Supporting occupational health and wellbeing professionals

The Society of Occupational Medicine is the largest nationally recognised professional organisation for individuals with an interest in health and work. SOM acts as a national voice for occupational health, engaging with government and policy makers to increase awareness of the role of occupational health. Our Patrons are Lord Blunkett, Dame Carol Black and Sir Norman Lamb, MP. SOM hosts the:

-MSK at work network - see https://www.som.org.uk/msk-work-network

-Academic forum https://www.som.org.uk/research-and-academic-forum

Both these groups have informed this response.

Our 1,700 members are occupational health professionals who work collaboratively with the Government and stakeholders. With our members and our Corporate Supporters[1], SOM aims to ensure that OH services are appropriately designed and funded.

For further information, please contact Nick Pahl, CEO, SOM, nick.pahl@som.org.uk Tel 0203 478 1047

SOM welcomes the Government's consultation on improving health at work alongside proposed changes to improve statutory sick pay. We welcome the focus this consultation brings to the importance of quality OH services, amongst measures to secure improved employee health, and productivity, particularly enabling those with long term health conditions and disabilities to remain in work if they wish to do so.

We also welcome the recognition that occupational health professionals are uniquely placed to enhance the productivity of the nation while keeping workers healthy and safe[2]. We are pleased that the consultation recognises the lack of access to occupational health (OH) services, which are currently provided only to around half of all employees. We hope following the consultation steps are taken to build capacity and rapid access to modern occupational health advice, particularly doctors and nurses; There is a serious shortage of specialists in occupational medicine; in the NHS alone, numbers of consultants have declined from 80 to 60 over the past two years.

SOM welcomes investment in occupational health for small businesses and we urge the Government to invest in occupational health professionals to allow this scale up to occur. SOM agrees with the consultations' focus on encouraging employers to support employees with health issues and applying the evidence base around what works in getting people back to work.

---

[1] https://www.som.org.uk/corporate-supporter

[2] Health, work and wellbeing – evidence and research
https://www.gov.uk/government/collections/health-work-and-wellbeing-evidence-and-research
\

We note the strong evidence base for occupational health in return to work. SOM is also working with research funders to secure investment in the co-ordination and funding of academic research to provide answers to key questions related to workplace health. It is calling for a Centre for Work and Health – a concept note for this is in Annex 1.

SOM is a member of the John Lewis *working well* coalition and agrees with their statement as follows:
1. **Early intervention and prevention**. Government should be incentivising and supporting employers to intervene early when someone is in work, rather than focussing reactively on sickness absence. This should be reflected in tax policy and Government's policy objectives.
2. **Parity of esteem**. Mental health and musculoskeletal conditions should be put on an equal footing in government policy and not treated in siloes. This should be reflected in Access to Work, Disability Confident, the Equalities Act and health prevention policy and advice for employers. Government should support employers to put in place adjustments by streamlining, simplifying and properly funding the Access to Work scheme.
3. **Flexible sick pay**. SSP should be reformed to support flexible returns to work. Government should ensure that calculating pay for phased returns is simple and easily understandable for employees and employers.
4. **A thriving market for high quality, holistic, workplace support.** Including Government focusing on increasing the capacity and quality of the occupational health market.
5. **Equality of access to support for all employees.** Government should remove financial barriers which could prevent low paid workers, low margin large employers and SMEs from taking up support. For example, Government research shows that blue collar workers are more likely to be off sick, with no enhanced SSP and no access to support. As a first step, the Government should stop taxing these services as a benefit-in-kind - where they are provided to all employees. Government should be measuring workers' take-up of occupational health services and their outcomes to assess effectiveness, rather than a focus just on supply.
6. **Business-friendly information and advice.** Businesses, health experts and Government should work together to draw together existing advice and best practice including:
- Measuring RoI from workplace health support, including preventative approaches
- What options are available to businesses to support their workers, tailored for different types of businesses
- How businesses can measure success and what 'good' looks like.

1: What needs to change

Q1. Do you agree that, in addition to government support, there is a role for employers to support employees with health conditions, who are not already covered by disability legislation, to support them to stay in work?

Strongly agree, agree, neither agree nor disagree, disagree, strongly disagree.

Q2. Why do you think employers might not provide support to employees with health conditions not already covered by disability legislation to help them stay in work?

Open question.

1) a lack of knowledge about effective absence management:

- **many employers don't understand the business case for helping employees remain in work**
- **many employers lack the management skills to develop and implement an absence policy that enables them to distinguish between absence caused by ill health, social reasons, disability or malingering. This lack is not confined to SMEs**

- **Economic Incentives. If a person becomes unwell in the course of employment and struggles to stay at work, there is no obligation on the employer to assist them to recover, and in many instances, the employer will feel it is cheaper just to hire a replacement rather than help the existing employee get back to work, particularly if there is easy access to a pool of potential new hires.**
- **Employers frequently do not understand how they might be contributing to the problem by creating or prolonging sickness absence. Because they don't appreciate how their efforts may impact on incidence and duration, they are unlikely to see the value of taking an active role in the employee's recovery and return to work (RTW).**

2) a lack of skills

- **Many employers do not even understand how to interpret, never mind implement, the recommendations in a fit-note, and how to roll it into an overall absence management/return to work plan.**

3) A failure to build skills in the workplace

- **In many instances employers, lacking the skills to manage the sickness absence/return to work, will attempt to outsource these workplace decisions to external advisors. If, as often happens, that advisor focuses on the individual's health issues rather than identifying the appropriate RTW support, the employer will not receive useful information on what they should be doing to help the individual stay or return to work.**
- **Lack of in-house skills, particularly line managers, on how to manage sickness absence effectively in the workplace. Employers may look to their Human Resources (HR) advisors to manage sickness absence, but unless these individuals have been adequately trained in the core evidence-based principles of disability management, case management and RTW plans, they are unlikely to have the skills to effectively manage sickness absence. Nor will they have the skills to educate and advise managers on the prevention and management of sickness absence.**

4) Regulation to guide socially responsible procedures and practices in the workplace:

- **Government entrusts the health and safety (including sickness absence management) of the workforce to employers, without adequate guidance or training to ensure they are equipped to carry this out responsibly and effectively. Nor is there proper oversight to ensure employers are fulfilling their obligations, and there are few adverse consequences for failing to do so.**

2: A clear legal framework for employers

Comment:
Overall we support the proposals on phased return to work and removing qualifying days for SSP as it simplifies things for employers. We know some people could be missing out on workplace support. However, creating a multilevel system including a right to reasonable adjustments (for people with disability), a right to request flexible working (for all), and a right to request workplace modifications (for people with LTCs/scope TBC), starts to feel quite complex.

Q3. Do you agree that a new '*right to request work(place) modifications'* on health grounds could be an effective way to help employees to receive adjustments to help them stay in work?

Yes / *No* / *Don't know* *(with reasons)*

We are unsure of the evidence base but support empowering employees to bring a request and suggestions to an employer in these circumstances. Referring simply to "modifications" seems to limit the complexity and scope that can often be involved in supporting an employee with health issues at work.

We consider that referring instead to "return to work planning" provides a broader and more descriptive banner under which many actions might fall – including the more specific idea of "modifications".

Talking of a return to work plan sets a clearer expectation that there is a process and an ongoing discussion, which should be fluid and allow for flexibility (due to potential fluctuations in health conditions), and should include responsibilities, timeframes, contingencies, and bespoke solutions clearly addressing an individual employee's specific obstacles.

Q4. If the government were to implement this new right to request work(place) modifications, who should be eligible?

Any employee returning to work after a period of long-term sickness absence of four or more weeks;

Any employee with a cumulative total of 4+ weeks sickness absence in a 12-month period;

Any employee returning to work after any period of sickness absence;

Any employee who is able to demonstrate a need for a work(place) modification on health grounds;

Other, please state.

We also recommend a strong focus on prevention

Q5. How long do you think an employer would need to consider and respond formally to a statutory request for a work(place) modification?

0-4 weeks;

5-8 weeks; or

9-12 weeks?

Q6. Do you think that it is reasonable to expect all employers?

To consider requests made under a new 'right to request' work(place) modifications?

Yes / no / if no – why?

Where is the evidence for this?

To provide a written response setting out their decision to the employee.

Yes / no / if no – why?

Where is the evidence of effectiveness of 'a right to request'?

Q7. Please identify what you would consider to be legitimate business reasons for an employer to refuse a new right to request for a work(place) modification made on health grounds:

The extent of an employer's financial or other resources;

The extent of physical change required to be made by an employer to their business premises in order to accommodate a request;

The extent to which it would impact on productivity;

Other – please state ALL OF THE ABOVE – on the same basis as the Equality Act – re "reasonable" adjustments

Please give further views in support of your response.

Q8. The government thinks there is a case for strengthened statutory guidance that prompts employers to demonstrate that they have taken early, sustained and proportionate action to support employees return to work. Do you agree?

Yes – no – maybe – don't know

There may be a statutory requirement, but can guidance be statutory?

Considering the aforementioned, does this relate to those with LTHC who are not disabled within the meaning of the Act?

Q9. If no, please give reasons for your answer.

Q10. If yes, would principle-based guidance provide employers with sufficient clarity on their obligations, or should guidance set out more specific actions for employers to take?

Principle-based guidance provide employers with sufficient clarity;

Guidance should set out more specific actions for employers to take;

Don't know;

Other – please state.

Q11. The government seeks views from employers, legal professionals and others as to what may be the most effective ways in which an employer could demonstrate that they had taken – or sought to take – early, sustained and proportionate action to help an employee return to work. For example, this could be a note of a conversation, or a formal write-up.

Yes, there should be a record. This is normal practice as part of managers duties as described e.g. by Acas and part of case management supervised by OHS. Best practice is already there.

Q15. All respondents: in order for employers to provide effective return to work support, what action is needed by employees? Select all that apply.

To have discussions with their employer to identify barriers preventing a return to work and to inform workplace support;

To agree a plan with their employer to guide the return to work process;

To engage with OH services; or

Other – please state. Good communication (with consent) with community health providers

Q16. All respondents: do you think the current SSP system works to prompt employers to support an employee's return to work?

Yes – no – maybe – don't know. Please give reasons for your answer.

It is not SSP but 'generous' occupational sick pay which acts a barrier to RTW

Q17. All respondents: what support would make it easier to provide phased returns to work during a period of sickness absence?

Guidance on how to implement a good phased return to work;

A legal framework for a phased return to work which includes rules on how it should be agreed and implemented;

Clearer medical or professional information on whether a phased return to work is appropriate; or-

Other suggestions. Access to a competent OHS to provide option 3 above

Q18. All respondents: would the removal of rules requiring identification of specific qualifying days help simplify SSP eligibility?

Yes – no – maybe – don't know. Please give reasons for your answer.

it would simplify but would it increase absence spells and frequency?

Q19. Do you agree that SSP should be extended to include employees earning below the LEL?

Yes – no – maybe – don't know. Please give reasons for your response.

Q20. All respondents: for employees earning less than the LEL, would payment of SSP at 80% of earnings strike the right balance between support for employees and avoiding the risk of creating a disincentive to return to work?

Yes – no – maybe – don't know. Please give reasons for your answer.

This might amount to more than earnings after paying for transport to get to work and paying for food at work

Q21. Do you agree that rights to SSP should be accrued over time?

Yes – no – maybe – don't know. Please give reasons for your response.

Q22. Should the government take a more robust approach to fining employers who fail to meet their SSP obligations?

Yes – no – maybe – don't know. Please give reasons for your answer.

It is clear that cases of employers not keeping to their legal requirements on SSP are widespread. The Work and Health Unit's own commissioned research found that 13% of employers admitted to paying no sick pay. 5.5% of respondents to Mind's survey told us they received no sick pay, despite their answers suggesting that they would be eligible. This is after allowing for waiting days and those who said their incomes were too low to qualify.

Some participants told MIND that they were not paid any sick pay due to being on zero hour contracts, which suggests a misunderstanding of the law by employers. There appears to be a lack of awareness or a disregard that in cases of changing income, eligibility is determined by average earnings of the past eight weeks. For survey respondents, reasons included that it was in their contract that they would not be paid, that they had not been in the job long enough, that they later left the job, and in one case it was policy for the sick pay to be taken out of the next month's pay. These are clearly not in compliance with the law.

Current HMRC fines are far too low and must be raised considerably: £3000 is unlikely to act as a disincentive to many employers. Fines should, of course, reflect the size of the organisation. Enforcement must also be more proactive and should not solely rely on employees, who often do not know their rights, to report employers. The enforcement approach within HMRC should be scaled up, and we are supportive of the Government's proposal to create a single enforcement body on employment rights.

Q23. Do you think that the enforcement approach for SSP should mirror National Minimum Wage enforcement?

Yes – no – maybe – don't know. Please give reasons for your answer.

Enforcement of the National Minimum Wage has been increased in recent years due to a recognition of the volume of non-compliance amongst employers, alongside the variety of reasons for which is it crucial that workers are paid what is due to them. The threat of increased fines, criminal investigations and being publically named as an organisation that has broken the law, are key deterrents for employers.

Even with this tougher enforcement, there is a high rate of non-compliance (as found by the Low Pay Commission, 2019) and this is a growing area. Enforcement of SSP should therefore keep pace with any stronger enforcement action undertaken on the National Minimum Wage. Again, a key way to do this is through the single enforcement body being proposed.

Q24. Do you support the SSP1 form being given to employees four weeks before the end of SSP to help inform them of their options?

Yes – no – maybe – don't know. Please give reasons for your answer.

The current timing of one week before the end of SSP is far too late. Employees must be informed if their income is to be removed and to know what their options are. There are also

wider resources that would be helpful for employers to be required to give employees at an earlier point. For example, employers should be required to give employees guidance on the Equality Act and rights to reasonable adjustments, as well as information and examples of adjustments.

Q25. All respondents: how could a rebate of SSP be designed to help employers manage sickness absence effectively and support their employees to return to work?
Open question.

As the Government acknowledges, any rebate of SSP must be carefully designed. Rebates could be available to organisations that create and promote positive and open working cultures. As a part of this, the Government should consider using the Thriving at Work employer standards.

Any rebate must not be conditional on the employee returning to work, as this will put high and undue pressure on individuals. It is not constructive to simply require employers to get someone back to work. It is important that an employer supports them in a way that works for the employee. They should ensure that an employee is able to focus on their health and that both parties can think about any flexibility or adjustments that are needed if they return to work.

Whilst a rebate of SSP could help to allay business concerns about hiring people who an employer assumes may need time off sick, any rebate must not be just for disabled people. This would be incredibly stigmatising and ignores the value disabled people bring to the workplace. Many people experiencing a mental health problem for the first time do not initially fit the definition of disability under the Equality Act and therefore do not qualify for this. Such a scenario would not be good for the employer or individual. Instead, if a rebate was introduced that was linked to an organisations policies and procedures, we would recommend that these were, at a minimum, linked to the Thriving at Work Core and Enhanced standards, and were verifiable through a third party.

This is also an opportunity to look at the rate of SSP. There is clear evidence of the large negative effects of the current low rate of sick pay – which we explore further in response to the next question - and it is Government's responsibility, regardless of the size of an employer, to ensure that individuals are not at risk poverty when they are unwell.

Q26. All respondents: at this stage, there are no plans to change the rate or length of SSP. The government is interested in views on the impact of the rate and length of SSP on employer and employee behaviour and decisions.

As noted earlier it is generous occupational sick pay (not SSP) which acts as a barrier to RTW

3: Occupational health market reform

We support the Government looking at the case for small employers to get financial support to purchase OH services and choosing the most effective option e.g. co-funding schemes, such as by subsidy or vouchers. We also support:

- ***Facilitating development of data infrastructure about the OH workforce***
- ***Ways to encourage an increase in OH specialists; training opportunities e.g. for OH nurses***
- ***Promoting workforce training model***
- ***Building leadership and developing a workforce strategy***
- ***Supporting the development, testing and evaluation of new ways of delivering OH services – including dedicated funding***
- ***new models would work best to support the prioritisation, coordination and dissemination of working-age health research and development. This could take the form of a new Working-Age Health Research and Development Network***

- ***Improving standards***

Q27. In your view, would targeted subsidies or vouchers be effective in supporting SMEs and the self-employed to overcome the barriers they face in accessing OH?

Yes – no – maybe – don't know. Please give reasons for your answer. **Needs pilot studies e.g. would it be appropriate to be claimed by the employer when they purchase OH?**

Q28. Please provide any evidence that targeted subsidies or vouchers could be effective or ineffective in supporting SMEs and the self-employed to overcome the upfront cost of accessing OH services.

No evidence known

Q29. In your view, would potentially giving the smallest SMEs or self-employed people the largest subsidy per employee be the fairest way of ensuring OH is affordable for all?

Yes;

No;

Don't know - since there aren't any subsidies how would we have experience?

If no or don't know – what would be better?

Q30. All respondents: what type of support should be prioritised by any potential, targeted OH subsidy for SMEs and/or self-employed people?

OH, assessments and advice;

Training, instruction or capacity building (e.g. for managers and leads);

OH recommended treatments. (covered by NHS treatment free at the point of need)

Q31. Please give reasons and details of any other categories of support you think should be included. OH advice to management re: health-related policies

Q32. How could the government ensure that the OH services purchased using a subsidy are of sufficient quality?

Only use quality assured services e.g. SEQOHS certified, but reform needs to occur so that OH services can demonstrate outcomes and use employee experiences as indicators of quality

Q33. As an OH provider, would you be willing to submit information about the make-up of your workforce to a coordinating body?

Yes – no – maybe – don't know.

Q34. If no, maybe or don't know, what are your reasons for not providing your data?

Q35. As an OH provider, expert or interested party, what are your views on private OH providers' involvement in the training of the clinical workforce?

Private providers should be more involved;

Private providers should be more involved but with additional support;

Private providers should not be more involved.

Q36. If providers should be more involved but will need support, what additional support would be needed?

Training remains a real issue in the provision of occupational health services. This is not just about resources but the training process including applying for a trainee is extremely bureaucratic and is very difficult to undertake for a provider other than those who are quite large or who have within their consultant ranks previous experience of training. That is to say the barrier to entry to be a trainer remains high.

Q37. As an OH provider, expert or interested party, what changes to the training and development of the OH workforce could support the delivery of quality and cost-effective services?

More flexibility and recognition of past training for those who wish to transfer into OH. Also, encouragement of flexible training e.g. part-time contracts, maternity leave, etc.

Q38. As an OH provider, should there be a single body to coordinate the development of the OH workforce in the commercial market?

Yes – no – maybe – don't know. Please state reasons for your answer.

Yes

Q39. If yes, what should its role be?

Q40. As an OH provider, what would encourage providers, particularly smaller providers, to invest in research and innovation in OH service delivery? Research grants and access to expertise e.g. economists, statisticians

Q41. What approaches do you think would be most effective in terms of increasing access to OH services for self-employed people and small employers through the market? Please order in terms of priority:

1. ***New ways of buying OH;***
2. ***New OH service models; and***
3. ***The use of technology to support OH service provision. 1***

Q42. If applicable, what other approaches do you think would be effective? Please explain the reasons for your answer.

Financial incentives through HMG or insurers

Elsler D, Treutlein D, Rydlewska I, et al. A review of case studies evaluating economic incentives to promote occupational safety and health. *Scand J Work Environ Health*, 2010; 36: 289-98.

European Agency for Safety and Health at Work. *Economic incentives to improve occupational safety and health: a review from the European perspective*. Publications Office of the European Union. Luxembourg. 2010.

Q43. As an OH provider, expert or interested party, what more could be done to increase the pace of innovation in the market?

- ***Co-funding;***
- ***Access to finance;***
- ***Help with innovation or evaluation;***
- ***Commercial advice;***

Don't know;

Other – please state

Q44. As an OH provider, expert, interested party, what methods would you find most helpful for finding out about new evidence and approaches that could improve your service?

A one-stop shop from a credible respected source which independently reviews all evidence and recommendations

Q46. As a provider, what indicators of quality could help improve the standard of services in the OH market?

Work outcomes;

Quality marks;

Process times;

Customer reviews;

Other – please state;

Don't know;

Also, qualifications of practitioners, services based on evidence based stepped care approach

Q47. All respondents: how could work outcomes be measured in a robust way?

Need to measure *sustained* RTW. Most studies only examine RTW up to a year at most. What happens to people who RTW after one year? Do RTW programmes just delay the inevitable? The research which we rely could be providing an 'illusion of truth'. Work outcomes should encompass psychosocial outcomes. One validated example is the Work Ability question (see HSE RR1053). Employers need to be aware of the true extent of sickness absence in their workplace, and we recommend that employers be obligated to collect these basic statistics. Total absence figures are important as some absence will not be sickness-related but still amenable to approaches from a supportive employer. Also, staff turnover may reveal hidden sickness absence.

It is important that outcome measures include the perspectives of employees. Employees should be able to anonymously rate their experiences in order for employers to be able to see when services have met the expectations of employees, employees have felt listened to, and that they were able to collaboratively come up with solutions which have helped them.

4:Advice and support for employers

We support the Improving the provision of advice and information to support management of health in the workplace and encourage better-informed purchasing of expert-led advice. We also support investment to provide information to employers on how and where to access OH services and a multiyear communications campaign outlining what is available, targeted at SMES and the self-employed

Q48. Do you have suggestions for actions not proposed here which could improve capacity, quality and cost effectiveness in the OH market?

There is currently a lack of incentivisation for employers to provide access to OHS; and insufficient punitive measures for those who don't provide

The Government should look more at the role of the NHS and how more individuals who are self employed or the precariat can be enabled to access OH independently. People can feel more in control of the process.

Q49. Do you need more information, advice and guidance?

HMG needs to understand why people don't access what is there rather than invent more of the same

Q50. If so, what content is missing?

Legal obligations and responsibilities/employment law;

Recruiting disabled people and people with health conditions;

Workplace adjustments, such as Access to Work;

Managing sickness absence;

Managing specific health conditions;

Promoting healthier workplaces;

Occupational health and health insurance; [cont.]

Best practice and case studies;

Links to other organisations, campaigns and networks;

Local providers of services and advice;

Q51. What would you recommend as the best source of such new advice and information?
- **The main government portal (GOV.UK);**
- **The Health and Safety Executive;**
- **Jobcentre Plus; or**
- **Other – please state.**

The key question is how to disseminate – and that may be through a single point of contact most relevant to the audience – trade unions, trade bodies, etc.

Other - All of these places, as employers should be able to find them easily.
The Government should revisit their plans to bring information together into a one-stop shop for resources on health, disability and work for employers. This can be signposted to in many other places, but enables employers to go to one place for such information

Q54. All respondents: do you agree with the proposal to introduce a requirement for employers to report sickness absence to government?

Yes – no – maybe – don't know. Please give reasons for your answer.

To what extent and with what end in mind?

The Government should explore how holding information about an individual being off sick could enable a smoother process for people applying to Universal Credit.

Q56. Do you think this overall package of measures being explored in this consultation provides the right balance between supporting employees who are managing a health condition or disability, or on sickness absence, and setting appropriate expectations and support for employers?

Yes – no – maybe – don't know. Please give reasons for your response.

Not evidence-based

Annex 1 – concept note for centre for work and health

The productivity of the UK population, in both paid and unpaid work, is critical to the UK's economy. This productivity depends on the health and functional capacity of the population. It is vital that an increasingly ageing workforce is enabled to remain productive and be retained in work. The nature of work, employment and associated ill health in the first quarter of the 21st century is very different from the 20th century.

The contemporary world of work in the UK is now dominated by service industries, with an increasing proportion of the workforce employed in small and medium sized enterprises or self-employed, with an increasing proportion in 'precarious' work, employed on zero hours contracts or in the gig economy. During the 21st century improved safety and disease prevention in the workplace has allowed the emphasis in occupational health to shift from a focus on reducing the adverse effects of work on health to recognising the benefits of work for health. This change work and pattern of ill health impacting on the capacity to work poses new questions to those concerned with ensuring the functional capacity and optimal health of those of working age, whose age at retirement continues to increase. The answers to these questions need to be informed by high quality research, with findings widely and effectively understood and disseminated.

The centre draws on the Government consultation, *Health is everyone's business,* a public consultation seeking views on different ways in which government and employers can take action to reduce ill health-related job loss, including:

- Measures to improve availability of high-quality, cost-effective occupational health (OH) services for employers; and
- Improving advice and support from government for employers to understand and act on their responsibilities.

It also builds on "Healthier Wales" and was initially recommended in the Black Report. In her report, Dame Carol Black estimated the economic costs of sickness absence and worklessness associated with working age ill health at more than £100bn each year, "greater than the current annual budget for the NHS and equivalent to the entire GDP for Portugal".

In June 2019, the Society of Occupational Medicine published an evidence-based report on 'The Value of Occupational Health Research', funded by the Health and Safety Executive The report identified the important impact of workplace ill health on productivity in the UK, the high associated economic costs and the unmet need for effective research to guide future policy by government and in the workplace.

Vision - Policy and practice for health at work is informed by reliable evidence - enabling the working age population to remain in work and be productive.

Purpose

Through an effective network of partners, it will co-ordinate and facilitate answers to research questions relevant to government, policy makers and employers through:

Research Prioritisation/development. Setting and communicating research priorities; co-ordinating and signpost funding opportunities; identifying new funding sources and horizon scanning and building collaboration opportunities.

Building Research Capacity - in and between institutions by making training and development opportunities available; promoting collaboration/co-production opportunities (Inc. data sharing) to other academics/researchers, OH providers and employers and raising awareness of OH research careers and signpost to the opportunities available.

Dissemination - translating research and evidence into useable formats and disseminate to employers, trades unions and employees, disseminating research and evidence to inform policy design, and enabling regular refinement of research priorities. Evidence based interventions will include tools to reduce sickness absence and improve job retention.

It will measure and track progress to provide a clear picture of the occupational health of the UK working age population and the factors that affect it; supporting the improved collection and use of routine data on health, occupational risk factors, behaviours taking into account wider health determinants; and be a focus for the identification of the requirement for new routine health information development where gaps exist; to provide early identification of developing issues.

Key issues

Much is known about the nature and causes of illnesses which can impact on the capacity to work. Less is known about *how and when to intervene* to prevent ill health having an adverse effect on the capacity to work. Research focused on evaluating the effectiveness of interventions to prevent work-related ill health and to improve the capacity of people with health conditions to remain in or return to work must be an important priority for new research programmes. The UK workforce is becoming increasingly mobile. Few people now expect to have the same job for life. It has become normal to change jobs or even careers on a frequent basis, with portfolio jobs and homeworking becoming increasingly common. Work in the gig economy or on zero hours contracts is increasing. However, little is known about the effects of the changing work pattern on workers' health. Furthermore, approximately 17% of the UK workforce are migrants, who overall are more likely to work in poorer working environments and in unregulated industries that UK born workers. Foreign-born workers often have important genetic and cultural differences to UK workers, and little is known about how exposures at work may affect their health

Other issues include:

The health consequences of an ageing and changing workforce. An increasing proportion of future workforce will be older and long-term conditions, for example diabetes, coronary heart disease, and COPD will increasingly impact on the capacity to work. With increasing age, an increasing proportion of the working population will suffer from multiple long-term conditions, with or without cognitive decline. Furthermore, those in manual occupations, whose work often depends on their physical fitness, are more likely to be forced to leave work early due to the consequences of ageing than those employed in non-manual work. Loss of work may result in a higher risk of risky health behaviours, such as alcohol abuse and an increased risk of mental ill health. The effects of ageing represent a major challenge to the health and productivity of the future workforce and there is an urgent need for effective research in this field.

Musculoskeletal, Chronic Pain and Mental Health disorders. Musculoskeletal and mental health disorders combined are the major cause of absence from work and being out of work because of ill health. Most disability benefits' claimants have one or both conditions. The relationship of these illnesses to the nature of work, to psychosocial influences, including beliefs and expectations and the means to prevent people with these disorders from falling out of work, are matters of considerable importance to individuals, their families and to society.

The contribution of exposures at work to the burden of diseases common in the community. These include COPD, 15% of the burden of which the American Thoracic Society has estimated is attributable to occupation, and occupational dermatitis which remains the most prevalent occupational disease in the UK Some 6-7000 cases of cancer annually have been estimated by HSE as attributable to occupational exposures. Research needs to include identification of the specific occupational causes of these diseases, the circumstances in which they occur and the potential for multiple exposures and co-factors increasing the risk of disease. While genetic susceptibility may be of importance, more critical when determining control of exposures and estimates of occupationally related burden, is the need to identify relevant biomarkers, for both exposure and disease, to provide the opportunity for early intervention and assessment of risk control.

Evaluation of the health impact of novel materials introduced into the workplace. An important contemporary example is nanoparticles and nanotubules. There is now unequivocal toxicological evidence for important biological effects of nanoparticles and, by analogy with asbestos, increasingly concern about the possible biological effects of nanotubules. To answer these questions will require both basic research into mechanisms of disease, particularly mesothelioma, and population studies of exposed workforces.

Current research capability and capacity

The present occupational health academic base is relatively weak in numbers and in its level of funding; putting its future sustainability in jeopardy. Several senior academics are in the latter part of their careers and there are relatively few of high quality who have been attracted to follow: the current position of research into the health of the working age population is understandably attracting few research scientists and clinical academics in training to invest their future in this speciality.

At present occupational research is primarily limited to a few university departments in UK, Glasgow, Birmingham, Manchester and Southampton (MRC Unit) with specialist units at Southampton (MRC Unit), musculoskeletal, Imperial College (respiratory), King's (mental health) and Cardiff (bio-psychosocial). In addition, basic research into fibre toxicology is being undertaken in Edinburgh and Cambridge. This in part reflects the relative lack of funding for occupational health research from Research Councils and Charities. In the UK the HSE, once a major supporter of external research funding, has in recent years greatly reduced the proportion of external funding. The Colt Foundation has for the past decade been the major non-government funder in UK of investigator initiated competitive peer-reviewed research. Despite this relative paucity of research funding, the scientific output of the UK occupational health research community has been relatively strong, publishing a disproportionate number of research articles in *Occupational and Environmental Medicine*, the most highly cited journal internationally in the field.

Research into understanding the threats to the health of the working age population requires a sustained investment in research infrastructure which will rebuild the capacity and capability in the several relevant disciplines. These include epidemiology, toxicology, medicine, environmental assessment, economics and social sciences. Such investment will enable important research questions to be addressed and will provide the next generation with future career opportunities in this field, without which it will remain unattractive.

Funding for the work of the Centre will require:

- Infrastructure funding for the Centre, primarily for staff of the Centre. This could also include supporting several PhD students for which spoke members of the Centre may bid.
- Project/programme grant support for research proposals, awarded in open competition through peer review by Research Councils, NIHR, charities, etc. Future research capacity will be enhanced by a clear career trajectory supported by sustainable funding. This would probably be best achieved in the first instance by focused calls for research in relevant areas.

October 2019 Drafted by the Academic Forum centre for work and health working group, hosted by the Society of Occupational Medicine and Chaired by Professor Sir Mansel Aylward