The Skills Programme Action Group are:

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- Mr Roger Bibbings — The Royal Society for the Prevention of Accidents
- Ms Tessa Blewchamp — Chadwick House Group Ltd
- Dr Shaun Chambers — Land Rover Vehicles
- Dr AP Colvin — North Sea Medical Centre
- Professor Sue Cox — Lancaster University
- Dr Robert Davies — University of Wales
- Dr Kerry Gardiner — The University of Birmingham
- Mr Donald Goodhew — HSE
- Dr John Harrison — The Medical School, Newcastle
- Ms Jan Maw — English National Board for Nursing, Midwifery and Health Visiting
- Dr Alastair Robertson — Institute of Occupational Medicine
- Ms Carole Spiers — Carole Spiers Associates International Stress Consultancy
- Professor David Stubbs — University of Surrey
- Ms Claire Sullivan — Chartered Society of Physiotherapy
- Ms Nina Torbett — Forth Valley Health Board
- Mr Steve Walter — The Engineering Employers Federation

The Group were invited to consider how the occupational health community could act upon the skills programme, as set out in Securing Health Together:

> *To ensure that all interested parties have the necessary competence and skills.*
>
> To achieve the 2010 headline targets, all parties need to have the relevant competence and skills to perform their role effectively. Managers, workers, doctors, nurses, hygienists, designers, ergonomists, human resource professionals, students, and children (in their own context) need to be aware of how they can contribute to protecting and enhancing health during work activities. This will involve identifying the standard of skills required for different roles, and working towards ensuring that at whatever stage you are in life, or whatever your occupation, you have been given an opportunity to gain the necessary skills.

Index

Introduction	3
What do we mean by ‘skills’?	3
Our conclusions – creating the demand for occupational health skills	3
Issues	7
……Prioritising	7
……Small Firms	7
……Best Practice	8
……GPs/Primary Care Trusts	8
……Designers	9
Our Vision	9
……The Workplace	9
……Health Care Professionals	10
……HSE and LA inspectors/enforcement officers	
Recommendations	11
Appendix 1 – Summary of 3Rs Report	14
Appendix 2 – Best practice – some examples	15
Appendix 3 – Suggested content of occupational health component in health and safety courses (R. Bibbings, RoSPA)	16

1. Introduction

1.1 This is the report of the Securing Health Together Skills Programme Action Group. They first met in November 2001, and have held five meetings. Together the members represent a wide range of organisations concerned with Occupational Health[1], and have links to industry, government, education and the health service.

2 What do we mean by 'skills'?

2.1 In our discussions, we've talked about 'skills' in three broad ways:

- generic, or 'key' skills
- skills which are transferable or acquirable by the general public – eg through training sessions or workshops
- expert2 skills acquired through specialised study and qualifications

2.2 The generic, or 'key', skills most needed are: the ability to find and interpret information; communication and negotiation skills; a sense of responsibility; awareness of one's rights; self-confidence; and so on. However, vital though these skills are, for the Group to contemplate addressing these would be an impossible task. The provision of programmes to support the acquisition of 'key' skills for those who lack them is the responsibility of others.

2.3 Therefore in formulating our recommendations we have concentrated on transferable and expert skills. These are the 'skills' referred to in the rest of this document.

3. Our conclusions – creating the demand for occupational health skills

3.1 We are agreed that skills are not the first priority in implementing Securing Health Together. What is most needed is much more widespread awareness of occupational health issues, across the population. The first priority, then, is

[1] Occupational health in its broadest sense - that is anything concerned with the impact of work on people's health or the impact of a person's health on their work, and the use of the workplace environment to promote health.

[2] In this report, several groups with such expert skills are referred to:
occupational health professionals such as occupational health doctors and nurses, occupational hygienists, ergonomists, occupational psychologists; health professionals such as doctors, nurses, physiotherapists, chiropractors and 'alternative' therapists; and Heath and Safety professionals, including enforcement officers dealing with health and safety and environmental health.

for the HSE policy makers to have an understanding of, and access to, sophisticated marketing skills. This would enable targeted consumer research, audience segmentation, prioritisation (according to need, impact and cost/benefit) and tailored communication. All these are necessary to effect a real improvement in awareness. Above all, industry must be engaged, and this means programmes that are developed and tailored to industry's needs, not to the needs of providers. The senior management of organisations must be a key target group for improved marketing; for them the link between company performance and good workplace health management needs to be forcefully made.

3.2 Having said that skills are not the first priority, we do envisage that the need, and demand, for skills will emerge from greater awareness. Other necessary precursors are:

- *regulation or policy changes*: The Compliance Programme Action Group is considering whether (or what) changes in legislation are needed to ensure we meet the targets by 2010. They have already concluded that changes in legislative frameworks need time to develop and the outcome is unlikely to be seen within the 10 year strategy framework. Policy changes are faster to take affect and already the emphasis that the Priority Programmes for Stress and Musculoskeletal Disorders have put on these two big causes of work-related ill health has changed the way HSE works.
- *better systems to track sickness absence costs and causes*. HSE is developing advice on good attendance management practice.
- *the National Occupational Health Support and Rehabilitation Service* recommended by the Support Programme Action Group would provide the necessary infrastructure. Specific skills needs would flow from its implementation.

It is important that programmes for developing skills are in place as part of policy implementation plans to meet demand as it increases.

3.3 It is vital, too, that the next phase of Securing Health Together implementation should link the hitherto separate strands – Compliance, Continuous Improvement, Knowledge, Support and Skills – more closely together.

3.4 Any ambitions for new services, or improvements to existing ones, must be seen in the context of a shortage of trained medical professionals across the board, and an overstretched NHS which struggles to provide effective occupational health provision to its own employees.

3.5 Health should however not be seen only as a clinical issue. Everyone in the workplace can play a part in health improvement. But change will only be effected if we have a good understanding of people's attitudes and motivation.

3.6 The main transferable skills are:

- the ability to analyse the working environment (work design as well as machinery/hardware) and effect change;
- the ability to detect (early) the signs of ill-health in oneself and others, and then to find and interpret information and know when and where to seek help;
- and for employers and managers, skills in risk assessment, policy formulation and communication, evaluation, and in judging when and where to refer for help.

3.7 The Group feels strongly that much of the framework for the acquisition of these skills is already in place, in that managers and others already attend Health and Safety courses, conduct safety risk assessments, attend general management courses, and so on. First aiders and trades union safety reps also receive training (the 'body-mapping' technique has already been widely adopted by Trades Unions, under the auspices of the TUC). Amendment of these courses to incorporate a stronger health element, where necessary, and improve awareness of occupational health issues, as well as to empower individuals, would be effective and economical. What's more, 'best practice internationally integrates the promotion of occupational health/safety, organisational development, improvement of individuals' competence and well-being, and organisational culture'[3].

[3] 'Healthy Working Lives- A Vision for Health Improvement in Scotland', Dr Ewan Macdonald and Gabe Docherty (2002).

3.8 As far as expert skills are concerned, here it was harder to come to a conclusion. Many amongst us are convinced that there is a serious shortage of occupational health professionals. Some pointed to a diminishing number of University occupational health departments, for instance. Others disagree that this is an issue. We are certainly agreed that the supply of occupational health expertise is critical to the effective implementation of Securing Health Together, and it's certainly clear that access to occupational health support in UK companies is very limited [4]. But demand is difficult to measure or quantify. There certainly is a sense that occupational health professionals could be used more effectively, and that there could be a better appreciation of occupational health as a career. There is a need for more work on analysing demand and then matching it with appropriate supply. Establishing a correlation between the availability of occupational health expertise and improvements in outcomes would also be a useful step.

3.9 We were however persuaded by those who argue that the most pressing need is for intermediate occupational health skills, both for generalists and for experts. For generalists, the case has been made (notably by Dr Andrew Curran of the Health and Safety Laboratory in Sheffield) for introducing a range of occupational health training opportunities. The idea would be to create a cohort of in-house 'experts' within small or medium sized companies who would enhance those companies' ability to make informed decisions about occupational health matters. The proposed Occupational Health Technician qualification would range from NVQ1 to Diploma level. We support the development of ideas of this sort as a cost-effective means of increasing the critical mass of occupational health expertise. It may be possible to take this forward with the Employment National Training Organisation (EMPNTO), who are already doing some development work on other technician qualifications.

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[4] Only 15% of UK companies employ occupational health support in the form of hazard identification, risk management, and provision of information. If a more stringent definition of occupational health support is used (ie one that includes modifying work activities, providing training on occupational health related issues, measuring workplace hazards, and monitoring trends in health) then only 3% of UK companies fulfil these criteria. (More large companies fulfil the criteria than small ones). Source: Survey of Use of Occupational Health Support, prepared by the Institute of Occupation Medicine for the HSE, RR445(2002).

3.10 For experts, we are concerned both with the structure of intermediate occupational health qualifications (such as for occupational health nurses) and the availability of occupational health training for other intermediate health professionals (such as practice nurses and nurses working in occupational health who don't have occupational health qualifications), and would like to see opportunities increased and progression routes made clearer.

3.11 There is a paucity of hard facts or evidence to support a concerted campaign either to increase awareness or to improve skills. HSE is under-resourced either to research what already exists, or to drive the kind of research programmes that will provide the necessary evidence. Currently HSE spends around 8% of its budget on research. Unless this is rectified, it's hard to see how Securing Health Together can be effectively implemented

3.12 Notwithstanding the above, we have articulated our vision, and agreed a set of recommendations that we believe are practical and achievable.

4 Issues

4.1 *Prioritising*

In order to avoid addressing issues that are too big to tackle, we conducted a rough and ready analysis of which groups were most in need of skills, and then which groups could have the greatest influence on improving occupational health. This led us to assign a high priority to adults in work, to small and medium firms, to GPs and to Designers. Further discussion led to a refinement of this list (see 4.2, 4.4 and 4.5 below). We assigned a lower priority to children and students as these groups are in any case already being targeted by other HSE initiatives such as the Risk Education programme, work on passport training schemes, and the developing work with Department for Education and Skills and Learning & Skills Council on work experience and workforce development.

4.2 *Small firms*

Small firms initially emerged from our own analysis as a priority. However a presentation about the 3Rs report[5] convinced us that 'small firms are not just

[5] A summary is at Appendix 1

like big firms only smaller', and very different solutions need to be found for the small business sector. A separate drive is almost certainly needed to educate and motivate small businesses about occupational health. But skills, though needed, would not be a major element of that drive, and such a drive would need to be co-ordinated with others which seek to target this sector (such as the Learning & Skills Council's Workforce Development Strategy, or the Government's Skills for Life [Basic Skills] Strategy).

The proposed National Occupational Health and Rehabilitation Service will be particularly important for small firms for whom setting up in-house occupational health expertise is usually less cost-effective. We have the opportunity to learn a lot about what this may mean for skills gaps and increases in demand for skills from both NHSPlus (which is already providing occupational health medical services to small firms in England) and the Scottish Executive's small and medium enterprises service (that is just beginning to provide a free baseline assessment of occupational health and safety needs and access to expertise for small and medium enterprises and individual workers in Scotland).

4.3 *Best practice*

We have uncovered many examples of good, even excellent practice in the management of occupational health, some of which are described in appendix 2. However companies/organisations that have introduced occupational health policies rarely refer to skills development or training.

We note too that it has also proved difficult to find examples where there has been rigorous evaluation of projects or policies. It will be hard to persuade sceptical or hard-pressed individuals and businesses to adopt good occupational health practice unless we have evidence that it makes a measurable difference. Measurement and evaluation are essential.

4.4 *GPs/Primary Care Trusts*

There is broad agreement that it is essential to enlist GPs in an effective occupational health strategy. Most cases of work-related ill-health are seen by GPs – research in Lothian showed that nearly a quarter of GP consultations were due to work related problems – and they can undoubtedly play a more

effective role in identifying causation, and in encouraging rehabilitation. Once again, the need is for greater awareness of the issues, and knowledge about sources of support and advice, rather than for skills *per se*.

Practice nurses, who probably see as many cases as GPs do, can also play a significant role. Para 3.10 has already referred to the need for intermediate occupational health training for practice nurses.

We are also conscious of the impracticality of imposing yet another set of demands on the primary health care system. A simple, pragmatic solution can only be found if it is done in partnership with representative organisations.

4.5 *Designers*

Although there was considerable agreement in the Group that designers could make an important contribution to occupational health, once again we failed to find a specific skills issue. As with GPs, conversation with representative organisations might illuminate opportunities for simple interventions.

5. Our Vision

Our recommendations have emerged from the following description of ‘an ideal world’:

5.1 *The workplace*

Every workplace should ideally demonstrate awareness of occupational health issues through monitoring of sickness absence, attention to the design of work and/or the workplace, and risk assessment. Medium to large firms should have clear occupational health policies in place, and have a ‘champion’ for health issues on their Boards. All firms should collect and analyse data and ensure that they have the human resource capacity to address occupational health issues, including (where appropriate) employing, or having access to, or knowledge about, occupational health expertise.

In terms of skills, this means that:

- *Employers and Managers* need to have, or have access to, the skills
  - to develop, implement, monitor and evaluate policies which support their own and their employees’ physical and mental health;
  - to conduct risk assessments for occupational health;

  - to recognise and remedy contributory factors to ill-health in the design of work and/or the workplace;
  - to recognise the signs of mental or physical ill-health in others, and to empower others to take appropriate steps to address the causes and seek treatment, if necessary;
  - to understand the legal and regulatory framework for occupational health;
  - to recognise the signs of mental or physical ill-health in themselves, and take appropriate steps to address the causes and treat the symptoms; and
  - to manage employees' rehabilitation/ return to work.
- *Trade Union Safety Reps* should be trained to recognise, and work with employers to remedy, the contributory factors to ill-health in the design of work and/or the workplace and to support workers in taking ownership of the issues.

5.2 *Health Care Professionals*

All medical professionals, including but not only GPs and practice nurses, and including alternative therapists, should, as part of their initial as well as in-service training, be trained

- to ask the right questions of patients about possible links between their work and their diagnosis
- to build rehabilitation for work into their prescribed treatment
- to understand workplace issues and realities

5.3 *HSE and LA inspectors/enforcement officers*

All Enforcement Officers need to have a good understanding of occupational health (as well as safety) so that they can recognise relevant hazards in the course of workplace inspections and give appropriate advice or take enforcement action where appropriate.

6. Recommendations

i) Policy makers in the HSE need to understand and have access to marketing skills and methods (para 3.1).

Action: HSE

ii) HSE's capacity to commission and evaluate research, in support of Securing Health Together, should be increased. We recommend that HSE increase its research budget in line with comparable government agencies and departments, and in recognition of the cost of occupational ill health to the UK (para 3.11).

Action: HSC/E and The Minister for Work.

iii) The content of all health and safety courses (qualification-related courses for health and safety practitioners, nationally certified vocationally-related courses, health and safety courses provided through NTOs/Sector Skills Council, and health and safety courses for general managers provided by external training organisations) should be reviewed, and if necessary amended in order to ensure an appropriate health (as opposed to safety) component. Appendix 3 contains a list of suggested components. The emphasis should be on practical skills that are easily transferable into the workplace. Accreditation and regulation of such courses should be encouraged (para 3.7).

Action: Regulating and awarding bodies with the Employment National Training Organisation (EMPNTO), facilitated by the HSE[6]

iv) Research should be conducted to establish the extent to which bodies that undertake health and safety auditing or certification address health as well as safety, and appropriate measures taken to address weaknesses. Relevant professional bodies (including BSI, BSC, ROSPA) should be involved in this research (para 3.7).

[6] RoSPA, BSC, IOSH and CIEH have also written to the Minister for Work calling for a major review of the extent of unmet health and safety training needs, and the adequacy of current systems of delivery.

Action: Employment National Training Organisation (EMPNTO) or National Audit Office

v) All Trades Unions should adopt effective techniques for engaging people in identifying and addressing their workplace-related health issues. Body-mapping is one technique that the group supports (para 3.7).

Action: TUC, facilitated by the HSE

vi) Research should be conducted to establish information on the supply of and demand for occupational health experts (ie occupational health-qualified doctors, nurses, hygienists, ergonomists, psychologists) (para 3.8).

Action: HSE and professional bodies

vii) There should be a thorough review of intermediate professional occupational health skills (eg hygienists, nurses, ergonomists) with a view to overhauling entry requirements, course content, qualifications, and progression/ promotion routes (para 3.8).

Action: Professional bodies and Employment National Training Organisation (EMPNTO) facilitated by HSE.

viii) (para 3.9) Opportunities for the acquisition of intermediate occupational health skills for generalists (such as health and safety practitioners, middle/lower management, TU health and safety reps) should be developed and piloted, with industry involvement to ensure their relevance, appeal, and flexibility. The proposed new Occupational Health Technician qualification should be piloted in this context.

Action: Sheffield Occupational Health Development Group, CBI/industry representatives, trade bodies and* Employment National Training Organisation (EMPNTO)*, facilitated by HSE

ix) (para 5.1) A 'toolkit' of effective training techniques and systems (including relevant data) should be developed, to be used by training managers and companies/ institutions which supply management training. The first stage of this work should be an audit of existing techniques and systems.

Action: HSE to convene a 'lead group' of best practitioners, drawn from the companies listed in Appendix 2, plus the IPD and Employment National Training Organisation (EMPNTO) to supervise this work.

Appendix 1: Summary of 3Rs report

This study carried out by HSE looked at how small firms (less than 20 employees) handle safety issues. The firms all used chemicals in the workplace: dry cleaning, hairdressing; electroplating; timber treatment etc. The origins of the study lay in concerns that the HSE's risk messages were ineffective in helping users control the risks from chemicals, and a belief that safety data sheets could be used to carry approved risk messages.

The key findings were:

- that the target group do not use safety data sheets
- knowledge of health effects (of chemicals) is poor, especially the long term risks
- experience is an important indicator of the level of concern about risks (ie if a person had experienced, or knew someone who had experienced, ill effects)
- small firms have an oral culture
- literacy rates in small firms are low (30% have a reading age below 11)
- differences between managers and employees are not marked in terms of education, literacy rates and attitudes to risk
- management structures are non-hierarchical
- most thought they had good knowledge of the products concerned
- most 'knew' how to protect themselves
- but one third were wrong about the short term health effects of the products
- small firms are not just like big firms only smaller

Answers:

- risk messages need to be user-centred
- face-to-face discussion is needed to gain understanding of peoples knowledge and experience
- need to focus on what people believe and also on why and how they reduce risks
- do not assume that the expert model is better than the worker's
- risk information must address people's personal concerns eg 'what can it do to me?', and must be based on what people already know and believe
- language must be plain

Appendix 2: Best practice – some examples

The list concentrates on examples where the acquisition of new, different or improved skills was a key aspect of an occupational health intervention.

There are many examples of companies that had introduced occupational health policies. However few can provide evidence of the effect of those policies on outcomes. The examples chosen here can demonstrate such evidence.

City of York has introduced a programme to help teachers reduce pressure. This includes workshops on personal action planning, and one-to-one sessions to improve leadership skills, resilience, and ability to manage pressure. The authority measured quantitative evidence of success.

Halifax plc has provided training to Business Managers, human resource and line managers in attendance management procedures, identifying the underlying cause of absence, and developing action plans to retain or return employees to work, including using flexible options. In addition, human resource managers were able to access GPs direct, using standard letters provided by the Occupational Health Manager. The pilot project involved 14 groups and saved £361,000 in four months. If rolled out across the Group, projected savings would be in the region of £7million.

Horsham District Council has introduced a full programme of training in stress management, communication and management issues, following a 1999 survey which showed high levels of stress. Sickness absence rates have fallen from 1002 days in 2000 to 152 in the first 8 months of 2002)

In addition, some large industry bodies are taking a strong lead in emphasising the importance of good occupational health management in their sectors:

The **Engineering Employers Federation** has developed a comprehensive occupational health strategy, which includes employing a Federation-wide Chief Medical Adviser.

Water UK has also pioneered good occupational health management and aims to reduce cases of ill health by 20% over 10 years by improving rehabilitation techniques.

Appendix 3: Suggested content of occupational health component in health and safety courses: from Roger Bibbings, RoSPA

Examples of generic health issues which need to be understood by managers

A. Impact of work on health

Hazards to health

- Physical (noise, vibration, radiation, ergonomics, manual handling)
- Chemical (toxicity, carcinogenicity, teratogenicity, mutagenicity, sensitisation etc)
- Biological (micro biological factors)
- Psychological (stress)

Issues:
Assessment and monitoring techniques
Latency
Multifactorial causation
Understanding health risk assessment (deterministic versus stochastic effects, dealing with uncertainty etc)
Hierarchy of approaches to control
Protecting the vulnerable etc etc

B. Impact of health on work

- impairments due to common conditions (stress, alcohol, drugs etc)
- impacts on safety and performance
- employment/insurance issues

Issues:
Fitness for work standards (e.g. safety significant work);
Confidentiality
Costs
Disability issues

C. Management

- Policy (establishing objectives)
- Accountabilities and training
- Planning for health
- Monitoring
- Review and feedback

Issues:
Consultation/involvement
Corporate target setting and tracking performance
Recognising, celebrating achievement
etc etc

D. Solutions

Services/support
First aid/counselling
Health education/promotion etc etc

Issues:
Information
Access etc etc