Response by the British Occupational Hygiene Society to the Public Consultation
Occupational Health: Working Better.

I am responding as or on behalf of:	
Employee	N
Manager	N
Employer	N
Organisation / Company	Y
Your sector[1] (Please type)	Occupational health and Hygiene
Size of your company/organisation[2] *(Large -250+ staff, medium (50-249 employees) or small/micro (0-49)* (Please type)	BOHS represents all of the qualified professional occupational hygienists in the UK, including 1,500 members
Which region(s) do you operate in – (London, South West, South East, North West, North East) (Please type)	All (UK wide)
Your Employment type	
Self employed	N
Public sector	N
Private sector	N
Voluntary Sector	N
Professional membership organisation	Y
Health sector only	
Your sector (public or commercial) (Please type)	
Occupational Health Professional	Y
Occupational Health Profession (Please type)	Occupational Health and Hygiene
Occupational health professional body (Please type)	British Occupational Hygiene Society
Other (please state)	

The British Occupational Hygiene Society (BOHS) is a science-based, charitable body that provides information, expertise and guidance in the recognition, control and management of workplace health risks. www.bohs.org

[1] As a guide, you may want to state which section under SIC codes your firm operates in eg construction Nature of business: Standard Industrial Classification (SIC) codes (companieshouse.gov.uk)`

[2] Business population estimates for the UK and regions 2022: statistical release (HTML) - GOV.UK (www.gov.uk)

It is the Royal Chartered Society for the protection of people from workplace health risks and home of the professional body for Occupational Hygienists.

For 70 years it has been the expert voice guiding the management of health exposures in the workplace.

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?

1.1 Over the last 50 years, the UK has almost entirely lost any clear reference to baseline standards in relation to the nature of occupational health. International definitions by the ILO and WHO define occupational health as the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations.

This is an approach based on the objectives and outcomes of an effective occupational health system. Prevention is at the heart of the international approach, which aims towards the sustainability of the workforce, the workplace and the health and economic infrastructure of a country.

1.2 In contrast, the definition in the UK is of occupational health as a specialist branch of medicine that focuses on finding out what impact work has on staff health and make sure that staff are fit to undertake the role they are employed to do both physically and emotionally, or otherwise judging the exclusion of staff from the workplace.

This is an input-driven approach which is medicalised and focuses on diagnosis and treatment of the problems caused by the workplace or impacting the workplace. This model is based around the provision of a service which may impact the sustainability of the workplace, but which does not directly influence the workplace factors that drive ill-health and demand on the NHS.

1.3 The BOHS assert that the baseline of occupational standards should be taken from the ILO Convention on Occupational Safety and Health, 1981 (No.155) and associated specific standards (see response to question 6). When the Convention was adopted by the ILO, the UK had a fundamentally different employment model and infrastructure for occupational health. When a review was undertaken in the late 2000's it was concluded that Convention was incompatible with the UK's membership of the EU.

1.4 The UK's current baseline and approach was instead set as a result of the Science and Technology Committee on Occupational Health and Hygiene Services and of the Government's Response (2nd and 5th Reports, H.L. 99 and H.L. 289). This approach was developed in the context of the UK still being a traditional industrial economy, with the public sector a major employer. The infrastructure of a National Occupational Hygiene Service (focusing on the prevention) was still present, and it was assumed that occupational health providers (largely those employed within industries) would focus both on prevention, as well as medical services.

1.5 Over subsequent decades, the shape of employment has changed beyond recognition. Europe has not influenced how occupational health (in the ILO/WHO sense) is delivered and assured because of the radically different models of provision of health services and employment support across the Continent.

1.6 As a result, despite the quality and commitment of those at the core of the occupational health profession, occupational health provision has withered. What was observed by Lord Gregson as a finding of the 1984 Parliamentary Committee Report, could hardly be said now:

> "…it soon became apparent that on the whole this country is well served by its occupational health and hygiene services, but this tends to be more so relative to the majority of the large organisations, be it in industry, the manufacturing

sector, the services, Government and other bodies."

This is manifestly not the case. Relatively few UK workplaces have in-house occupational health support, with fewer than a dozen with occupational hygiene specialists. The number of providers of occupational health services has dwindled and there are only a few hundred independent occupational hygiene specialists.

1.7 What continues to be true is the following observation by Lord Gregson:

> "Considering that the working population spend approximately one-third of their waking hours in their place of work, it must be recognised that occupational medicine is a substantial part of primary health care. It would be easy and logical to suggest that primary health care should be provided by a National Health Service that would cover all activities all the time in a person's lifetime. This may well be a future ideal, but one must look at the practical reality of what is possible, and *the committee recognise that the occupational health service has developed as a separate, wholly private activity quite distinct from the National Health Service, financed by the employer*, and we explain in the report the many reasons for recognising this and building upon it. Nevertheless, occupational health is part of primary health and it should not remain uncovered or totally avoided."

1.8 The narrowing of the definition of occupational health in the UK is a result of the impact of social and economic change. The employment market has moved away from largescale homogenous workforces, facing common health risks and the influence of former public sector employment practices. There remains within the Occupational Health profession a vestige of this experience and value-set. However, the employment market has been affected by de-industrialisation, the rise of SMEs, the end of union influence, the impact of economic recession and the removal of a University research and training infrastructure focused on workplace health.

1.9 While today's occupational health specialists are no less committed to the health of individuals, they do not operate within a national policy framework which sees health in the context of a third of person's life. Occupational health (even in the narrow UK sense) training is marginalised for health workers and occupational hygiene training (in the sense of a focus on prevention of ill-health in the workplace) is by and large absent from public health and medical education. OH education is narrow, inadequate and possibly lacking effectiveness in providing the minimum skills level needed to safeguard the health of workers.

1.10 BOHS has had the opportunity to see several of the submissions being made to this consultation by Occupational Health professional and national bodies. While we are wholly supportive of their genuine aspiration to move the UK forward to a better place in occupational health provision, we consider their starting point to be one which is an overly-narrow view of occupational health when contrasted with the ILO minimum standards. This is inevitably the result of leaving occupational health to be a driven by a market which is only willing to pay for what it absolutely needs to avoid jeopardy in Employment Tribunals or falling foul of the Health and Safety Executive.

1.11 The occupational health industry will assert that its professional experience and forest of fragmented professional and trade bodies can set the baseline standards for occupational health in the UK. The sum of these professional bodies includes deeply impressive individuals and forces for good and great change. However, BOHS do not believe they can achieve this on their own.

1.12 The state of occupational health standards that we observe falls short in every way of

the minimum occupational health aspirations which the country needs and deserves if it is not going to see an ever-increasing level of workplace ill-health and economic inactivity.

a) In determining the basic clinical evidence baseline, we see a fundamental deficit. The scientific and research base to inform occupational health practice is threadbare, with no significant University or independent research underpinning practice, epidemiology and outcomes. For example, it has been acknowledged by both the Health and Safety Executive and the Industrial Injuries Advisory Committee that there is an absence of evidence of how women are impacted by workplace health risk, despite women having the largest share of workplace ill-health. The occupational health industry has done next to nothing to fund or promote the development understanding of their own basic clinical baseline, with notable exceptions, such as the Institute of Occupational Medicine and Society of Occupational Medicine. It is inconceivable that any modern healthcare standard can be founded on such an absence of clinical, epidemiological or associated evidence.

b) In professional and training standards, the leading voice for Occupational Health Nursing standards, the Faculty of Occupational Health Nurses operates on a shoestring with less than 100 of the thousands of practitioners members and without recognition by the Nursing and Midwifery Council of their status as distinctive professional practitioners (despite their valiant efforts). The fact that for the majority of those delivering occupational health services, they are not recognised as a specialism by the regulator, or that Occupational Health professional standards for the context of their practice are not front and centre, speaks volumes about how occupational healthcare standards have been sidelined from primary care.

c) Training and education of Occupational Health Medics is a sideline, with occupational medicine excluded from the core medical curriculum, thereby leaving medical students in ignorance of where the major part of adult health exposures happen. Occupational Medical Education is an optional, niche bolt-on, considered with distain by many in the medical field and pursued by relatively few, motivated individuals. The quality of provision is potentially problematic, with significant issues in delivery in the area of health risk management highlighted in late 2022. Occupational medicine standards need to be embedded in mainstream medical education to provide a robust platform for specialist provision to be built upon.

d) It is unfortunate that the Society of Occupational Medicine and the Faculty of Occupational Medicine operate separately and distinctly, as does the Faculty of Occupational Health Nursing and the Institute of Occupational Health. The absence of interprofessional connectedness between practice, education and standards and between the medical provision of occupational health and the healthcare practitioners who deliver it is indicative of a challenge in connecting standards to practice so that they inform and support each other. This is a function of context, not a reflection of the exceptional people who lead and support these organisations. This does not provide a coherent platform for consistent and simple standard-setting or a baseline for evidence for standards.

e) There is a disciplinary distinction that has arisen between occupational hygiene (as dealing with the control of exposures and the prevention of ill-health) and occupational health provision, addressing itself to individual health and management of health in the workplace. This is fundamentally problematic, even though it has been necessary to ensure the survival of occupational

hygiene knowledge, education and standards. Without linking what is going on in the working environment with health outcomes for individuals, UK occupational health provision will be focused on treating the problem, not addressing the route cause of most workplace ill-health. The absence of clear and credible reference to prevention and occupational hygiene in the SEQOSH standards, to BOHS is a serious and fundamental shortfall.

f) Service delivery in the occupational health sector is suffering heavily from economic pressures and resulting in behaviours which are detrimental to economic well-being and to human health. The selling of blanket health surveillance services, more frequently delivered remotely by providers who have not been on site is reported as a concern by employers and the Health and Safety Executive. Tick-box occupational health, designed to sign off compliance with minimum employment law requirements has developed as a feature of the industry. High quality providers, with interprofessional services are trying to establish a business case in the market, but cannot compete with low standard providers in certain segments of the employment market. We fear that unless carefully designed the proposed national standard will exacerbate and reinforce this trend.

1.13 BOHS believes strongly in the value and qualities of the occupational health professions in the UK. We work daily with professional and sector organisations which contribute significantly to the health of the nation. Much of the work is driven by phenomenal voluntary contributions of time, effort and funds.

However, an objectively established baseline is required:

1) The ILO Convention provides inspiration, if not the blueprint for what our definition of Occupational Health should be in the UK. If we are to maintain world-leading standards in the field, as it is claimed we are committed to, then we must align with what WHO and ILO state are the basic principles of occupational health. The country is legally committed to committed to promoting these standards, but we need to more clearly articulate them and ensure professional are aligned with a clear national legal expectation in terms of health outcomes. Without this clarity, occupational health outcomes will be defined by market needs and professional aspirations, sidelining them from the national health agenda.
2) National standards that articulate to the general medical and healthcare educational strategy (including the strategy for public health) are required. The Faculties and the National School for Occupational Health cannot be add-ons or sidelines of health education. Given the growing number of people getting ill at work and the direct impact of work on health, it cannot be excluded from medical and healthcare education. Having the OH professions doing this for themselves is not going to impact the generality of healthcare and medical practitioners who need to have sufficient expertise to address the impact of occupational health on general health.
3) Employers need to know what they should expect when procuring occupational health services, both in terms of discharging their duty of care to employees and avoiding civil liability, but also in terms of achieving value and sustainable support. Occupational hygiene is supported by an HSE-endorsed Buyer's Guide and will shortly be underpinned by a Register of Occupational Hygiene Professionals, regulated under statute by the Professional Standards Authority for Health and Social Care. Procurers of Occupational Health and of Wellbeing Services need similar protection and support, especially when fiscal support is underpinning their procurement. Otherwise, not only will the objectives be undermined, but there is a serious danger of waste of public funding.
4) In the years since the Health and Safety at Work Act, we have moved away from a paternalist model of health protection and a unionised view of worker voice.

Individuals have a right to know and understand the things that impact on their health. Vague Health and Safety policies with obscure processes of occupational health surveillance do not empower workers to help protect their health. Employees need to understand clearly and directly the things within the workplace that are going to make them ill or make them economically vulnerable through ill-health. They need to know how the protections provided will mitigate these effects and what protection and support is present to directly address this. However, in the UK this is not how we tackle workplace health. We keep the employee in the dark. This is out of step with the modern world and removes the major driver for better individual health – that is personal choice, information and responsibility. We need to move away from Health and Safety being something done for and to a worker and occupational health and hygiene as a service procured and provided for the employer. The complexity of data protection, confidentiality and liability also needs to be cut through like the Gordian Knot. Otherwise, we will continue with employer, occupational health/hygiene provider and employee all only seeing part of the picture and none having the information, evidence-base or context to assume responsibility, make decisions or judge the performance of each other.

1.14 Evolving a national baseline which is clear, relevant and useful is not possible by referring back to the same people and organisations in some loose way or creating an "Expert" group. Such an approach has failed to deliver meaningful, economically beneficial or healthy outcomes over the last 40 years because it is not supported by the impetus of national priority, objective standards or impartial and complete evidence bases. Experts will continue to promote anecdotal examples of the good, while failing to understand the areas beyond their own expertise or where poor standards prevail. There is a continuing need for defined goals, underpinned by international standards, national strategic objectives, evidence-based decision-making, objectivity, independence and fresh thinking. This consultation is an important step and is asking the right questions, but the danger is that those who answer are unable to see the big picture because they are too deeply ingrained in the rut of neglect of occupational hygiene and health.

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?

2.1 The default examples of good practice provided by occupational health tend towards organisations which have "traditional" models of employee engagement and working patterns and are of scale. The pattern in those organisations tends to integrate occupational health with human resources and uses scale to then build on a basic provision to bring in specialist and interdisciplinary services to provide added value.

2.2. Often the success of these approaches is because of the existence of an in-house resource with enough understanding of how to target and focus procured resources and a close articulation to HR systems and processes to ensure that they are supported on the shop floor and through management systems. Notwithstanding claims of apparent success, relatively few of such examples are integrated with successful health risk management processes which prevent the workplace being a cause of ill-health or which control the work environment (e.g. through integrated occupational hygiene) so as to maximise the benefits.

2.3 Examples from employers such as Royal Mail, John Lewis, Rolls Royce etc, while representing beacons of good practice do not reflect common organisational patterns and are as remote from the experience of SMEs and even many large UK companies as the NHS would be. They are valuable examples of the potential for businesses of scale to promote good health, nonetheless and show the importance of inspirational

and talented professional teams with a vision that they are able to promote to senior management.

2.4 In large scale industries, there are other examples where there has been a journey towards better occupational health practice. In UK construction large (Tier 1) contractors have been on a journey over the last decade to move health by design, occupational hygiene standards and occupational physical and mental health significantly higher on the agenda, as typified by the focus of the Health in Construction Leadership Group. Much of this progress has been driven by the influence of occupational health standards being embedded in major infrastructure projects. Access to publicly financed contracts has been conditional on meeting occupational health and occupational hygiene outcomes.

2.5 This has resulted in demonstrable development in occupational health and hygiene in projects such as the Olympic Park, Tideway, Hinkley Point and HS2. While these do not themselves provide clear and unambiguous models for the commercial and SME sector, there is a clear indicator of how occupational health good practice and standards can be influenced and that is through and informed supply chain and an expectation that public money should not be spent in a way which will cause increased burdens on health and social care now or in the future.

2.6. The close intersection of public and private provision through central government, local government, public bodies (including schools, universities and health) mean that clear buyer's standards and a baseline of expectations can influence understanding of what good occupational health looks like and some dimensions of employer behaviour.

2.7 The most difficult part of the employment market is the sector which is served by limited expert services. Companies which operate with shoe-string HR support will seldom even understand their own legal duties and risk. Understanding the occupational health needs of the workforce without a legal framework is challenging because it then requires an appreciation of health risk which is not available without getting expert advice. Guidance on SME occupational health tends to focus on bureaucratic systems, general advice and on up-selling occupational health businesses.

2.8 Occupational health providers themselves tend to be SMEs, creating economic drivers in the pattern of support that they can provide, as exemplified in the 2020 Understanding the provision of occupational health and work-related musculoskeletal services Report. It remains an open question whether this form of provision can provide sustainable, integrated and high quality coverage to raise a national baseline of provision.

2.9 The approach of OH providers may be contrasted with the provision of health benefit schemes by employers directly to employees. Schemes which are provided with employer subsidy or at the expense of the employer allow employees direct access to health advice, health benefits and/or cash for basic health needs (eyesight, hearing etc). Often GP access, mental health support and physiotherapy are bundled in. Because the employer is not having to maintain or manage the health data of their employees, this can be a relatively effective way by which employers can meet their employee's occupational health needs.

3.0 To make the best use of health plans, however, the employee needs to be aware of the health risks involved at work and the health plan providers need to understand occupational health. Neither of these factors are a given, but it is likely the industry would be open to this. Workplace health plans can be taxable benefits and some consideration of the fiscal policy to support use of such plans would be required. The Health Plan approach is more in line with an international view of the employer providing health insurance as a benefit.

3.1 Given the current state of occupational health provision and the absence of free occupational services at the point of need, a policy which encouraged employers to link coverage for ill-health caused or exacerbated by work with occupational health provision through health plans or health insurance may not lead to a worsening of provision and may encourage more of a focus on health protection.

3.2 Health plan providers/insurers may provide a network of practice to promote standards and a market platform to match SME OH providers to need in a way that allows for business sustainability. At the heart of what will improve and maintain good practice and raise standards in OH must either be a direct and immediate link between occupational health outcomes and the sustainability of the employer's business (including concerns about litigation and prosecution) and the sustainability of the business model for OH providers to maintain standards and coverage.

3.3 in the current economic environment BOHS cannot see how direct government funding of OH providers or fiscal incentives for businesses to procure primary care solutions can be sustainable, sufficiently well-targeted or provide credible measurable outcomes to drive good practice. Indeed, it may result in the focus of resources on those things where funding is available and greater margins for OH providers or lower costs for employers may be available.

3.4 Funding to support better controls on workplace health hazards, training on managing health risk and designing out of health risks is an investment in infrastructure and training. Removing VAT on on-tool dust extraction systems is likely to have a greater impact on respiratory health than increasing the prevalence of health surveillance. Reducing the level of noise within the workplace by better process design and noise reduction technology will impact not only work-induced hearing loss, but also premature menopause, depression, but also is likely to influence long-term sicknesses such as dementia.

3.5 These approaches, which are about targeted support for occupational health protection invariably have better impacts on the environment and reduction in demand for scarce health resources. BOHS view is that increasing primary care provision by Occupational Health without clear targets, standards and focus simply dilutes and stretches our scarce national health resource. By following the ILO and WHO principles, we can reduce demand on health and social care, increase the length of worker's periods of economic activity and remove bureaucratic burdens on businesses such as maintaining untargeted health surveillance. This approach is demonstrated on a large scale be the Olympic Park approach, but is scalable down to SME level as well as up to the biggest infrastructure projects.

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

N/A

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

4.1 Occupational health professions have not seriously and systematically addressed the impact of the workplace on people with protected characteristics (other than perhaps in relation to disability). Studies outside of national health service that provide an

evidence base in relation to gender and occupational health outcomes are extremely sparse, leading to depleted and inadequate evidence base.

4.2 The UK has no coherent strategy on reprotoxins and data collected at national levels largely fails to relate occupation, protected characteristics (even gender) and outcomes. This creates an in-built set of pre-suppositions that occupational health strategies if applied "equally" will result in outcomes that are consistent across groups.

4.3 BOHS sees nothing material in the proposals or discussions that seriously reflects an understanding of the learning and lessons around tackling inequalities in general or, in particular, that would positively impact on continued health inequalities for those with protected characteristics. Indeed, we hope that this will not be a major missed opportunity to tackle, in particular the hidden women's workplace health crisis we highlighted earlier this year. https://www.bohs.org/app/uploads/2023/08/Uncovering-the-UKs-Hidden-Crisis-in-Womens-Workplace-Health-2.pdf

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

N/A

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?

6.1 It is not within the expertise of BOHS to recommend or prescribe the detail of standards for Occupational Healthcare or Occupational Medicine. However, any quality standard on Occupational Health in general should reflect minimum International standards relating to preventing workplace ill-health, as summarised here. These must be the starting point of standards underpinning the ILO principle of a right to a safe and healthy working environment:

C161 - Occupational Health Services Convention, 1985 (No. 161) identifies the function of "Occupational Health" as including, by definition, being

> "entrusted with essentially preventive functions and responsible for advising the employer, the workers and their representatives in the undertaking on- (i) the requirements for establishing and maintaining a safe and healthy working environment which will facilitate optimal physical and mental health in relation to work;"

The limits of occupational healthcare expertise and occupational medical practice in terms of competence mean that much of the *Occupational Health* (as opposed to hygiene) profession focuses on the care of individuals and the impact of the working environment on individual human health.

The expertise needed in terms of engineering, design, measurement and control to prevent exposures from happening within the workplace requires a distinct interdisciplinary scientific expertise which is not native to general health and medical education. As the workplace has become more complex in many industries, this has required significant specialization, with Industrial and Occupational Hygiene developing over the last hundred years to assure competence in this area.

In practice, therefore, the competence to undertake a range of the tasks listed in Article 5 of C161, although exercised in a collaborative and interdisciplinary context with health professionals, means that the following areas are internationally regarded as

falling primarily or exclusively into the competence of the global occupational hygiene profession:

> "Without prejudice to the responsibility of each employer for the health and safety of the workers in his employment, and with due regard to the necessity for the workers to participate in matters of occupational health and safety, occupational health services shall have such of the following functions as are adequate and appropriate to the occupational risks of the undertaking:
>
> (a) identification and assessment of the risks from health hazards in the workplace;
> (b) surveillance of the factors in the working environment and working practices which may affect workers' health, including sanitary installations, canteens and housing where these facilities are provided by the employer;
> (c) advice on planning and organisation of work, including the design of workplaces, on the choice, maintenance and condition of machinery and other equipment and on substances used in work;
> (d) participation in the development of programmes for the improvement of working practices as well as testing and evaluation of health aspects of new equipment;
> (e) advice on occupational health, safety and hygiene and on ergonomics and individual and collective protective equipment;
> …
> …
> (i) collaboration in providing information, training and education in the fields of occupational… hygiene and ergonomics…."

The existence of a competent and independent hygiene profession is also specifically critical to the effective realization in practice of rights under:

- Articles 7-18, C120 - Hygiene (Commerce and Offices) Convention, 1964 (No. 120)
- Article 28, C167 - Safety and Health in Construction Convention, 1988 (No. 167)
- Articles 7-11, C176 - Safety and Health in Mines Convention, 1995 (No. 176)
- Article 7, C184 - Safety and Health in Agriculture Convention, 2001 (No. 184)
- Article 13c), C115 - Radiation Protection Convention, 1960 (No. 115)
- Article 1 and 3, C139 - Occupational Cancer Convention, 1974 (No. 139)
- Article 6, C170 - Chemicals Convention, 1990 (No. 170)
- Article 7, C162 - Asbestos Convention, 1986 (No. 162)
- Articles 8 and 9 of C148 Working Environment (Air Pollution, Noise and Vibration) Convention, 1977 (No. 148)

Much of the generality of C155 - Occupational Safety and Health Convention, 1981 (No. 155) and C187 - Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187) is predicated on professional occupational hygiene expertise being available to national competent authorities and to workplaces.

Occupational hygiene expertise also underpins competence and the capability of nations to deliver their obligations under C081 - Labour Inspection Convention, 1947 (No. 81).

The importance of the recognition and support for the occupational hygiene profession and its professional standards are embodied in the statement in Article 10 of C161:

> "The personnel providing occupational health services shall enjoy full professional independence from employers, workers, and their representatives, where they exist, in relation to the functions listed in Article 5."

6.2 Without the inclusion of these essential preventative standards, any national occupational health standard will not be credible internationally or effective in practice.

6.3 We strongly believe that Occupational Health and Medical Professionals should individually be subject to the discipline and transparency of individual professional registration under the auspices of the Professional Standards Authority for Health and Social Care with a commitment to a single quality standard.

6.4 While Faculty of Occupational Medicines SEQOSH quality standards provide and important and useful means to support the OH industry in maintaining standards, for reasons already articulated, we do not feel that this alone provides a sufficiently robust and objective framework to protect the health of the near 34 million UK workers.

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

6.5 At the heart of the provision of occupational health is the centrality of the employee's health. Because services are provided at the expense of the employer, it is an obvious and significant ethical conflict for providers in having legal obligations to the organisation contracting them and professional duties towards the employee. BOHS is not convinced that the current framework for OH procurement provides adequate safeguards for this.

6.6 The independence, access to contextual information and right to disclose in the interest of the health of the individual or the general workforce needs to be present and access to clear routes to complaint about practice by employees to an independent body is essential.

6.7 Professional standards need to be underpinned by competency and robust mechanisms for ensuring that sufficient attention is placed on gathering adequate clinical context, together with a right of the employee, exercisable with the support of the OH provider to access data and information relevant to factors in the workplace impacting on their health.

6.8 The OH profession does not have safeguarding standard or processes. OH providers are very likely to encounter vulnerable people and there is no direct set of standards relating to safeguarding or relevant infrastructure for support.

6.9 The removal from practice of OH practitioners or sanctions requires a clarification of the complex governance through the Faculties to enable accountability and ethical conduct in this field to be made obvious and understandable.

6.10 The SEQOSH standards again are an invaluable reference point, but reflect a national healthcare governance architecture which has somewhat sidelined the importance, impact, complexity and scale of OH practice.

6.11 We agree that something more is needed to provide credibility and objectivitiy.

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?

7.1 The basic Tier for all workplaces of access to support for workplace health is access to advice on preventing ill-health in the workplace. We are strongly supportive of an approach which provides free, consistent and comprehensive advice and tools to enable health risk management. This is a necessary precursor to procuring occupational health support.

7.2 BOHS has worked with HSE and industry to try and provide this approach and has a number of examples. Our Breathe Freely in Construction in manufacturing materials are now used as the benchmark health protection materials across the UK, Australia, New Zealand, Canada and the United States.

7.3 Self-service tools, such as the Welding Fume Selection tool to help businesses of all size make decisions to minimise exposure to carcinogens. The general ventilation too, launched to assist businesses manage ventilation to prevent COVID spread was accessed over 10,000 times in the first four days of launch and was adapted globally.

7.4 BOHS developed a buyer's guide in association with HSE which enables employers to determine the level and type of provider best suited to their needs.

7.5 Our feeling is that the national OH standard proposed perhaps creates a bureaucratic burden which is disproportionate to the benefit derived from the initiative itself. What is crucial is the availability of usable and clear advice without having to pay for it. Professional providers may well overcomplicate things to upsell advice and focus on the need to have paid for services as opposed to the opportunities to effectively control risks.

7.6 By selecting the right advice at the right time, employers can avoid unnecessary cost or expenditure which has limited cost-benefit. We endorse the view that employers need support, but that is through educating them on need.

7.9 The Danish model operates because it is supported by a particular model of health and safety management, the AMO system, with in-built training requirements and associated planning. Without a fundamental alignment of existing health and safety management and training regulations, the positive impact of the Tiered Danish system for OH is unlikely to gain traction and is likely to divert from the desired goal.

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.

N/A

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

N/A

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?

9.1 Assuming that a national standard were moved forward with, we would recommend that a similar approach to the Modern Slavery Statement is adopted – or some other form of non-financial reporting. Given the complexity and diversity of British business, it would be very difficult to benchmark organisations in a fair way that would signal

anything meaningful and the impact on recruitment, reputation and credibility of businesses could be significant.

9.2 Qualitative and transparent statements of business goals in OH and outlines of the steps being undertaken to promote and develop those published annually are very much in line with other sustainability standards developed for business and by business. Governance and management processes are in place to deliver such approaches in larger organisations, while stakeholders have come to be familiar with this approach to ethical standards. In this way, businesses can both articulate and reflect on their goals and challenges and stakeholders can benefit from contextualised information.

9.3 A general accreditation scheme requires a level of external scrutiny and governance which may create a distracting infrastructure. Standards bodies such as BSI and ISO already exist and elements of the existing ISO45001 and ISO45003 cover the territory anticipated. If there is a need for an ancillary standard, then perhaps this is the more appropriate route than one delivered through government or by the OH industry itself.

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?

10.1 This question is hard to understand. Government needs to link the drivers of workplace health together. HSE, DWP, UKHSA and Department of Health need to be working in concert, rather than in silos. When this does happen it is effective. A single workplace health strategy, derived from first principles and focused on supporting workplaces not to be drivers of ill-health is required. Ensuring that occupational data is collected and accessible for analysis throughout DWP processes, in primary care contexts, shared by OH practitioners and linked into HSE intelligence is essential. At present we have data, but the occupational context which can help businesses and government make decisions is simply absent.

10.2 A single national resource base for definitive free guidance and tools needs to be developed, including free online awareness training for managers and business owners, buyer's guides, tools and mechanisms for health protection, templates for health management, case studies and other materials. It would need to be designed for easy navigation and support at appropriate levels for businesses.

10.3 Government is an influencer of educational standards and occupational health awareness needs to be deeply embedded in all national educational standards, including apprenticeships.

10.4 We have signalled earlier on that national leadership is needed. We need to accepting that the workplace is the single greatest determinant of health outcomes over which we have materials control. Government must send a clear message to society that if workplaces continue to add to the premature and irreversible illness of British people, the burden of ill-health and social security demands will become unsustainable. This will ultimately become an economic burden for business.

10.5 When determining the cost benefit analysis for compliance with health standards, business needs to factor in the economic and societal costs of making someone ill. Fiscal, financial and regulatory policies need to be aligned with this message. If not, any progress in occupational health will simply result in people becoming retained in the workplace to become more broken, less capable of self-care and more dependent.

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.**

11.1 No. This is likely to provide yet another barrier to access to occupational health and create a sub-business od advice to gain accreditation, rather than deliver services. We need to understand behavioural economics. Those who accredit are likely to use funding to off-set costs they may well have spent anyway. The market for providing OH is likely to follow the funding, leaving non-accredited employers less desirable as clients and more driven towards a minimalist approach.

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?

12.1 It is hard to draw effective parallels with many jurisdictions. BOHS feels the examples alluded to in the report are drawn from jurisdictions where the organisations of health, government, health and safety and the regulatory, legal and enforcement context is very different. The Government should be very wary of seeking solutions inspiration from part of a system when the UK system is so idiosyncratic and fragmented.

12.2 There are examples of specific actions which have driven better occupational health in a measurable and effective way. In British Columbia (Canada) after the lowering of the Occupational Exposure Limit for Respirable Crystalline Silica, the government produced a free online tool to enable construction SMEs to enter health protection information into it to estimate if those health controls would be adequate to meet the statutory level. The tool itself has had high take-up and is widely regarded as positively impacting SME behaviour (in a similar way to the BOHS Welding Fume Selector Tool or General Ventilation Tool). However, it also appears to have driven greater awareness and greater engagement with the statutory health surveillance duty.

12.3 The Netherlands (as an example in Europe) and several states in the USA and in Australia, as well as Singapore are some of the examples of economies where there is statutory requirement to use qualified Occupational Healthcare and Hygiene professionals. At present in the UK, while there is duty to use a “competent person” for occupational health and hygiene tasks, there is no legal duty to use someone qualified. Thus, an individual being screened for cancer in a hospital needs to be supervised by a range of qualified and registered professionals. However, the people offering occupational hygiene advice to prevent a thousand workers in a factory being exposed to cancer or the setting up of occupational health surveillance (as opposed to medical surveillance) operate within no clear regulatory standard. Recent HSE interventions, including prohibition notices indicate that unregulated, unqualified operators are present in the market, putting the health of individuals at risk. The field

of mental health (including wellbeing) is even more problematic, with extreme fragmentation within the professions themselves and a market where anyone can provide services aimed at reducing suicide risk and mental health episodes.

12.4 BOHS believes that rather than leaping into a mass of additional red tape and jargon, explicit modification to the Management of Health and Safety at Work Regulations (under the powers of the REUL Act) to specify:

a) the use of a competent/registered Occupational Hygiene professional for work in relation to the identification, recognition and control of health exposures in the workplace:

b) the use of a qualified/registered Occupational Health professional for the provision of occupational health advice;

c) the use of people with a recognised/registered professional qualification in psychotherapy, mental health or counselling for the support of occupational mental health.

12.5 It is unconscionable, if public money is to be expended in delivering primary care or public health outcomes in the workplace, it the safeguarding of people should be less than that expected in any other context. Moreover, the increased use of the workplace as the appointer of healthcare providers means that their potential liability for personal injury and in negligence could be very significant and could be a serious reason for not adopting the national occupational health standard. A legal requirement that registered professionals are used is fundamental.

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

13.1 BOHS has considered carefully what the legal and regulatory framework should be to ensure the effective implementation of a national occupational health strategy. It will be the subject of a more extensive and detailed report later in 2023. However, our findings are:

a) UK regulation should be tied to minimum International Labour Organisation Standards outlined for Health and Safety. Without his UK-based organisations will struggle to operate competitively in developed economies and UK employees will be deprived of the minimum standards all workers can reasonably expect. Ratification of the ILO Convention 161 on Health and Safety will provide civils servants, legislators and adjudicators a clear international benchmark for compliance, filling the void left in interpretation by our exit from the EU. This is a highly cost-effective way of creating policy and interpretative certainty, preventing extensive test cases, litigation and civil service policy activity, ensuring continued alignment with international standards and maintaining our global credibility and competitiveness as a place to work;

b) Powers under the REUL Act should be used by HSE to revise the Management of Health and Safety at Work 1999 Regulations to specify the use of qualified/registered professionals for the provision of both occupational health and hygiene services (as outlined in 12 above). Without this, employers will continue to be vulnerable to those who exploit the market, increased legal duties will lead to greater liability for businesses, particularly affecting SMEs and public money is likely to be mis-spent. Clear requirements to use registered professionals (as we do with Gas-Safe) will move the burden of regulation from the Government to professional bodies who have the expertise to understand technical and ethical competence. It will make the process of determining competence more straightforward and cheap for businesses and enable the marketing of high quality services more effectively. Ultimately, it will push up the

quality of services in the occupational health and hygiene space with significant health, social and economic benefits;

c) The current Health and Safety at Work Act predates the era of personal data access, autonomy in health decision-making and accessible information about the management of personal health risk. It places a burden on businesses to receive and assimilate information about health risks, formulate policies and then consult and implement those policies. This approach is fundamentally paternalistic and leads to fundamentally problematic behaviours amongst employers and employees.

Employers are reticent to share workplace health risk data, making it almost impassible to create an evidence base for what is effective in workplace health. Employees regard Health and Safety policies as bureaucratic and officious and often circumvent them. At present, there is a greater right of access to information about hazards to fish life in rivers than there is for employees in workplaces.

These problems would be remedied by updating the HASAWA section 2 (2) (c). At present, the implication is that employees are given the information "necessary" so far as reasonably practicable to ensure their health. This is very far from current practice in relation to all other areas of activity which impacts on human health. In any other context, a person would have a right to be directly informed in a manner that they could understand, of any risks to their health that they might be exposed to. In the current context, a canteen in a workplace has a duty to advise of allergens in the sandwich to workers who do not have an equal right to information on the shop floor about carcinogens,

The Act should be updated to provide a duty to employers to provide employees information (in a manner they can understand) about hazards or factors in their working environment which could harm their immediate or long-term health, as well as information that they may require to manage specific health conditions and vulnerabilities (such as the presence of gender-impacting reprotoxins).

Such a duty would encourage employers to share health impact data and analyse it, creating a better evidence base for the management of health; it would place the power and responsibility for making decisions and feeding back on the management of health risks in the hands of employees, rather than leaving it to employers; it could reduce the risk of litigation arising from workers who claim to have been unaware of health risks to which they have been exposed. It is in line with existing rights and duties which have been demonstrated in being effective in ensuring better engagement with management policies and practices.

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.

14.1 BOHS endorses the view of the Council for Work and Health that a basic requirement for all requiring a Fit note to be referred for assessment with employer confirming this has happened in order to qualify to receive SSP support could ensure such – main streaming this in NHS provision would reduce reliance on employer or self-referral whilst ensuring provision to consistent care pathways.

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.

15.1 There are exceptional people working and leading in the field of occupational health education and all the professional organisations are taking the importance of professional education seriously and attempting to articulate a coherent multi-professional provision and workforce. Much of the successful delivery of such solutions is to be found in a new generation of firms which are of the scale to be able to create an internal market for the correct identification of specialisms from occupational hygiene through to approved surveillance doctor.

15.2 This “internal market” model is also to be found in some larger employers with in-house occupational health capabilities who have sufficient expertise, volume of employees and variety and depth of provision and resources to procure and focus on a multi-professional model.

15.3 However, this contrasts heavily with the reality for most employers, which is accessible only to smaller, less specialised services, procured by employers with no expertise or real understanding of health needs and a workforce whose size and diversity may not justify access to higher level expertise. Experience of interventions by regulators confirms the probability that cheaper and less scrupulous providers in the market are more likely to offer services and advice beyond their area of competence. This approach tends to undermine the value and appreciation of different disciplines within the market.

15.4 In reality, without consistent national direction about the need to engage appropriate specialists from occupational hygiene through to ergonomists and the importance of provision by qualified regulated professionals, market forces, distorted by those exploiting need, will undermine the workforce. What is needed is clarity in regulatory direction towards regulated professions and enlisting the expertise of professional bodies to ensure that they work within their competence and understand the roles of complementary professionals.

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

16.1 While it is not really a matter of benefits to professionals, the absence of linkages into primary care in an ordered and systematic way creates waste for the public purse, cost for employers, slower and more fragmented services and more health risk for the individual.

16.2 In terms of impact on individual health, the workplace is likely to be the place where most adults come into contact with significant levels of carcinogens, mutagens, reprotoxins and asthmagens. Many of the costliest long latency diseases for adults find their causes in the workplace. In addition, the workplace is likely to be a driver of noise exposure (associated not only with hearing loss, but premature menopause, depression and associated with dementia) and Musculo-skeletal disorders (with associations to chronic pain, immobility and consequent obesity, insomnia and depression). Workplace stress contributes directly to mental health issues, but indirectly to smoking, substance abuse, insomnia and eating disorders.

16.3 While the objective of BOHS's work as a scientific charity and the role of occupational hygienists is to prevent these, we cannot ignore the fact that these preventable hazards are visited upon workers every day. Where there is effective occupational health provision, within the workplace, it may be possible that individuals have the cause and the consequence identified. It is vital that occupational health professionals feed back to occupational hygienists and/or to employers the links between detected health issues in the workplace and their possible or likely causes. Without this, employers cannot act to prevent further harmful exposure. It is also vital that occupational health professionals have sufficient expertise to be able to understand the links between occupational exposures and illness, but also can access expertise in occupational hygiene to determine whether such exposures may have taken place and the extent.

16.4 However, it is equally important that systematic feed forward is enabled to primary care, not only of the healthcare issues, but also data on occupational causes and the exposures associated with them. This is essential to ensure effective diagnosis and treatment, not just as a point of referral, but also for patients in later life to understand the causes of long latency diseases. Occupational exposures are some of the most significant environmental factors causing disease and susceptibility to illness, yet they are not systematically captured in patient data. Inevitably this may lead to late diagnosis, inappropriate screening and waste of health resources.

16.5 Creating a clear linkage of occupational health and hygiene data into patient records will, we think, have a significant impact on patient care, resource use, but also provide a better evidence base for where occupational intervention can support better outcomes.

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?

17.1 At present, it would be very difficult for any healthcare professional to advance their career and professional standing in medicine, academia or traditional healthcare prestige areas with a background in occupational health or hygiene. Part of this rests with the absence of available data (because of the confidentiality of workplace health data and the lack of occupational data in health records). Part is because of the absence of research funding which stimulates research-led expertise. This is reflected in the number of Professors of Occupational Health, Hygiene or Medicine (less than a dozen in the UK), compared to the number of people ill as a result of work (2 million) and the limited number of research centres, competitive research publications or research funding. Seniority within professions is not always linked to research, but opportunities to advance medicine or health are critical to recognition in many contexts. More to the point the mainstream professional bodies need to address a culture of neglect of occupational health as a specialism.

17.2 The context of occupational health and hygiene is largely in the private sector, outside the scope of the benefits and pensions available in the public sector and often working in contexts which are not immediately attractive.

17.3 The exposure of healthcare and medical students to occupational health is marginal to say the least, The appreciation of occupational causation within health education is limited, while the opportunity to study in depth or for all healthcare and medical students to have training are limited. Occupational health needs to be core to medical and healthcare education.

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?

18.1 We agree with the Council for Work and Health that there needs to be integration in all basic HCW (and others such as leadership and management curricula) at undergraduate and postgraduate level), enabling career breaks and secondments to work within OH departments, enabling retiree return and opportunity for flexible working.

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)?

19.1 It's relatively low-tech, but regulatory clarity on what professionals are legally competent to provide what service would do the job. Perhaps a joint HSE, DWP, UKHSA, NHS, DOT hub webpage with one source of truth and links to professional registers?

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?

20.1 See answer to question 15.

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?

21.1 For most employers the fit note system is not an occupational health, but a payroll issue. The system at its best could be useful, but currently fit notes could be signed by anyone with an objective clinical basis for determining the claimed incapacitating illness, from psychotherapists to dentists. In some ways, this diversification may even provide more objectivity that the current restricted class.

21.2 However, for real ethical credibility, fit notes should be signed as part of a process of primary care management. If a person is genuinely so incapacitated that they cannot work, then that is something that should be reflected in their medical history and an early warning sign of other matters. The link of who can sign fit notes should be based on who has the objective expertise to make an assessment of whether the healthcare issue is incapacitating, taking into account the relevant medical history of the individual and who is capable on acting to ensure that the issue is being managed in some way. Resting on the professional ethics of the healthcare professional signing it to assure knowledge of healthcare history, understanding of the impact of the issue and the commitment to manage the issue should be the guiding factors.

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?

22.1 BOHS main concern is that there is a real lack of general understanding of the occupational factors in the causation of healthcare problems within the mainstream health service. Invariably the focus drifts to personal health factors - smoking, rather than workplace respiratory exposures, family history of allergy, rather than occupational exposures to allergens, social stress, rather than occupational stressors. This leads to occupational factors being potentially overlooked. We need to ensure that healthcare and medical personnel understand enough about occupational health to have an informed conversation.

22.2 Allied to this is the means to record in a standardised and systematic way occupational contextual information within the right data contexts to help inform diagnosis, treatment and the evidence base. If an individual worked with asbestos, or is a baker or works with isocyanates, it should be on their health records and the medical personnel treating them should immediately understand how that occupational context is likely to manifest in relation to disease.

22.3 In short, BOHS believes that without education and information derived from occupational hygiene science and occupational health practice, the NHS will waste time, resources and energy. The result will be greater inefficiency, wasted diagnostic and treatment costs, increased demand on resources, more social care, increased benefits costs and ultimately more people suffering unnecessarily, being less able to care for themselves, economic inactivity and shorter lifespans.

BOHS welcomes the Government's initiative to focus more attention and resource on occupational health and the opportunity to respond. We hope that our submission will be read as informed, constructive and supportive.

Professor Kevin Bampton

Chief Executive Officer, BOHS