ensuring OH is represented in undergraduate curriculums** to raise awareness of the field.
- Once qualified from an undergraduate degree, all fields, bar the physicians, do not have a **clear pathway for postgraduate training in OH**, with a range of people with a variety of training practicing in OH areas. This makes tracking the numbers and demand difficult and poses additional complications for employers of these individuals who may not understand the differences between the breadth of backgrounds and experience they have.
- **Formal accreditation** would ensure standards are maintained and a minimum set of competencies achieved (the NSOH are working on a strategic plan to improve quality of training for the multidisciplinary OH workforce, which will fill an unmet need highlighted in the discussions).
- There has been **a reduction of speciality training numbers in Occupational Medicine** over time, in contrast to funding committed to increasing recruitment in general practice, psychiatry and emergency care[20] which is much needed, but accommodating the needs of the ageing population also includes keeping them in work. Retaining employment as people age is not only advantageous to their health, but also necessary for their economic security as state pension age rises, an issue that needs to be addressed with robust OH services.
- **Clarity required regarding which professions OH encompasses –** roundtable discussion highlighted the issue of how some professions feel they are not considered within the OH remit by employers, and hence their role within OH is poorly understood. Certain professions also mentioned the lack of emphasis on preventative approaches to workplace health as a barrier to their services being utilised effectively, such as occupational psychologists and occupational hygienists.
- **Acknowledging the value that the variety of OH disciplines contributes** was mentioned by many such as the occupational hygienists, ergonomists, psychologists and those in vocational rehabilitation. Unless these professions are understood and given their due merit the opportunity to integrate them into the OH workforce will be missed, at a time

when there is clear evidence of the benefits of keeping people in work for their physical and mental wellbeing. Expected data from projects such as The Link and the FCP pilots will be key in providing the evidence base needed to demonstrate the benefits of multidisciplinary working in OH and the positive outcomes these provide for rehabilitating people back to work, with additional benefits of employers receiving specific advice rather than just a fit note.

- Suggestions of **alternative care models using a multi-disciplinary workforce to** work at scale to meet the demands of a growing and ageing population. The expected positive outcomes of The Link and FCP projects will add further strength to this suggestion, made by many of the professions. The concept of requiring less specialised individuals at the top layer of any model could assist the delivery of OH at scale, dependent on having enough professionals with the appropriate training in the layers below. The roundtable discussion emphasized the need for a clear vision of how an effective model would be structured and to learn from other successful similar extrapolatable models.
- Additional **innovative approaches to working** such as digital health apps and telephone/video consulting could be researched as having potential to further assist in covering OH provision to all workers.
- **Robust leadership** will be necessary to bring together the variety of professions and optimise the benefit that can be drawn from the breadth of skills available. Whilst the NSOH is responsible for leading the strategy for postgraduate training there does not appear to be a clear body responsible for leadership of those working in OH. One of the proposals mentioned in *Health is everyone's business: Proposals to reduce ill health related job loss* is the formation of a collaborative leadership post to work amongst MDTs and experts to generate an OH workforce strategy. From our roundtable discussion this would appear vital and would need to include ongoing leadership to guide and maintain the OH MDT.
- The ability to accurately postulate on numbers needed in the profession for future needs is hampered by the lack of data on current staff. As the bulk of OH services operate within the private sector numbers are challenging to track and there is no formal reporting service, such as the National Minimum Data Set for Social Care (NMDS-SC). The NMDS-SC collects information such as staff numbers, movement, vacancies and salaries, allowing planning in this sector based on current data[4]. Our roundtable discussion stressed the need for **data collection** to be clear on what numbers the OH workforce does actually require.
- Our roundtable discussions established that data collection will allow for more **evidence based predictions of the OH workforce** leading to the ability to formulate an appropriate **economic argument** and **cost effective solutions** based on conclusions. There was also acknowledgement that many health sectors have faced or are in a workforce crisis and learning from the approaches they have taken to mitigate this would be of great value.
- The **NHS's commitment to providing a public OH service still appears to be lacking** despite an ageing population, the cost benefits to the NHS[2] it would provide and the wider benefit to the country's economy. Furthermore, despite the NHS's stance on the importance of their own staff's wellbeing[21] there has been lack of evidence of funding provided for this, particularly in primary care where there is no NHS OH provision.
- **Support for small and medium sized businesses in particular**, to provide OH is required. Going forward, following *Health is everyone's business: Proposals to reduce ill health related job loss*, it should be clearer if or how government may subsidise businesses.

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