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HEALTH AND SAFETY EXECUTIVE

The HSE Board Meeting

CORPORATE MEDICAL CAPABILITIES REVIEW

A Paper by Peter Baker

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Cleared by Sandra Caldwell on 28 August 2007

Issue

1. To consider the findings, conclusions and recommendations of the Corporate Medical Capabilities Review

Timing

2. Pressing. Decisions are required on the Review's proposals so that steps can be taken quickly, in particular, to maintain the viability of HSE's medical capabilities to meet current and short-term business needs.

Background

3. In November 2006 the HSE Board considered paper B/06/95 on the short and longer-term optimal deployment of HSE's doctors. This was against the backdrop of reducing doctor numbers, increasing demands of internal and external drivers for specialist medical expertise, and principally external interest in HSE's delivery of the Employment Medical Advisory Service (EMAS).
4. The HSE Board commissioned the Corporate Medical Capabilities (CMC) Review to:
 - Quickly review HSE's medical capabilities against HSE's occupational health priorities and business needs in the short- and longer-terms; and
 - Consider and advise the HSE Board on what medical capabilities HSE needs to deliver those priorities and meet those needs, including any business risk management arrangements, and the implications of best delivery for HSE.
5. The view was that the outcome of the Review would then enable the Board to decide, in particular:
 - How to develop and maintain the necessary medical capability;
 - The optimum balance between in-house (including HSL) or external provision of that capability;
 - Whether the EMAS function remains a suitable vehicle for delivering all or part of that capability;
 - How to ensure suitable professional leadership to in particular HSE's medically qualified staff;
 - How to manage any risks to HSE's business and/or reputation in the meantime;

- How to engage external stakeholders in developing HSE's capability.

Review Report

6. The attached Report sets out the CMC Review main findings, conclusions and proposals. The Review concludes that despite some uncertainties about the direction of HSE's future health strategy, maintaining the *status quo* is not a viable option and risks HSE's ability to deliver policy and front-line activities in the short- and longer term. The Review's proposals comprise a package of minimum governance and organisational changes requiring immediate and longer-term action that aim to, in particular:
- ensure a viable medical capability to meet short-term needs of Policy Group and front-line operations,
 - provide a flexible and sustainable capability to enable HSE to meet future internal and external developments, and
 - to ensure HSE is making best use its current medical capabilities.

Recommendations

7. The Board are asked to consider the report and:
- Agree to appoint a Chief Medical Advisor (CMA) on a part-time basis for an initially limited period, and the Board's preferred option for resourcing the post. The CMA would:
 - act both as a senior medical advisor to the HSE Board, the Chief Scientific Advisor (CSA) and Policy Group;
 - provide professional and technical leadership (but not line-management) to HSE's doctors; and
 - be line managed by the CSA.
 - Agree to recruit a Band 3 Medical Inspector in the South East to support front-line operations and provide the portfolio function to Construction Division;
 - Agree HSL CWH resource and deliver additional respiratory disease expertise to the Disease Reduction Programme.
 - Agree that for the short-term that:
 - all of the medical capability currently in CMU is retained within a single Unit with the biomedical scientists and FAAMS;
 - the Unit moves to the Science & Technology Group in October 2007; and
 - the Unit continues to be line managed by a T/P Band 1 doctor - to be reviewed after 12 months.
 - Note and endorse the proposal to improve quickly the current process and procedures for engaging doctors in both policy and front-line decision making.
 - Agree that HSE takes steps to increase the cadre of field-based doctors over the coming 2-3 years to the level suggested in the report, indicate which option the Board would prefer for its delivery → ←.

- vii. Provide a clear steer on the immediate and tangible action to be taken to clarify for, in particular, external stakeholders, how HSC/E's discharges its responsibilities regarding EMAS.
 - viii. Provide a clear steer on whether HSE should activity pursue an alternative approach to the assessment and approval of Appointed Doctors.
 - x. Agree the extent to which this 'closed' Board paper and the Review Report are made available to staff, and externally, after the Board meeting.
8. Board members are also invited to note that, as with the MBUS proposals considered at the July HSE Board, implementing the necessary changes and making best use of HSE's medical capabilities will also require cultural and behavioural changes across the piece. The November Board paper highlighted the low morale amongst HSE's doctors and that they felt that their expertise was undervalued and to some extent underutilised by HSE in, for example, developing its occupational health strategies. HSE needs to move to a culture of greater inclusion and where the specific skills and expertise provided by doctors in both HSE and HSL are actively sought and valued. This will also require doctors to recognise that their small number means that their skills need to be much more effectively targeted at delivering agreed business priorities, and the important contribution other health professionals in HSE can make to delivering that business.

Consultation

- 9. A range of stakeholders from Operational Directorates, Policy Group, LAO and HSL were engaged throughout the Review.
- 10. The Review Team also consulted a small number of external stakeholders in DWP, DH and the Faculty of Occupational Medicine on basis that, where necessary, more formal external consultation would take place after the Board had considered the review findings and agreed a way forward.
- 11. PFPD, HR and CommsD have also been consulted on the content of this paper and the attached Report.

Financial/Resource Implications for HSE

- 12. See paragraphs 69 to 85 of the attached Report.

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CORPORATE MEDICAL CAPABILITIES REVIEW

REPORT AND PROPOSALS

1. This paper summarises the main findings, conclusions and proposals from the Corporate Medical Capabilities (CMC) Review, to informing the HSE Board's discussion at the 5 September meeting.

APPROACH, CONTEXT AND CONSTRAINTS

2. The Review Group's approach was in effect 'zero-based'. It focused on capturing the current thinking on future occupational health priorities and key stakeholders' views on their needs - now and in the future - for medical input, advice and support that can only be provided by qualified and GMC accredited physicians, from which to draw conclusions and develop proposals. The Review's terms of reference are attached in Annex 1 for ease of reference.

3. The Review Group found that HSE's approach to occupational health has shifted over its history, reflecting the changing world of work, and the developing nature of the demands placed on it by its internal and external customers. A number of key drivers now influence our current and future occupational health priorities. These include:

- Increasing focus on the health and well-being of working age people at population level, and acceptance of a 'bio-psychosocial' model of health at work;
- Changes in the employment market – e.g. more service sector-led economy, growth in flexible-hours employment, and an ageing population;
- Duty holders' access to occupational health service providers and advice from sources other than HSE;
- Making best use of S&T within HSE;
- Ever-changing and new evidence about work-related health risks – e.g. COPD, night/shift work, chronic and long-latency disease.

4. Against this back-drop, developing proposals and recommendations based on quantitative and objective evidence has been difficult, particularly in relation to HSE's business needs in the longer term. This is because:

- HSE's business priorities from 2009/10 onwards are uncertain, and HSE's longer term future health strategy is still in development. A paper from the Health Agenda Steering Group on the latter will be considered by the Board in September/October.
- Internal stakeholders found it difficult to quantify or even estimate the likely future need for specialist medical input in the absence of coherent planning arrangements for 'in-house' S&T resource.

- Internal stakeholders did not fully understand their existing and future needs for specialist medical input and how medical expertise can contribute across a wide range of HSE preventive and enforcement activity. This was particularly acute in FOD front-line.
- In some field offices for example, the perceived current demand for medical input fell short of the real business need, due largely to difficulties in accessing medical input (because of ineffective processes and systems) or the limited resource available. A culture was evident of 'making do without doctors' and thereby risking adverse outcomes.

5. Nevertheless, a number of common themes have emerged and the Project group has been able to:

- draw broad conclusions from its findings about the 'direction of travel' of HSE's business needs, and the risks HSE faces from in particular maintaining the status quo, and
- propose a range of proposals and options to move HSE towards a flexible and sustainable corporate medical capability to meet immediate and short-term needs and equip HSE to develop strategies and mechanisms to make sure it is best placed to meet future internal and external developments.

WHAT THE 'CUSTOMERS' THINK!

6. Views were sought from a wide range of current and potential users of medical capability in HSE. The views of a small number of external stakeholders were also sought.

Policy Group

7. Policy Group (PG) currently has the greatest demand for specialist medical advice. Their demands are diverse, are driven as much by the maturity of existing programmes as by their nature, and require the widest range of skills and input. Accordingly, the Corporate Medical Unit (CMU) currently plans for 60-70% of available doctor resource in support of Policy Group activities, with the majority dedicated to policy and strategy development and the remainder to delivering aspects of PG projects.

8. PG currently needs medical input at three levels:

- Input into the development of HSE's occupational health (OH) strategy alongside the contributions made by policy makers, occupational hygienists, analysts, communications specialists, etc.
- Contributing to HSE policy on specific health issues, e.g. health surveillance, first aid standards, ageing working population, and work in special environments, such as diving.
- Contributing to policy development and projects on specific diseases, including non-topical ones such as cardiovascular and neurological disease

9. Health and Work Division (HWD) has a need for significant input at the strategic level, in particular to enable HSE to develop interventions and policy at working population level (e.g. in respect of Common Health Problems), to engage effectively with the wider medical community, and inform and influence a wide range of internal and external bodies, many of whom are not medical professionals. Whilst collaborative working with OH physicians in DH, DWP and elsewhere has been reasonably effective, HWD's view is that HSE would benefit from having appropriate access to a senior occupational physician who:

- is able to take a broader view of medicine,
- can speak authoritatively with wide audiences on very broad areas of health and well-being at a population level,
- is respected by the occupational medical community, and
- can work closely with PG.

10. Currently CMU and HSL's Centre for Workplace Health (HSL CWH) are not resourced to fill this role: their staff do not carry the senior status that would be needed to perform it effectively. HWD judge that achieving the right level of engagement and influence across Government is possible without such a senior physician, but would require more effort and would take longer as gaining the trust and respect of the medical community is a key ingredient. Nevertheless, past experience of appointing a 'senior medical officer' highlighted that the individual needs a clearly defined role and clear accountabilities to maximise influence and leverage externally in support of HSC/E business objectives.

11. There remains a need for medical input into other Policy Group areas – policy development and delivery in relation to specific topics and diseases and Sector work - including new and emerging issues where a strategy will be needed in due course – health issues in the waste/recycling industry is a possible example. This is currently supported in an ad hoc way because of the limited resources in CMU. CMU doctors hold portfolios in topic areas broadly aligned with current programmes, and some sectors and hazards where OH expertise in a regulatory context is required.

12. Where disease-specific expertise is particularly required, the medical epidemiologist in CoSAS contributes some of his time on respiratory disease to the DRP and a respiratory physician from HSL CWH sits on the DRP Strategy Board and brings with him access to the national and international network of respiratory physicians and organisations such as the British Thoracic Society. The OH and other medical and nursing expertise in HSL CWH is also accessed by PG and programme managers when required.

13. Although, there is much evidence of effective working between HSE/HSL's doctors and PG in relation to specific topics and diseases, all involved recognise that these arrangements are incoherent, fragmented, unsustainable and fragile. Inherent weaknesses include:

- programme managers being uncertain over nature of specialist medical input required.

- process barriers to ensuring that the right level of input is obtained, at the right time, within the framework of a partnership relationship resulting in mismatches between the medical skill provided and what is required.
- with some notable exceptions, skills within HSE's medical community are not well matched with those required leading to a tendency to look elsewhere for such input or 'make do without'.
- Geographical and organisational isolation of HSE's medical community from Policy Group exacerbates these difficulties, and perpetuates the lack of a shared vision.

14. The potential demands on HSE's doctors to support PG activity is also likely to increase in the longer-term because of other drivers, for example:

- HWD see that influencing the medical community at a local level, e.g. GPs/PCTs, public health professionals, OH Service Providers, will be a key part of any future Health Strategy and HSE's doctors could play a key role in coordinating and delivering this work.
- The need for HSE to meet its responsibilities as a partner in Local Strategic Partnerships and Local Area Agreements.
- Meeting the TUC' call for HSE's help in training up Safety Representatives in the 'modern health agenda'.
- The need for medical input (or biomedical scientist input) into HSE's emerging Health Strategy in the longer-term.

Chief Scientists and CoSAS

15. HSE's Chief Scientific Adviser (CSA) feels that HSE is vulnerable in some areas due to its limited medical capability, and in particular that HSE could struggle to demonstrate that it has a sustainable system to ensure that its OH strategies are consistently informed by quality medical evidence and advice. The CSA is also concerned of the lack of clarity regarding:

- accountabilities for the governance and maintenance of appropriate standards of HSE, HSL and any externally procured medical support and advice; and
- the 'line of sight' between medical activity and HSE's business needs.

16. The CSA's calls for greater emphasis on robust evidence-base supporting initiatives and the need for medical input (or biomedical scientist input) into evaluation are likely to increase the demands on HSE's medical capability.

17. More specifically, CoSAS has a full-time Band 1 doctor as part of its epidemiology capability. However, the doctor is currently deployed about 1 day a week supporting the DRP's needs for respiratory disease support. The scale and nature of this work really requires on average 3 days a week and the demand is unlikely to diminish. Meanwhile, CoSAS needs for medical epidemiological expertise is also being only partially met.

Front-line delivery and support to operations

18. For the purposes of the Review, front-line operational work is providing medical input, when required, into:

- Directorate or divisional operational and technical policy and intervention planning by, for example, Sectors, CTGs, HID CI Strategy Unit, Field teams.
- Front-line delivery of OH aspects of national (e.g. LOPP) or local campaigns or interventions.
- Fatal accident and other investigations.

19. The use of CMU's expertise in operational and technical policy or intervention planning is inconsistent across HSE and even within operational directorates. In recent years there has been little call on CMU's doctors to provide input into national or regional intervention planning in FOD. CMU has however been directly engaged in helping HID CID plan and deliver its OH 3-year strategy for the chemical industry, but has had little business from OSD despite it having a dedicated OH inspection team and an ongoing OH strategy offshore. Despite significant activity in the past, few Sectors now engage CMU in industry-specific activity. CMU is not currently engaged in any ND activities.

20. A substantial proportion of front-line OH delivery and investigation support to FOD – delivered principally by doctors in the past – is now delivered by 26 regionally-based Occupational Health Inspectors. CMU doctors now act as consultants to field teams and OHIs, with OHIs being the primary contact to both internal and external 'customers'. Whether, or how, doctors are then subsequently engaged by OHIs is covered by a 'Ways of Working' agreement developed in 2005. This is reflected in CMU's current planning assumption that the ratio of time allocated to front-line activities compared with PG activities is roughly 30:70.

21. HSE's doctors may also lead the investigation into cases of occupational disease and ill-health, and provide advice to duty-holders and other external stakeholders on the provision of occupational health services in the workplace, specific health topics (e.g. health surveillance, risks if working in specific hazardous environments), and generic and emerging topics (e.g. ageing, obesity, shift work and reproductive hazards).

22. It was broadly agreed amongst stakeholders that this wide range of planned and reactive demand principally continues to require access to doctors with occupational health expertise who could also, if necessary, act as 'intelligent customers' in sourcing other medical expertise not available in HSE from HSL CWH, or even using their professional contacts and networks on other agencies e.g. the NHS and HPA. Recent incidents, such as the Powertrain investigation, have also highlighted the value of having ready access to doctors able to apply OH medicine in a regulatory context to provide expert advice and evidence to investigations and enforcement activities, and in cases with a wider public health implications inform (and occasionally challenge) diagnoses by non-OH physicians in other agencies.

23. It is also recognised that as well as their OH expertise, doctors are also valuable sources of advice on other generic medically-related issues relevant to inspection,

investigation and enforcement e.g. maintaining workers' and witnesses' medical confidentiality.

24. However, stakeholders across the piece expressed concern about the diminishing number of doctors available to, or based in, the field and cited examples where the lack of availability of the right capability or at the right time has resulted in field staff taking calculated risks in relation to an intervention or investigation as a result. Feedback also suggests that the recent further decline in doctor numbers due to retirement has exacerbated this problem. This suggests a **substantial** gap in parts of the country between the resource required to coherently support delivery of many of HSE's front-line activities and the appropriate medical capability available. Stakeholders also pointed to a perceived lack of doctors' investigative skills that was also hampering front-line delivery and, in some cases, relationships with regulatory inspectors. Current distribution of CMU doctors is shown below.

HSE Region	Office	Band/Role	FTE
Scotland	Edinburgh	B2 SMI	1.0
YNE	Newcastle	B3 MI	0.8
NW	Manchester	B3 MI	0.7
Midlands	Birmingham	B3 MI	0.6
WSW	Bristol	B2 SMI	1.0
ESE	Basingstoke	B3 MI	0.6
London/CD	-	<i>none</i>	<i>none</i>

25. Despite the planning assumption, front-line delivery and reactive support work now accounts for less than 5% of CMU doctors' available time. Use of CMU in support of front-line proactive and reactive work also varied considerably across FOD. HID CID was more consistent. Reasons suggested for this included:

- a lack of clarity over the relative roles of OHIs and doctors, and the appropriate route and level at which to bring in specialist advice. In some cases this led to non-medical health specialists providing advice on topics outside their main area of expertise, e.g. the need to engage physicians in interpreting health surveillance results and developing health-risk management strategies.
- Absence of any or sufficient available medical capability in a FOD Region.
- Inconsistent application of the Ways of Working agreement leading to both a substantial down-turn in some regions in the numbers of RIDDOR reported cases of ill-health investigated and the proportion in which doctors were involved despite static reporting rates. This also has implications for HSE's doctors maintaining their GMC re-licensing and specialist recertification – see later.
- HSL CWH doctors are hardly used at all due to front-line staff's lack of knowledge of the medical resource available, and/or how and when to engage it.

However, where medical support has been delivered effectively, there was an increased tendency for field teams to engage their services again.

26. Feedback from both PG and operational staff suggested that future demand in the field for the support described above is likely to grow slowly but significantly because of:

- the changing emphasis of HSE's occupational health business
- the need for support on common health problems affecting the broader working population.
- existing barriers to engagement between field inspectors and doctors, which if addressed, would result in a considerable increase in demand.
- Local Strategic Partnerships and a stronger and more explicit role for the NHS and Local Government in promoting health and well-being.

27. OH advice to stakeholders in HSE Regions is principally delivered by OHIs calling on doctors where appropriate. HSL CWH also handles enquiries on non-regulatory OH and wider medical issues. A small number of organisations have access to private OH service providers and other (albeit limited) services such as Workplace Health Connect and initiatives in Wales and Scotland aim to support SMEs. However, the wider promotion of health and well-being throughout society is likely to mean that demands on HSE for OH advice from in particular SMEs is likely to increase in the foreseeable future. There are also topic-areas where HSE's doctors are uniquely placed to (and should more actively) advise, e.g. the relevance of and duty holders' approach to health surveillance as part of coherent management of health risks.

Reputation and External bodies

28. It is important to bear in mind that HSE's doctors are themselves part of the external medical community parts of which HSE aims to influence in delivering its health outcomes. The 'health' of HSE's in-house capability therefore sends very strong signals to the wider community about HSE's approach and commitment to occupational health. Unlike, many other specialist disciplines, HSE may need to put additional effort into supporting and maintaining its in-house capability than would otherwise be the case.

29. This was reflected in feedback from the stakeholders in the medical community spoken to. They feel that HSE should continue to play an active part in championing occupational medicine in the wider medical community and as the regulator provide some leadership and direction for the community and be actively engaged with the professional bodies in setting minimum standards for e.g. OM practice and training.

OTHER BUSINESS NEEDS AND DEMANDS

Local Authorities

30. Demands for medical support from HSE are currently minimal. However, raising the profile of CMU's doctors with LAs, e.g. in the recent flour dust initiative, inevitably leads to increased demand. There is some evidence that where necessary LAs look to their own sources of advice e.g. HPA. However, HPA doctors are unlikely to have

sufficient knowledge and experience of OH medicine and associated management issues.

EMAS

31. The legal requirements regarding maintenance of an Employment Medical Advisory Service (EMAS) are relevant to HSE's medical capabilities only in so far as the HSC/E is required to appoint doctors as Employment Medical Advisors (EMAs, plural) to deliver the function. Other obligations are less explicit and legal advice is that HSC/E has discretion as to how it otherwise delivers the EMAS function and need not directly employ its EMAs. In the view of the Project Group based on advice from LAO, HSC/E is currently fulfilling its obligations under s.55 HSW Act because currently more than 2 doctors are appointed as EMAs and they are involved in the delivery of a range of the functions of an EMAS.

32. Nevertheless, because of continued external interest in this issue it may be sensible for HSE to consider publishing how it goes about delivering its responsibilities under s.55. HSE was recently required to articulate how all of its health professionals work together in delivering improvements and advice on OH in the workplace in response to an enquiry from the Clerk to the *House of Lords S&T Select Committee (Sub Committee 1) Inquiry on Allergy* prompted by Prospect's Press Release on HSE's resourcing of its OH effort. The response from Patrick McDonald is reproduced in Annex 2 and could form the basis of a more general statement on EMAS delivery. Alternatively HSE5 "the Employment Medical Advisory Service and you" leaflet, last revised in 2000, could be updated.

33. The Review Group also explored whether the principle of an EMAS is relevant today. As discussed above some employers now have access to OH service providers, but the majority do not. The group therefore felt that there is still a need for some sort of State-provided service to fill that gap for the foreseeable future. However, given the much broader approach being adopted by Government, developments in areas such as NHS Plus, HSE's financial circumstances, and the other demands on its limited resources, a more fundamental issue for HSE are:

- should HSC/E continue to be solely responsible for delivering an EMAS for the 21st century, or
- should that responsibility more appropriately reside at a cross-Government level?

Appointed Doctors

34. HSE appoints external doctors under six sets of Regulations to carry out medical surveillance (including biological monitoring) in certain high-hazard activities such as work with lead and in some cases advise employers whether an employee should be suspended from certain work because of levels of exposure. Once appointed HSE reviews an AD's appointment periodically, although there is no statutory requirement to do so but it is probably prudent to continue some oversight of doctors appointed under Regulations. CMU spend around 10% of their time on this work which is a significant reduction compared with previous years.

35. HSE's assessment, supervising and monitoring of ADs provides an independent mechanism to ensure that duty holders have access to quality medical services in high-hazard areas. However, the current appointment system is too 'one-size fits all', although reduced doctor numbers has meant that a variety of methods, including contracting out, have been deployed across the country to deliver the scheme and has led to a very inconsistent picture. The appointment process is currently under review by CMU to better target doctors' effort at e.g. poor performers or ADs that do not perform this function frequently and bear down further on doctor resource expended on this work. It is also proposed that AD reviews are incorporated into the GMC re-licensing and FOM re-certification arrangements with HSE retaining only an oversight role.

36. An alternative suggested by Policy Group is that more reliance could be placed on the requirement for employers to obtain competent advice under the Management Regulations and possibly move to a position whereby the onus is placed on the employer to engage a suitably qualified doctor to perform statutory medical surveillance and thereby removing the need completely for an HSE approvals process.

Continuous professional development

37. HSE's doctors are unique amongst scientific disciplines in that they have very specific needs for continued professional development and professional revalidation to maintain their GMC licence as a registered medical practitioner and recertify as a 'Specialist' in an area of medicine. The regulation of doctors is already extensive and increasing in its rigour following the recommendations of the Shipman Inquiry. A helpful summary prepared by Dr John Osman in CoSAS of the revalidation and re-licensing requirements is in Annex 3.

38. The Faculty of Occupational Medicine (FOM) is now recommending OH specialist doctors perform at least 50 hours CPD activity each year and be able to demonstrate an adequate level of clinical activity. Many CMU doctors perform much of this in their own time and a number have, or have had, other external appointments enabling them to see patients. The significant reduction in the cases of ill-health and diseases being referred to doctors is limiting their opportunities for clinical work as part of their employment with HSE. In contrast, HSL CWH doctors CPD/revalidation/relicensing is managed by their 'parent' organisations (e.g. NHS) enabling them to focus all of their time with HSE on delivering medical support.

39. Therefore, when considering the appropriate scale and deployment of HSE's medical capability, CPD needs of its employed doctors is an important factor.

CONCLUSIONS

40. Overall, the views of stakeholders indicate:

- There continues to be a strong business need for HSE to have access to competent medical advice and support to deliver its current and future business.
- The basic needs of Policy Group are partially met at present, largely from within the medical and biomedical capabilities within CMU and HSL CWH as well as from external sources, and demands are likely to increase in the future.
- Policy Group has a particular need for access to a medical capability increase external leverage with the wider health community – this does not currently exist other than via DWP or DH.
- Support to front-line demands is being barely met, and is absent in some parts of the country.
- Maintaining the *status quo* poses substantial risks to policy development and delivery and front-line operational activity.
- The main demand for medical capability from within HSE continues to be for specialist occupational health physicians with a clear understanding of HSE's business including its regulatory functions.
- There are current needs for other medical specialists to varying degrees, and an increasing demand for doctors with public health and biomedical expertise. CoSAS continued to require the significant input of a medical epidemiologist. PG require the expertise of a respiratory physician and dermatologist to a lesser degree, the former being delivered adequately by a doctor from HSL CWH.
- Best use is not being made of HSE's existing corporate medical capability because of in particular:
 - the lack of an 'intelligent customer' capability
 - existing processes are barriers to the effective and flexible deployment of resource
 - limited use of HSL CHW.
- HSE's governance arrangements have not ensured that the scale and nature of its medical capability has kept pace with the changing nature of its occupational health business at all levels, from operational delivery to engagement with external stakeholders.
- HSC/E's responsibilities to maintain an EMAS are of limited relevance to HSE's medical capabilities. Nevertheless, there is a need to clarify for, in particular, external stakeholders how HSC/E discharges its responsibilities and HSC/E's future role in this respect.

PROPOSALS AND OPTIONS

41. Maintaining the *status quo* is clearly not an option! What follows is a package of measures requiring urgent action to ensure a viable medical capability in the short-term, and some longer-term proposals to provide a flexible and sustainable capability to enable HSE to meet future internal and external developments.

Immediate steps

42. HSE needs to enhance its medical capability to:

- i. Deliver input at the strategic level, to provide the medical perspective alongside that of policy makers, analysts and other specialists and to enable HSE to engage effectively with the wider medical community and better inform and influence a wide range of internal and external bodies;
- ii. Ensure the capability is well-led professionally and functionally, operates coherently, and is focussed on delivering HSE's business needs;
- iii. Provide adequate medical inspector support to front-line operations in London (and the East of England) and portfolio function to Construction Division;
- iv. Provide respiratory disease expertise to the DRP.

Proposal 1 – Appoint a Chief Medical Advisor

43. It is proposed that requirements (i) and (ii) above are delivered by appointing a senior, respected physician as Chief Medical Advisor (CMA) to act both a senior medical advisor to the HSE Board, the CSA and PG, and to lead professionally both HSE and HSL's doctors.

44. The Review Group judge that this could be delivered on a 3-days/week basis, but the individual's knowledge, skills, expertise, professional standing and networks will be most critical. The Group also see advantages from someone who is also a practicing OH physician for the rest of their time, e.g. they have up-to-date knowledge of the external 'environment', and CPD/revalidation issues could be handled solely by, or jointly with, their other employer. However, potential loyalty/conflict of interest issues may pose challenges.

45. The CMA would need to have very strong links with Patrick McDonald and possibly also deliver one of the Senior Scientific Advisor roles under MBUS. This relationship and the CMA's corporate role also point to the CMA reporting to the Chief Scientist. The CMA would also need access to and support from the range of other specialist physicians from within HSE/L and should work at further strengthening the links with DWP OH physicians.

46. The CMA would provide the broad professional and technical leadership to HSE's doctors, but not line manage them to ensure that HSE maximises the CMA's professional input for the limited time they are available to HSE. CMU's doctors would continue to require occupational medicine professional leadership and line management from a Band 1 doctor, particularly during the initial stages of the proposed changes.

47. Two options are suggested for delivering the CMA function:

- Option A: Directly employ a suitable occupational physician on a part-time basis, and (given the uncertainties described above) on a fixed-term contract.
- Option B: Extend the current HSL model for procuring medical services to provide a CMA through the CWH on the basis of a 12-month pilot programme.
- In both options: Maintain the T/P Band 1 Head of CMU post, and reviewing the post after 12 months depending on progress with the options and development with HSE's Health Strategy.

48. Option A:

- Provides greatest scope for meeting HSE's longer-term policy and strategic needs, and achieving the right level of influence amongst the occupational medicine community, which would not be possible other than through a fellow member of the Faculty.
- Has greater chance of success in relation to the professional leadership of CMU's doctors.
- Will be expensive (see financial and resource implications later)
- Require great care in setting clear roles and accountabilities and managing any loyalty/conflicts of interest given the individual's other interests. Appointing a doctor from the NHS, Government Service or from academia may be preferable to someone who holds an appointment in private industry or with a commercial OH Service Provider.
- Require greater use of HSL's CWH to procure other medical services and access networks in other medical disciplines

49. Option B will not provide the depth of occupational medicine expertise to meet all of HWD needs, but benefits of the CWH approach include:

- A respected physician as CMA with a broad view of medicine and highly developed networks within the NHS and wider medical community.
- T/Head of CMU with much experience of occupational medicine, existing networks within the occupational medicine community, and a senior position in the FOM.
- Access to practising physicians with a National/International reputation with a wider range of clinical skills to compliment existing capabilities and meet other policy and operational demands.
- Immediate access to a wide range of professional networks including FOM.
- Scope for tackling the current deficit in commissioned research
- Management of clinical governance/CPD/revalidation issues through NHS Trust mechanisms.
- Use of NHS salary scales, and access to rewards schemes (e.g. Clinical Excellence Awards at local and national levels).
- Opportunities to build HSL's capability and external reputation, and take advantage of HSL's possible involvement in wider Government thinking - e.g. Lord Mackenzie wants to explore in November how HSL can assist with the HWWB strategy.

Proposal 2 – Recruit a Band 3 Medical Inspector in the South East

50. The medical inspector capability (iii above) can only be realistically secured in the short-term by recruiting a suitably qualified OH physician in London or Northern Home Counties. Offering a training appointment for a newly qualified doctor will take some time to arrange, there are no guarantees as suitable 'partner' organisation will be identified and the individual will be remote from their mentor.

Proposal 3 – Resource Additional DRP Respiratory Support

51. The DRP support (iv. above) is currently delivered on a very limited basis by the CoSAS doctor. He judges that the scale and nature of this work requires on average 3 days a week. The demand is unlikely to diminish. Although the warranted regulatory skills of a MI are not required, the respiratory physician would require a sound knowledge of the statutory framework relating to OH.

52. Given the uncertainties over the future direction of the DRP post-Fit3 the proposal is to look to HSL CWH to resource this demand for the immediate future. The position can then be reviewed once the shape of the DRP's successor is known when a decision can be made whether to directly employ a respiratory physician if this is appropriate. The appointee would, initially at least, require oversight and mentoring by the CoSAS doctor until they had achieved an appropriate grasp of the regulatory frameworks.

Proposal 4 – Retain the existing CMU Organisation and move to the STG

53. There are strong arguments in principle for separating CMU's strategic and corporate advice function from its front-line support and delivery function and with the smaller corporate team also acting as the 'intelligent customer' for the procurement of other medical support from other providers, principally HSL CWH. However, this is not a viable option because of the small size of CMU at present and the significant proportion CMU's resource currently dedicated to PG support.

54. The recommended option is therefore to retain all of the medical capability currently in CMU in a single Unit (along with the biomedical scientists and FAAMS). The Unit also moves to the Science & Technology Group in October 2007 on the basis of CMU's predominantly PG and corporate support activities and the opportunities for maintaining or forging closer links with health and medical specialists in other Units and in HSL.

55. However, as the scale and nature of the future demands for medical support emerge requiring a shift towards a larger proportion of HSE's medical capability being focussed on front-line activity and engagement with stakeholders at a local and Regional level, then a separation of these functions would become a preferred option considered.

Proposal 5 – Improve processes and procedures

56. The Review highlighted a number of process (and consequently behavioural) deficiencies indicating that best use is not being made of its current medical capabilities. In particular, those requiring specialist medical input are often unable to clearly identify the most appropriate source and commission it in an informed manner leading to mismatches between the skills sets obtained and those required. This arises because of, amongst other things, a lack of a clear understanding of the 'added-value', skills and expertise a doctor can provide policy and front-line staff, and weaknesses in existing procedures.

57. The Review Group consider there is an urgent need to improve the current arrangements for engaging doctors in both policy and front-line decision making,

involving, for example, a review of the 'Ways of Working' document, and increasing the 'visibility' and accessibility to MI resource in the field across HSE. Effecting the necessary process improvement is part-and-parcel of good governance and management, and can be delivered in the short-term by the existing organisational arrangements. The HSE Board are therefore invited to note that this work will be initiated and delivered as part of the CHSD/CMU plan of work and to simply endorse this proposal.

Medium- to long-term improvements

58. HSE also needs to look to the future and consider options for maintaining its in-house capability in the longer-term. Mechanisms for future delivery also need to be flexible enough to adapt to short- and longer-term uncertainty of demand. No HSE doctors are due to reach 60 until May 2010, however one has indicated a desire to retire early. CMU is also always at risk of its doctors being attracted by the packages and opportunities offered by private OH providers and enhanced pay and grading arrangements offered by some Government Departments and Agencies and the NHS.

Proposal 6 – Build a Sustainable Field-based Model

59. The Review has identified and highlighted a number of uncertainties about HSE's future 'health business' and recognises HSE's resourcing environment. Nevertheless, to realistically meet the range of demands and provide future flexibility, stability and sustainability the Review Group's best estimate is a field-based 'model' comprising seven Band 3 Medical Inspectors - one in each HSE Region – and the current three Band 2 SMI cadre. CMU's field complement currently comprises four Band 3s (2.7 FTE).

60. The Review Group therefore recommend that HSE take steps to increase the cadre of CMU doctors over the coming 2-3 years to the level suggested in this model by March 2011, and respond to unexpected vacancies as they arise in the interim. This can be done as follows:

- Option A: Directly employ OH physicians on a business needs basis particularly if further vacancies arise in the short-term, and as funding becomes available. This provides the greatest scope for longer-term sustainability. All of CMU's current B3 MIs work part-time and maintaining this flexibility provides scope for doctors to hold external clinical appointments and as well as limit salary costs; or
- Option B: (Re)explore offering a limited number training opportunities for newly qualified doctors. This is more economical and will also have the added advantage of demonstrating HSE's commitment to engage in supporting the wider medical community. The Board paper from September 2006 is attached in Annex 4 for reference.
- Option C: A combination of Options A and B

61. →←

62. →←

Proposal 7 – Clarify HSC/E’s role regarding EMAS

63. HSC/E’s responsibilities regarding EMAS continue to be a ‘live’ topic, often for the wrong reasons! Immediate and tangible action is therefore required to clarify for, in particular, external stakeholders, how HSC/E discharges its responsibilities and HSC/E’s position.

64. The Review Group feels that HSE should at least publish how HSC/E delivers its responsibilities under s.55 as part of a targeted communications strategy (e.g. including the revision of HSE5). The details of a strategy will be developed further with CommsD, but Colin Douglas has been engaged in some early discussions.

65. The Group also invite the Board to consider and provide a steer on whether the time is now right to also explore whether HSC/E should continue to be solely responsible for delivering an EMAS, or should that responsibility more appropriately reside at a cross-Government level.

66. Exploring this further will require engagement with DWP, DH and a range of other external stakeholders including the medical community. Broadening or changing responsibility for maintaining an EMAS would not require legislative change, but simply a new delegation by the Secretary of State.

Proposal 8 – Reduce further HSE’s role regarding Appointed Doctors

67. Work is already in progress to streamline and make more proportionate the Appointed Doctor scheme. The Review Group proposes that this work should be progressed to a conclusion as quickly as possible so that any efficiencies in doctors’ and others’ time can be redirected at other work.

68. The Board is also invited to consider and provide a steer on whether HSE should activity explore an alternative approach which places more of the onus on employers to engage and assure the suitability of a doctor to perform statutory health and medical surveillance, and thereby removing any statutory obligations to approve doctors. This will however require a change to the law.

FINANCE AND RESOURCE IMPLICATIONS

Proposal 1 - Chief Medical Advisor

Option A – CMA direct employment

69. Employing the person with the necessary skills and attributes will be critical to the success of this proposal. HSE will need to offer a package that is sufficiently attractive to an experienced NHS consultant occupational physician, or Chief Medical Officer in a large organisation. The current NHS pay range for experienced consultants is £82,000-£133,000 plus any London Weighting. Based on the top of

this scale and with other salary costs (eg. ERNIC), an annual total salary cost to employ a senior occupational physician (outside of London) on a 3-days/week basis would cost HSE approximately £100,000 p.a. A London-based CMA would add up to £3,500 to the salary costs. There will also be an annual T&C/T&S cost of approximately £1, 500.

70. This could be part-funded from within CHSD. CHSD's affordability plan to March 2008 anticipates the need to fill the currently vacant Band 1 Head of Unit post substantively, and based on an average Band 1 annual salary cost of £77,909¹ (2007/08). The remaining salary cost would therefore have to be found from elsewhere in HSE.

71. The additional salary cost to maintain the T/P Band 1 Head of CMU post is surprisingly modest because of the significant overlap between Band 1 and Band 2 doctors' pay ranges. Based on average salary costs (2007/08) maintenance of the T/P Band 1 will cost £420 p.a. and would also have to be found from elsewhere in HSE. →←

72. Recruitment costs. Given the small number of likely suitable candidates, the proposed approach would for a small number of 'teaser' advertisements in the broadsheet press and professional journals linking to the HSE website for details. This would cost up to £10,000.

Option B – CMA resourced through HSL CWH

73. The Centre for Workplace Health (CWH) is based on a Memorandum of Understanding between HSL, the University of Sheffield and the Sheffield Teaching Hospital Foundation Trust. This memorandum currently facilitates 3 clinical posts (1.8 FTE) with a fourth currently under negotiation (an additional 0.2 FTE).

74. The approximate additional cost to HSE of providing a CMA and to increase its medical cadre to include all key disease areas (skin, MSD, psychiatric, respiratory) whilst continuing to meet current demands on our clinical resource would be £450,000. This is based on full economic cost recovery through HSL's agreed hourly rate and with funding from the mainstream S&T budget.

75. The current 'under-spend' of the S&T budget provides much scope to fund this 12-month programme.

Proposal 2 – Medical Inspector in London/SE

76. All of CMU's Band 3 Medical inspectors work flexible hours, on average 3 days/week. Using 2007/08 average salary costs, directly employing a Band 3 Medical Inspector based in Rose Court on this flexible hours basis would cost HSE £56,885 p.a. T&C/T&S costs would be approximately £2,000 p.a.

¹ Average annual salary costs referred to in this report are salary plus ERNIC and Superannuation costs to HSE. They do not refer to full economic costs.

77. However, the need for medical support is not only need in and around London but in the north and east of ESE Region. The CD portfolio role could be delivered from any location in the South-East. The preference would be to base the doctor in Luton or Chelmsford. →← On this basis the salary cost would be £50,500 p.a.

78. This post could be funding for at least the first-year from within CHSD's affordability plan if the decision in Proposal 1 is to source the CMA from HSL CWH. Otherwise, funding for this post would need to be found from within HSE's budget.

79. Recruitment costs. As before, the proposed approach would for a small number of 'teaser' advertisements in the broadsheet press and professional journals linking to the HSE website for details. This would costs up to £10,000, but - subject to the Board's decisions and timing - combining advertisements for this post with those for the CMA post may give scope for savings.

Proposal 3 – DRP Respiratory Support

80. HSL CWH's respiratory physicians currently do not provide support to the DRP from a regulatory perspective. Answering this demand can be delivered by HSL from within their existing funding arrangements by re-focusing their specialist capability, and enhancing it where necessary as part of the CMA pilot outlined above.

Proposal 6 – Sustainable Field-based Model

Option A – MIs directly employed

81. Directly employing three further Band 3 Medical Inspectors to place an MI in Scotland and WSW and to cover the anticipated retirement in YNE on a 3-days/week basis would cost in £50,500 p.a. (using 2007/08 average salary costs) with a further £2,500 for T&C/T&S for each MI recruited. However, the aim is to move to this position over the next 2-3 years so future pay agreements and inflation will affect the actual cost. Overall costs could be managed by recruiting in each location in order of priority on a 12 month cycle beginning October 2008.

Option B – OH physician training scheme

82. HSE Board paper B/07/63 (reproduced in Annex 4) discussed the potential resource implications of a pilot to recruit and train OH physicians in partnership with an NHS Trust and Manchester University. It estimated that a 4-year accredited training package would cost HSE on average £47,000 p.a. for each trainee, including salary and other costs.

83. However, the estimates were based on 2006 NHS Trainee salary costs and the cost of the University Diploma in occupational medicine, and since then the national framework for the specialist training of doctors has changed substantially. It is therefore not guaranteed that suitable partners to offer a training package will be found in the timeframe suggested and the PMETB changes will involve considerably

greater 'up-front' effort by HSE to establish the necessary systems and agreements. However, The Head of CMU is confident that there is sufficient demand from newly qualified doctors and continued interest in running a pilot in the Faculty of Occupational Medicine and the NHS.

84. Funding for both of these options would need to be found from within HSE's budget.

CMC Review Costs

85. The CMC Review cost to date approximately £20,000. This comprises the salary costs of the SRO, SCS Project Leader and Project Group, and T&S.

CMC Review Group August 2007

ANNEX 1

REVIEW OF HSE'S CORPORATE MEDICAL CAPABILITIES

PROJECT TERMS OF REFERENCE

1. The **Terms of Reference** of this project are to:
 - Review HSE's medical capabilities against HSE's occupational health priorities and business needs in the short- and longer-terms; and
 - Consider and advise the HSE Board on what medical capabilities HSE needs to deliver those priorities and meet those needs, including any business risk management arrangements, and the implications of best delivery for HSE.
2. This will enable the Board to decide, in particular:
 - How to develop and maintain the necessary medical capability;
 - The optimum balance between in-house (including HSL) or external provision of that capability;
 - Whether the EMAS function remains a suitable vehicle for delivering all or part of that capability;
 - How to ensure suitable professional leadership to in particular HSE's medically qualified staff;
 - How to manage any risks to HSE's business and/or reputation in the meantime;
 - How to engage external stakeholders in developing HSE's capability.
3. The project scope, timing, objectives and management arrangements are set out below.

Scope

1. Delivering HSE's priorities and business needs will include:
 - Contributing to the development of HSE's broad policies and strategies in relation to occupational health, eg. through the new Health Agenda Steering Group;
 - Strategic support to policy development and delivery;
 - Developing and promulgating standards of occupational health management and provision for which HSE has the lead;
 - Expert support to HSE and LA reactive and enforcement activities.
2. The project will focus on the role of medically qualified staff. HSE's business needs should also be considered in the context of the work of HSE's biomedical scientists and occupational health inspectors. HSE's experience

to date with Workplace Health Connect should also be taken into account.

3. The review will not specifically address the Band at which to fill the current Head of CMU vacancy. This will be determined by the Board once it has decided on the nature and structure of the required corporate medical capability.

Timing and key objectives

4. The project should progress quickly. Key milestones and objectives are:
 - End-January 2007 – Commence project.
 - By May 2007 - Complete review including:
 - Capture current thinking on future occupational health priorities.
 - Determine and agree the likely scale and nature of HSE and HSL's effective and affordable contribution to addressing those priorities.
 - Determine the scale and nature of the necessary corporate medical skills, expertise and experience.
 - Map those requirements against existing capabilities, identify gaps and propose solutions for, eg. maintaining and where necessary enhancing that capability in the short- and medium-terms.
 - Inform and take account of the Making Best Use of Science project in relation to the optimum organisation and deployment of HSE and HSL's medical expertise and arrangements for its successful delivery across HSE.
 - Maintain engagement and communication with the corporate medical community throughout, and develop plans for continued engagement during the implementation phase.
 - June 2007 - Paper with recommendations to the HSE Board.
5. The views of DWP, DH and relevant professional bodies eg. Faculty of Occupational Medicine, on HSE's priorities and business needs will be captured as part of this review to inform the development of a range of options. External stakeholders will be engaged on delivery mechanisms after the Board has considered the Review's options and recommendations in June 2007.

Project management

SRO:	Sandra Caldwell
SCS Project Leader:	Peter Baker
Project Coordinator:	Anthony Lees
Project Group:	Dr Dil Sen (CMU) Dr John Osman (CoSAS) Dr David Fishwick (HSL) Howard Saunders (HWD)

ANNEX 2

THE ROLE OF HSE'S HEALTH SPECIALISTS IN ENFORCING WORKPLACE CONDITIONS, ADVICE AND EDUCATION

Patrick McDonald's response to a query from the Clerk to the House of Lords S&T Select Committee (Sub Committee 1) Inquiry on Allergy

Sarah

You emailed me on 28 May seeking clarification on the numbers and role of medical inspectors and occupational health inspectors in relation to the enforcement of workplace conditions and education in relation to occupational allergies.

Numbers of occupational health professionals

1 At 20 June 2007 HSE employed 9 doctors (7.3 Full Time Equivalents or FTE) – 7 as medical inspectors (5.7 FTE) and 2 in corporate roles. HSE also employs 26 (23.4 FTE) occupational health inspectors (OHIs).

2 HSE's Health & Safety Laboratory's (HSL) Centre for Workplace Health has 4 doctors (2.7 FTE) – all with clinical appointments in the NHS - and 4 occupational health nurses (3 FTE).

HSC/E's approach to regulating exposure to occupational allergens

3 As you acknowledge in your email, HSE's medical inspectors and OHIs are not solely responsible for the enforcement workplace conditions and education in relation to occupationally related allergic disease. HSC/E's deploys a range of regulatory, specialist and scientific staff to identify occupationally related allergic disease and its root-causes and to advise employers on effective strategies to eliminate or control exposure to allergens in the workplace. This is done within the context of an overall framework of good occupational health management with a view to sustained performance.

4 In the majority of cases HSE's regulatory inspectors (or enforcement officers in Local Authorities (LAs)) will themselves tackle occupational exposure to allergens. Regulatory inspectors are trained on the risks to workers' health of allergens (and other harmful substances) in a range of industries and the necessary management and control measures to protect workers, and can use a range of tools and techniques to influence employers' compliance with health at work legislation from advice through, if necessary, to formal enforcement including prosecution. There are currently over 500 regulatory inspectors in HSE deployed on front-line work in industries where they will encounter a wide range of allergenic substances for example, isocyanates (eg. motor vehicle repair), latex and gluteraldehyde (health care), epoxy resins (eg. construction) and flour dust (eg. commercial bakeries). There are also around 1,000 enforcement officers in LAs across Great Britain dealing with health issues in retail (eg. hairdressers) and office activities.

5 Regulatory inspectors (and their LA counterparts) are supported by specialists in a range of disciplines in HSE and scientists in HSE's Health & Safety Laboratory

(HSL). Inspectors and discipline specialists are also involved in the development and delivery of health-related Strategic Programmes (eg. HSC/Es Disease Reduction Programme) aimed at influencing a wider range of stakeholders including suppliers, customers, training organisations and professional bodies. HSC/E's and LAs' activities in relation to improving the incidence of dermatitis in hairdressing was described in Steve Coldrick's oral evidence to the Allergy Sub Committee.

6 Faced with evidence of an employer's poor control of exposure to allergens, HSE regulatory inspectors can call on a national network of 40 occupational hygiene specialists based in HSE's field offices, HSE's Corporate Health Specialist Division and HSL for further assistance to help them determine the levels of likely exposure of workers and identify reasonably practicable precautions required under relevant legislation, eg. COSHH. HSE's occupational hygienists have expertise in monitoring and evaluating exposure to allergens and other hazardous substances and current standards of 'hardware' controls eg. ventilation and Personal Protective Equipment and 'softer' controls eg. training and systems of work. A number of HSE's occupational hygienists are also directly managing elements of the Disease Reduction Programme (DRP), and lead on 'outreach' activities, for example, the Motor Vehicle Repair Safety and Health Awareness Days aimed at raising awareness of the health risks from isocyanate-based paints and control measures to protect vehicle sprayers.

7 Regulatory inspectors can also call upon 26 occupational health inspectors (OHIs) to advise on standards of occupational health provision in workplaces. OHIs are trained OH nurses and are based in field offices alongside their regulatory colleagues. As inspectors in their own right, OHIs also conduct primary inspections of OH services and service providers and can take enforcement action where appropriate to secure improvements in the standards of OH provision. OHIs also deliver many aspects HSE's health-related programmes. This capability can be supplemented by the 4 OH nurses in HSL.

8 HSE's medical inspectors in HSE's Corporate Medical Unit (CMU) are qualified OH physicians and are based in field offices. They deliver an expert consultancy role to regulatory inspectors and OHIs in complex cases on, for example, disease diagnoses and prevention, standards of the medical content of OH services, and provide specialist support to enforcement. CMU's doctors also provide the medical input into Strategic Programme design and delivery, and support HSE's involvement in wider government strategies eg. HWWB. Medical expertise in specific diseases is also available from HSL's Centre for Workplace Health. HSL has 4 doctors, including respiratory and skin specialists, who also hold part-time appointments in the NHS.

9 CMU's doctors also use their medical networks to influence GP's and other professional groups in the Regions and raise their awareness of occupationally related allergies and other diseases and HSC/E's activities in these areas. HSE/L's OH specialists are also working in partnership with health care professionals to encourage good practice in the wider community, eg. helping with the development of the BOHRF guidelines for the diagnosis of occupational asthma and the GORDS standards of care document.

10 In summary, HSE's proactive approach to improving standards of OH provision and reducing the incidence of occupationally-related allergies through advice and where necessary enforcement is very much multi-disciplinary.

11 This multi-disciplinary approach applies equally to HSE's and LAs' reactive work in response to cases of allergic disease identified at inspections or reported under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations. In some cases of ill-health involving the wider public, HSE and LAs will also work closely with colleagues from other organisations, eg. the Health Protection Agency and the NHS.

12 This approach was demonstrated in HSE's response to an outbreak of respiratory illness from exposure to metal-working fluids at Powertrain, Longbridge. At the outbreak's peak in 2003, over 100 employees had symptoms of occupational lung disease, including occupational asthma, extrinsic allergic alveolitis and humidifier fever. Some workers presented symptoms of more than one disease. The lead regulatory inspectors worked closely with respiratory physicians from the local Health Authority to identify the nature and scale of the outbreak and target HSE's intervention. HSE's medical inspector assessed and was able to identify deficiencies in the OH service provided to the company. HSE's occupational hygienists supported by a team of scientists eg immunologists from HSL sampled exposures with a view to identifying the processes and practices that had contributed to the outbreak, and advising on appropriate management and control measures.

13 Powertrain Ltd subsequently went into liquidation and therefore scope for enforcement action was limited. However, information obtained by HSE's investigation has improved HSE's and industry's knowledge and understanding of the risks of exposure to metal working fluids (MWFs). One outcome is a programme of stakeholder seminars aimed at manufacturing companies supported by HSE, the UK Lubricants Association (UKLA) and AMICUS. The seminars aim to raise awareness of how MWFs affect health and exposures occur, how control measures minimise exposures and how to recognise early symptoms of illness through health surveillance.

27 June 2007

ANNEX 3

KEY POINTS FROM “TRUST, ASSURANCE & SAFETY - REGULATION OF HEALTH PROFESSIONALS IN THE 21st CENTURY”²

This document is the White Paper on the future regulation of doctors in England. It acknowledges that doctors may work across the Devolved Administrations, and the need to make the emerging separate systems compatible across England, Wales and Scotland. This may be particularly pertinent to HSE given the OH&S is a “Reserved” subject.

Medical revalidation

In future all doctors will need to be revalidated on a regular basis if they wish to continue in medical practice.

Medical revalidation will have two components – relicensure and specialist recertification. The latter only applies to those wishing to remain on the Specialist Register (which gives entitlement to work as a consultant in the NHS and which has been the measure for recruitment as a doctor in HSE).

Relicensing as a doctor

This will be done every five years.

It will require positive affirmation to GMC of

- i) engagement in an annual appraisal process (and satisfactory outcome)
- ii) independent 360° feedback
- iii) satisfactory resolution of any “issues” locally (by medical director or responsible officer working together with the appropriate GMC “affiliate” – someone acting as a local link with the GMC)

Appraisal will need to be summative and formative. The GMC will need assurances about the quality of the appraisal process (and it cannot be assumed that current arrangements in HSE will suffice).

Recertification as a specialist

This will also be done every five years, preferably in conjunction with re-licensure.

It, too, will require positive affirmation to GMC, in this case by the relevant medical Royal College (though the individual does not need to be a member).

The College will advise GMC on the basis of a range of sources and activities including at least some of:

- i) employer appraisal
- ii) clinical audit (or presumably some other audit arrangements for non-clinical doctors)

² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946

- iii) simulator tests
- iv) knowledge tests
- v) patient feedback
- vi) CPD
- vii) observation of practice

DH is funding work to develop the procedures for recertification.

DH is asking GMC to consult with relevant specialisms in creating an effective framework, based on Good Medical Practice,³ for objective appraisal of standards.

Medical Royal Colleges and specialist associations will draw up standards which will be tested against needs of patients and health care providers and in consultation with a broader range of stakeholders. The Colleges will need to agree these standards with the GMC.

Para 2.23 states that government will discuss adaptation of standards for special settings (which would seem to be the case for HSE).

Also:

Para 2.35 The competent organisations to assess HSE individuals against the standards will probably be a medical Royal College, but perhaps it could be DWP or HSE.

Para 2.36 Implementation of revalidation should be sufficiently flexible to take account of the diversity of employment environments across the UK. This may be particularly important for HSE.

Para 2.39 Measures should be proportionate to the risk associated with the specialism (or at least I think this para means this).

Para 3.39 An indication that HSE could have a responsible officer who is not a medic.

Para 3.40 Raises the issue of “recorded concerns” ie. “real time” evidence that a doctor may not be working or behaving to the required standards, rather than waiting for 5 years.

(Note that introduction of the requirements of revalidation cannot happen overnight – there is still much work to be done on practical procedures, but doctors are currently expected to keep portfolios of evidence demonstrating continuing competence in the work that they do).

³ Good Medical Practice is the GMC's core guidance for doctors on professional behaviour.
http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

ANNEX 4

Open Government status: Fully closed

Paper Number: B/06/91

Meeting Date: 4 October 2006

Intranet embargo?: Members only

Type of Paper: Above the line

HEALTH AND SAFETY EXECUTIVE

The HSE Board

RECRUITING AND TRAINING OCCUPATIONAL HEALTH PHYSICIANS IN HSE

A Paper by Sandra Caldwell

Advisor(s): Peter Baker, Corporate Health Specialist Division

Cleared by Sandra Caldwell on 26 September 2006

Issue

1. Funding of a 4-year pilot to recruit and train an occupational health (OH) physician in the North West in conjunction with an NHS Trust and University of Manchester.

Timing

2. Urgent. A decision is required to enable the necessary preparatory work to be completed before Christmas 2006.

Recommendation

3. The Board is invited to consider this training proposal and agree in principle to initiate and fund the pilot from early 2007.

Background

4. Paper B/06/55 discusses the low number of doctors/occupational health (OH) physicians in HSE and proposes a longer-term strategy to improve and sustain HSE's corporate medical capability.

5. Against this background, HSE's Corporate Medical Unit (CMU) has been exploring the feasibility of supporting and funding a small number of occupational health (OH) physician training posts in the North West with the Faculty of Occupational Medicine, an NHS Trust and Manchester University. This initiative would provide an opportunity to increase the cadre of doctors in HSE at relatively lower cost than recruiting qualified OH physicians. The proposal would also help to raise HSE's 'standing' in the eyes of the external OH medical community.
6. This proposal also chimes with the New Model for Recruitment and Development of Specialist Inspectors agreed by the Board in December 2005 and considered by OMT at their recent meeting. The Board agreed in principle that the New Model approach should also encompass the recruitment and training of OH physicians.

Argument

7. The proposal is to recruit a newly qualified doctor and offer occupational medicine specialist training shared on a 50:50 (2yrs: 2yrs) basis between HSE/HSL and a Lancashire NHS Trust. This would include 'protected' training/study time of 2 sessions (one day) per week for 2 years at the University of Manchester. All of the parties agree that this scheme is feasible in principle.
8. The aim is to give the trainee maximum experience (NHS, industry, regulatory, research) and an opportunity to achieve all the required competencies necessary for the satisfactory completion of the Higher Specialist Training in occupational medicine recognised by the Royal College. Supervision in HSE/HSL for the 2 years would be by a Senior Medical Inspector, and in the NHS, by an experienced Consultant in occupational medicine.
9. However, wholesale changes to the arrangements for the training of all specialist doctors are to be implemented by the Postgraduate Medical Education and Training Board (PMETB) from January 2007 whereby training will be organised and managed on a national basis. Small-scale, regionally based initiatives such as the one being proposed are very unlikely to be supported under the new system. There is however a short window of opportunity to organise and pilot the proposal from 2007 provided the necessary preparatory work can be completed before Christmas 2006. Successfully piloting the approach will also increase the likelihood of it being adopted into the PMETB national scheme should HSE wish to continue to offer training posts in future.

Consultation

10. Limited. Head of Corporate Medical Unit.

Presentation

11. N/a

Costs and Benefits

12. N/a.

Financial/Resource Implications for HSE

13. The annual salary of a NHS Trainee in occupational medicine is currently around £35,000. Training costs would principally comprise the Manchester University Advanced Diploma which is currently £2,800 per year over 2 years. A tri-partite arrangement (NHS/HSE/University) could attract a discount.

14. A contribution towards the training over the 4-year period of around £800 per year is available from the North West Deanery. However, no direct funding is available from the NHS Trust. HSE would therefore have to cover the trainee's salary for the 4 years and most of the training costs. However, time with the NHS is critical to the trainee gaining sufficient clinical experience for Faculty of Occupational Medicine accreditation. The estimated annual costs to HSE would be as follows.

(£)	Year 1 (HSE)	Year 2 (NHS)	Year 3 (NHS)	Year 4 (HSE)
Salary	35,000	36,000	37,000	38,000
ERNIC/Superann	8,800	9,000	9,300	9,500
T&S	1,500	-	-	1,500
Diploma	2,500	2,500	-	-
Deanery	(-800)	(-800)	(-800)	(-800)
Direct HSE Costs	47,000	46,700	45,500	48,200

By way of a comparison the average total salary cost (including ERNIC, etc) for a Band 3 Faculty accredited Medical Inspector is currently £80,977, increasing to £84,167 in 2007/08.

15. To mitigate the risks and ensure HSE benefits from its investment it is proposed that a condition of training would be that the trainee works for HSE as Medical Inspectors for at least 2 years after satisfactory completion of their training and Faculty accreditation.

16. One option to fund this pilot is to add the costs as an additional pressure to FOD's payroll to be mitigated through its longer-term financial measures being developed for its Staffing Plan. Alternatively, the funding could be found from elsewhere as FOD is already committed to finding the additional salary of the proposed SCS Head of CMU position and the pilot will benefit HSE corporately.

Environmental/Other Implications

17. N/a

Action

18. See paragraph 3.

Contact : Peter Baker VPN 523 4179