Major conditions strategy: Call for evidence

Department of Health and Social Care

Introduction

The Institution of Occupational Safety and Health (IOSH), the Chartered body for occupational safety and health professionals, with approximately 47,000 members in more than 130 countries, with a vision of '*A safe and healthy world of work*'. We are pleased to provide feedback to the Department of Health and Social Care call for evidence to inform the 'Major conditions strategy'.

As a Chartered body, we have charitable and international NGO status. As an international non-profit organisation, IOSH influences important decisions that affect the safety, health, and wellbeing of people at work worldwide. We collaborate with governments, advise policymakers, commission research, set standards, engage with organisations such as the International Labour Organization (ILO), the World Health Organization (WHO) or the International Commission on Occupational Health (ICOH) and run high-profile campaigns to promote awareness of occupational safety and health (OSH) issues. The IOSH Policy and Regulatory Engagement function provides a strong foundation for key policy responses and public policy initiatives that focus on the crucial role of OSH. We believe that OSH is fundamental to building and maintaining sustainable work for the future and is essential for economic and business success.

Background

IOSH welcomes the opportunity to comment on the development of the 'Major conditions strategy' designed to tackle ill health, reduce the number of people out of work due to ill health associated to occupation-specific and non-specific exposures, and establish the foundations for a prevention-first approach. Long-standing health issues among workers are becoming an increasingly significant issue for regulators and employers, furthermore in the context of an economic recession and cost-of-living crisis, where many of these issues are being aggravated by healthcare shortages, lack of occupational health resources, and significant delays originated by constraints in public health systems (e.g., NHS waiting lists). The recent 'Plan for Jobs and employment support' call for evidence from the UK Parliament[1] put the spotlight on the complexities the Government is going through when getting people into employment, in particular for disadvantaged groups such as those in low-paid jobs and young people. This is an area in which IOSH has long advocated for more robust standards as our policy positions on work-related musculoskeletal disorders, rehabilitation, return to work and inclusivity and older workers policy positions reflect[2].

Non-communicable diseases (NCDs) are the leading cause of death and disability worldwide and are responsible for a staggering global loss in output, equivalent to about 5% of global GDP in 2010.[3] With a UK labour force exceeding 30 million, there is an opportunity to utilise the workplace as a platform to prevent and control NCDs as well as raise awareness. Benefits to governments include the ability to relieve strain on health and social security systems and businesses benefit through improved productivity from a workforce who are able to work, to remain at work, are fit to work and are engaged. There are recognised reasons why workers do not engage with the formal health services to screen for and treat NCD. This includes the fact that they cannot lose time off work and access to these services can be limiting. These factors need to be considered when developing systems to prevent NCDs.

Research has shown that Micro and Small- and Medium-sized Enterprises (SMEs) do not understand what services to engage[4] to positively impact overall health. Yet, SMEs have an appetite to do more, but lack the resources (knowledge, skill, financial and time) to implement health promotion programmes (HPP).

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[1] UK Parliament. Call for Evidence. Plan for Jobs and employment support https://committees.parliament.uk/call-for-evidence/2689

[2] Institution of Occupational Safety and Health. Policy positions https://iosh.com/about-iosh/our-influence/policy-positions/

[3] NCD Alliance. Realising the potential of workplaces to prevent and control NCDs: How public policy can encourage businesses and governments to work together to address NCDs through the workplace. Switzerland: NCD Alliance, Bupa; 2016.

[4] Burge P, Lu H, Smith P, Koch N. Incentivising SME uptake of health and wellbeing support schemes. London: Rand Europe, Care DoWaPaDoHaS; 2023 March 2023. Contract No.: DWP research report no. 1024.

Chronic diseases and an ageing workforce can negatively affect workforce participation and labour productivity, as well as increasing early retirement and disability. Changes in the population structure and evolving disease patterns continues to challenge health systems. Research demonstrates that with age the functional capacity of individuals generally declines, and the effects of adverse working conditions may well exacerbate the loss of functional capacity in older workers[5]. Common health issues causing workers to leave employment early include poor physical and mental health, musculoskeletal disorders, inflammatory arthritis, sleep disorders, common mental health conditions, depression, and non-communicable disease[6].

Chronic conditions such as cancer, chronic respiratory problems still represent a major disability burden among the workforces. In this context, attention and action should be on reducing occupational cancer, cardiovascular disease and other chronic diseases, occupational musculoskeletal disorders and occupational respiratory disease.

Mental ill health

It is true that the impacts of mental illness and ill-health in the workplace have never been higher or more visible. Rising mental health conditions in the context of unprecedented labour shortages and increasing numbers of workers leaving work because of long-term illness or disability leads to increased unemployment, lost productivity and loss of skilled labour.

A growing body of research demonstrates that there is a substantial prevalence of mental health conditions and work-related wellbeing issues amongst people who are from minority ethnic backgrounds. This is aligned with a stronger impetus on the need for an integrated approach that embeds the interplay of aspects such as race discrimination, sexual harassment, as well as gender equality. This creates a policy loophole in the prevention of workplace mental health and wellbeing harm, particularly for workers from vulnerable disadvantaged groups, which includes precariously employed people and employees returning to work after experiencing mental health issues or after sickness absence related to mental health.
New figures from the Health and Safety Executive[7] have estimated that the number of workers in Great Britain suffering a work-related illness is 1.8 million, with workers suffering work-related stress, depression, or anxiety making up around half (0.9million) of these cases in the period of 2021/22. If we connect these figures and the contributing factors to the numbers of working days lost due to work-related ill health, we can see how an estimated 17 million working days were lost due to work-related stress, depression, or anxiety in the same period.

A more tailored and holistic approach will have to be identified, promoted and supported by policymakers when it comes to preventing and managing workplace mental health and wellbeing risks in Micro- Small and Medium Enterprises (SMEs) as they usually face a large number of economic challenges that together with other issues (e.g. lack of competency, resource, etc…) don't allow them to effectively take preventative action and to tackle this issue. Despite improvements in awareness-raising initiatives and policies and practices, the context of SMEs in England remains particularly challenging when it comes to supporting staff at every stage of the mental health spectrum – and more specifically if diagnosed with a mental health condition. The fact that many of these businesses have no dedicated human resource management or

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[5] Wolf J, Prüss-Ustün A, Ivanov I, Mudgal S, Corvalán C, Bos R et al. Preventing disease through a healthier and safer workplace. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

[6] LYNCH, M., BUCKNALL, M., JAGGER, C. & WILKIE, R. 2022. Projections of healthy working life expectancy in England to the year 2035. Nature Aging, 2, 13-18.
SEWDAS, R., THORSEN, S. V., BOOT, C. R. L., BJØRNER, J. B. & VAN DER BEEK, A. J. 2020. Determinants of voluntary early retirement for older workers with and without chronic diseases: A Danish prospective study. Scand J Public Health, 48, 190-199.
WALKER-BONE, K., D'ANGELO, S., LINAKER, C. H., STEVENS, M. J., NTANI, G., COOPER, C. & SYDDALL, H. E. 2022. Morbidities among older workers and work exit: the HEAF cohort. Occupational Medicine, 72, 470-477.
SCHRAM, J. L. D., SCHURING, M., OUDE HENGEL, K. M., BURDORF, A. & ROBROEK, S. J. W. 2022. The influence of chronic diseases and poor working conditions in working life expectancy across educational levels among older employees in the Netherlands. Scandinavian Journal of Work, Environment & Health, 391-398.

[7] Health and Safety Executive. Health and safety at work. Summary statistics for Great Britain 2022. https://www.hse.gov.uk/statistics/overall/hssh2122.pdf, November 2022.

occupational health and safety function or occupational health service function, this naturally impacts on their ability to promote positive mental health and wellbeing and take preventative action and action to reduce and mange risks. This situation and the fact that around half of the UK working population has no access to occupational health advice and assessment should enable a more balanced investment in the capacity building of OH professionals and the training of OH professionals, including occupational medicine and OH nurses. This was noted as a pending action[8] for both the Department for Work & Pensions and the Department of Health & Social Care to prioritise support for disabled people and those with long-term health conditions by investment in OH capacity-building.

Occupational cancer

Cancer is considered to be occupational in origin when it results from workplace exposure to a chemical, physical or biological agent, or from conditions inherent in a work activity. The official figures on deaths from occupational cancers are stark but the UK's national picture is still unclear. Latest estimates from IOSH determined that work-related cancer claims 742,000 lives a year worldwide[9].

With regard to secondary prevention measures and control activities[10], a global policy aimed at effectively addressing the burden of occupational cancer should include not only interventions to limit or avoid future exposures but also actions to safeguard and protect the health of workers who have previously been exposed to occupational carcinogens. The follow-up of carcinogen-exposed workers is a very important topic, especially considering that many cancers have a long latency period after the initial exposure.

IOSH believes that public authorities / national governments can raise awareness amongst their citizens and employers by raising awareness of occupational carcinogens and promoting information on occupational cancer prevention. For example, IOSH's 'No Time to Lose' campaign at www.notimetolose.org.uk, works to raise awareness of the significant health issues facing workers in the UK and internationally with specific information on diesel engine exhaust emissions, solar radiation, silica dust and asbestos. IOSH advocates that administrations should also consider tailored strategies and policies for work-related cancer affecting blue-collar workers in low-profile occupational sectors (such as cleaning, industrial maintenance, waste recycling and treatment, etc.) to help reduce the 'invisibility' of the issue and raise public perception.[11] We also recommend the development and modernisation of comprehensive national databases on exposure to occupational carcinogens.

Cardiovascular disease, including stroke and diabetes.

How can we successfully identify, engage and treat groups at high risk of developing CVD through delivery of services that target clinical risk factors?

It is a well reported fact that cardiovascular disease (CVD) (including hypertension and high cholesterol) is a leading cause of death and disability in the UK, despite the fact that onset is preventable through improved lifestyle behaviours. In the occupational health context, research identifies factors associated with increased risk of CVD including long working hours (>55hrs /week) and poor-quality sleep, both of which are associated with increased risk of stroke. To that end, the World Health Organization and the International

[8] Department for Work & Pensions. Department for Health and Social Care. Health is everyone's business. July 2021. https://www.gov.uk/government/consultations/health-is-everyones-business-proposals-to-reduce-ill-health-related-job-loss/outcome/government-response-health-is-everyones-business#conclusion-and-next-steps

[9] Institution of Occupational Safety and Health. No Time to Lose. https://iosh.com/health-and-safety-professionals/improve-your-knowledge/no-time-to-lose/

[10] Lavicoli S, Driscoll TR, Hogan M, et al. New avenues for prevention of occupational cancer: a global policy perspective. Occupational and Environmental Medicine 2019;76:360-362.

[11] European Trade Union Institute. HesaMag #18 Work-related cancer: emerging from obscurity. Brussels: ETUI, Autumn-Winter 2018. www.etui.org/content/download/35670/354721/file/Hesamag_18_EN_web.pdf

Labour Organization estimated[12] that in 2016, 398,000 people died from stroke and 347,000 from heart diseases attributable to having worked 55 or more hours per week, compared to working 35-40 hours a week. The increase in teleworking[13], new information and communication technologies, and an upsurge in flexible, temporary, or freelance jobs has increased the trend of working long hours.

Some workplaces are associated with an increased risk of CVD due to work organisation. Health promotion, screening and lifestyle management programmes targeted at these occupations and risks are recommended to positively impact cardiovascular health. For example, night shift workers working 5 to 10 nights shifts per month were significantly more likely to be hypertensive that non shift workers[14] and yet they are often not included in HPP as a consequence of their working hours. Efforts to adjust programme delivery to meet their needs are necessary.

Onsite occupational health service (OHS) providers as primary care practitioners are well positioned to screen workers for NCD, to monitor progress on treatment regimes and then refer to advanced services where necessary. The Health and Social Care Services (HSCS) should make better use of these skills. In addition, the onsite delivery of ongoing cardiovascular health awareness training to these health professionals will promote screening aligned to HSCS activities. HSCS can support OHS through their inclusion in training courses to update their knowledge and skills and the provision of resources such as rapid testing kits. Where onsite OHS are lacking then screening services could be offered on a predetermined basis (six monthly or annually) at the workplace by the HSCS, allowing for early identification and intervention of diseases. This could be planned in conjunction with the safety professionals whose activities are directed by the protection of workers and the prevention of harm to health and safety or via the human resources department. HSCS staff should also have an understanding of the occupational risk factors which could contribute to CVD disease burden, so they are able to identify when an individual's poor health may be linked to occupational exposure. This allows for treatment of the cause as well as the symptoms which should lead to a better prognosis.

Chronic respiratory diseases

According to the Labour Force Survey[15] as of 2019 there were an estimated 49,000 prevalent cases of self-reported 'breathing or lung problems' each year caused or made worse by work. A significant portion of respiratory ill health is caused through occupational exposure (e.g., flour, wood dust, isocyanates, enzymes, animal proteins) and where there is existing respiratory ill health the workplace may well exacerbate the current condition. The HSE estimated[16] in 2018 that 15% of all chronic obstructive pulmonary disease (COPD) cases are attributable to workplace exposures. It must also be noted that many occupational respiratory diseases are known to be underreported making these statistics even more significant. While data to expose the magnitude of the issue is available for policymakers an All-Party Parliamentary Group (APPG) for Respiratory Health report suggested a specific regulatory framework for silicosis (as already exists with asbestos and lead) and allocating proper resources to the HSE to provide effective enforcement.

The prevalence and risk increase in occupations where workers are exposed to respiratory hazards. Where a worker reports their ill health through a primary care physician the link between occupational causation and the condition is often missed. It is essential that HSCS staff understand occupational causation and ask

[12] World Health Organization; International Labour Organization. Geneva, September 2021. WHO/ILO joint estimates of the work-related burden of disease and injury, 2000-2016. https://www.who.int/news/item/17-05-2021-long-working-hours-increasing-deaths-from-heart-disease-and-stroke-who-ilo#:~:text=%E2%80%9CWorking%2055%20hours%20or%20more,can%20lead%20to%20premature%20death%E2%80%9D.

[13] Telework defined by the ILO and WHO in the 'Healthy and Safety Telework technical brief, 2021 as 'the use of information and communications technology for work that is performed outside the employer's premises'. https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---lab_admin/documents/publication/wcms_836250.pdf

[14] Zhu J-l, Liu M-y, Qin Q-r, He J-l, Hu M-j, Zhu Z-y, et al. Association Between Night Shift and Hypertension: A Cross-Sectional Study in Chinese Adults. Journal of Occupational and Environmental Medicine. 2023;65(2).

[15] Health and Safety Executive. LFS - Labour Force Survey - Self-reported work-related ill health and workplace injuries. https://www.hse.gov.uk/statistics/lfs/index.htm

[16] National Institute for Health and Care Excellence. Chronic obstructive pulmonary disease https://cks.nice.org.uk/topics/chronic-obstructive-pulmonary-disease/background-information/prevalence-incidence/#:~:text=Occupational%20exposure,affected%20%5BHSE%2C%202018%5D.

the questions – 'where do you work?' and 'to what are you exposed in your job?' This approach enables health workers to treat the cause and not just the symptoms. Once a diagnosis has been made this should be communicated back to the workplace to identify root cause - or those causing aggravation- of the condition. This is especially true for adult-onset asthma as there are many known workplace exposures which cause asthma e.g., exposure to workplace chemicals or flour in the baking industry.

Smoking and the exposure to secondary smoke have a negative impact on not only respiratory health but also heart disease and strokes. The implementation of smoke free workplaces and the effectiveness of smoking cessation programmes could be facilitated by better and more affordable access to interventions (including individual, group and telephone counselling and certain medications) offered by the HSCS. Smokers using smoking cessation services are four times more likely to succeed than those who give up unaided.[17] Creating national public health campaigns that have a clear behavioural target and reinforce workplace NCD prevention efforts should be delivered in workplaces. Providing additional assistance to workplace professionals such as safety and human resources staff can promote the success of these programmes through workplace support.

Lung disease, including lung cancer, are estimated to cost wider society around £11 billion each year, and wider economy through working days lost (£1.2bn)[18]. Respiratory disease affects one in five people in England and is the third biggest cause of death. Hundreds of workers contract or die from silicosis and other occupational diseases, including occupational cancers, due to breathing in dust and fumes. This is entirely preventable, and managing and controlling exposure to dust remains a priority for the industry. Silicosis, a disease caused by inhalation of crystalline silica dust, is the most common chronic occupational lung disease worldwide. In Great Britain, the Health and Safety Executive estimates that 600,000 workers are exposed to silica dust.

Musculoskeletal disorders

Work-related musculoskeletal disorders (MSD), such as low back pain, tendinitis, hand-arm vibration syndrome and carpal tunnel syndrome, account for a major component of the cost of work-related illness. According to latest statistics, Great Britain has 477,000 workers suffering from a work-related musculoskeletal disorder (new or longstanding) in the 2021/22 period[19]. Even More worryingly, 139,000 new workers experienced a new case of work-related musculoskeletal disorder in the same period, with an accounted 7.3 million working days lost due to work-related musculoskeletal disorders in 2021/22. More broadly, musculoskeletal (MSDs) conditions affect 17 million people in the UK having the ability to cause forced early retirement due to the debilitating impacts on workability. The primary action here, must be prevention first, whereby employers prevent harm to workers by assessing, eliminating or controlling those risks. Interventions such as modifying equipment, or changes to work practices/job design and workstation layout, etc can we utilised. OSH professionals are well placed and competent to advise employers on these matters and integrated processes within the occupational health and safety management system. Workers with existing musculoskeletal disorders need individualised care plans tailored to their abilities allowing them to remain in work and to return to work safely. This often requires the implementation of work adjustments and/or accommodations. Communication with onsite professionals such as the OSH professionals for risks assessment advice and with human resources, as both functions can promote and aid integration into the workplace based on a worker's capabilities rather than their limitations. Allowing employers through OSH professionals with direct access into the necessary support services (not relying on a GP referral) would allow earlier and more efficient access to services (such as physiotherapy) to manage the condition and facilitate an efficient return to work. To that extent, OSH practitioners could be included in HSCS training

[17] NCD Alliance. Realising the potential of workplaces to prevent and control NCDs: How public policy can encourage businesses and governments to work together to address NCDs through the workplace. Switzerland: NCD Alliance Bupa; 2016.

[18] Public Health England. Respiratory disease: applying All Our Health guidance. May 2022. https://www.gov.uk/government/publications/respiratory-disease-applying-all-our-health/respiratory-disease-applying-all-our-health

[19] Health and safety at work Summary statistics for Great Britain 2022. https://www.hse.gov.uk/statistics/overall/hssh2122.pdf and LFS - Labour Force Survey - Self-reported work-related ill health and workplace injuries: Index of LFS tables.

programmes to increase their knowledge and understanding of the MSDs conditions and treatment methodologies, as well as the resources available for referral purposes. For many of the cases this could facilitate self-management with the assistance of the employer.

MSD incidents remain one of the major causes for sickness absence and these statistics have not shown significant improvement for years. Musculoskeletal conditions still remain as the most common cause of severe long-term pain and physical disability and their impact on individuals is pervasive. They affect all ages but become increasingly common with ageing and are the major cause of physical disability. With an increase in the number of older people throughout the world, an ageing workforce, along with changes in lifestyle, this burden will remain prevalent.

Multimorbidity also appears to be increasingly common in England, where the burden of chronic physical conditions (or non-communicable diseases (NCDs)) such as diabetes and heart conditions continues to rise.

This clearly sets the imperative case for policymakers and employers to be more proactive in accommodating the needs of an ageing workforce, in particular of an ageing workforce and those with chronic musculoskeletal disorder, those participating for the first time in labour markets, or the vulnerable and disadvantaged workers. It also requires that the 'Major conditions strategy' incorporates a stronger gender-sensitive lens as sex and gender differences as well as differences in social roles, activities and behaviours have to be better incorporated into the existing data. It's important that these differences be examined and understood in order to develop effective injury prevention approaches.

MSDs are preventable if risk factors are identified early, and risk reduction interventions are implemented at work and in the wider community. This applies to young people with MSD conditions to manage pain early and prevent future problems[20] of restricted access to employment opportunities due to pain or workability. The presence of MSD conditions or NCDs reduce work ability among ageing office workers but having MSDs and NCDs further reduced work ability.[21] With this in mind an effective way to eliminate MSD hazards in the workplace is to develop HPP aimed at advocating awareness and healthy lifestyle behaviours (e.g., move more) as well as raising workers' awareness of ergonomics and work organization, especially for older workers and those with existing conditions. This can be supported by HSCS through collaboration with workplace professionals to increase knowledge and understanding and making access to referral service less restrictive. The delivery of HPP (such as 'Live Life Better') in the workplace could improve the use of these effective resources in a more accessible manner for workers with the support of the employer.

IOSH advocates that organisations provide 'good work', and this is work that is safe, healthy, supportive and accommodates people's needs. Organisations must create well-designed, ergonomically-sound work that prevents work-related MSDs, is tailored to individual needs and capacities, and supports those with health conditions and disabilities. This will include leadership commitment and organisational arrangements, suitable and sufficient risk assessments, prevention strategies and control strategies; effective awareness and management of workload and physical and psychosocial risk factors; and the provision of appropriate training, equipment and supervision.

Tackling the risk factors for ill health – How can we support people to tackle the risk factors?

The workplace is a stable environment providing workers with the opportunity and ability to be effectively screened and often supported, advised and managed for NCD risk factors. Larger organisations have the necessary resources to screen for these risk factors and to provide interventions. Micro- SMEs would benefit

[20] SOM, Rheumatology BSf, Disparities OfHI. The Musculoskeletal (MSK) Health Toolkit for employers and further education institutions: how to support adolescents and young adults to a better future. London, England: SOM; 2022. p. 24.

[21] Rawdeng S, Sihawong R, Janwantanakul P. Work ability in aging office workers with musculoskeletal disorders and non-communicable diseases and its associated factors: a cross-sectional study. International Journal of Occupational Safety and Ergonomics. 2021:1-6.

from resource support offered through the HSCS. Support to all organisations could be achieved in a number of ways:

- Through the provision of screening services (options may include rapid testing kits for cholesterol or blood sugar levels) at/or provided by the workplace for early identification of risk factors and NCDs.
- Via delivery of local HPP in the workplace (e.g., 'Move More' programme, 'Live Life Better', smoking cessation programmes) to increase the populations understanding and awareness of risk factors and to inform lifestyle choices.
- Through alignment with public health campaigns and promotion strategies/policies as relevant to the needs of the workplace - as well as the community - to fully realise the potential of workplace NCD interventions.
- Through specific targeted efforts with Ministers and departments to strengthen cooperation amongst those responsible for health, work/employment and social affairs to improve the links and promote policy coherence between the health sector and industry. This includes policies that support access to NCD screening and treatment services, as well as vocational rehabilitation through the workplace.
- Through opportunities to standardise workplace interventions for NCDs to aid business's with knowing what action they can take, what works and are therefore provided with good practice guidelines to maximise their return on investment in workplace health and wellbeing, with positive outcomes/impacts for both workers, employers and society.

Supporting those with NCDs and other conditions

How can we better support local areas to diagnose more people at an earlier stage?

The workplace provides an opportunity to reach large numbers of people via their employers. As well as making good business sense, targeted interventions within the labour market will undoubtedly support economic growth and development. For these opportunities to be realised,

1. There needs to be improved efforts, resource, collaboration and communication between public sector services and workplaces.
2. The stability of the workforce provides the ideal setting for frequent screening with follow up. This can be achieved through the OHS or in consultation with the employer through on-site 'wellness days' where HSCS provide the resources.
3. All HSCS staff should be provided with basic occupational health awareness and training. Firstly, this is so they can lead/support on preventative efforts – whereby by working with occupational safety and health professionals within the risk assessment processes to identify health hazards, preventative strategies and control strategies. This training, from a reactive perspective, will also enable them to link the condition seen with possible occupational causation. By way of example, failure to understand that a patient could have developed adult-onset asthma as a result of exposure to flour in their work as a baker may hinder the delivery of effective treatment as the cause is not removed.

How can we better support and provide treatment for people after a diagnosis?

1. Follow up services can be communicated to and provided through the OHS provision (where available) who have the medical background to understand the condition and necessary interventions, along with the occupational knowledge, and the ability to provide follow up. Collaboration between HSCS and OHS can improve the quality of care for the worker. In addition, joint working with the occupational safety and health professional can also support workplace interventions and adjustments.
2. More effective use of the 'fit note' would assist in the delivery of supportive care in the workplace. Often a worker is categorised as 'unfit for work' when they are indeed able to perform limited work activities, or whether the person may be fit for work taking account of their advice. Employers need

to understand a worker's abilities to assist with their return to work, provision of a safe placement, and one which promotes 'good work' and continued rehabilitation in a supportive environment.

3. Management of NCD through the workplace (including initiation of treatment regimes under the control of an occupational medical practitioner and supply of medication through the NHS prescription services) would have the added benefit that pressure on the NHS is addressed, adherence to treatment can be monitored, control of conditions can be improved, less time off work to attend appointments and access to higher treatment levels when deemed necessary.

How can we better enable health and social care teams to deliver person-centred and joined-up services?

The delivery of health promotion activities through the workplace is a unique opportunity for person centred access. It allows for screening activities with facilitated follow up with the employees identified as needing further care.

Engaging with the workplace provided health professionals (both health through OHS and safety through occupational safety and health professionals) would provide insights into the work exposures which may exacerbate or cause a condition(s), as well as facilitating access to the worker.

Inviting, engaging with, and utilising H&S professionals as part of HSCS driven HPP will generate a better understanding between the public and private sector and improve the reach of HSCS driven programmes. It would also open the channels of communication between these sectors to the benefit of all stakeholders.

Targeted initiatives for businesses will also benefit from solution focused approaches. For example, strategies for workplaces to take are developed but they are inclusive of support options for the workplace, and they are provided with how they integrated, embed and monitor such strategies e.g., through alignment and integration with the occupational health and safety management system (OHSMS).

How can we make better use of research, data and digital technologies to improve outcomes for people with, or at risk of developing, the major conditions?

Research findings should be embraced and used to influence the design of HPP. For example, recent research has identified long working hours as a significant risk factor for cardiovascular disease[22], evidence which should be included in public health messaging. It must also be considered by employers within their normal risk assessment process for health and safety.

Occupational health groups that are identified through research as being at increased risk for NCD should be targeted by the HSCS through education and collaboration with the workplace. (e.g., night shift workers)

Recommendations

- Recognising that 'work' for people needs to be 'good work'. Good work is good for people's health and wellbeing. Among other key elements, this means work that's safe, supportive and accommodates people's needs. Employers should ensure that workers who have / develop conditions that require support or who are absent due to injury or ill health, are given assistance to join, remain in or safely return to sustainable work.
- Promotion of health and wellbeing at work as a contributor to higher participation in the labour market, longer healthy working lives, and the sustainability of social security systems, as well as reduced expenditure on public health services and sickness benefit costs (e.g., costs associated to anxiety and depression).
- With the number of working-age adults who are economically inactive due to long-term sickness reaching a record high of over 2.55 million according to latest data[23], increasing by 21 per cent since

[22] Pega F, editor The new WHO/ILO Joint Estimates of the Work-related Burden of Disease and Injury. Safety and Health at Work; 2022 2022 01 01.

[23] Resolution Foundation. Post-pandemic participation – briefing paper. https://www.resolutionfoundation.org/publications/post-pandemic-participation/

the eve of the Covid-19 pandemic. Supporting those who are out of the labour market due to long-term sickness must remain a policy priority over the coming months, in particular for vulnerable segments of the workforce such as older workers, women with children, and those affected by rising ill-health and disability.

- Intervene early with targeted public health programmes and active occupational safety and health interventions, linking in with the occupational safety and health profession.
- Increase investment in ill health prevention and occupational health services and systems.
- Improving the access to occupational safety and health and occupational health services, for vulnerable workers or those experiencing long-term conditions or chronic diseases.
- Encouraging the adoption of partnership or improved ways of collaboration between Department of Health and Social Care/ UK Health Security Agency/ Office for Health Improvement and Disparities and Department for Work and Pensions and employers to provide health management programmes at the workplace where health promotion activities can be encouraged and early identification with interventions resourced, applied and followed-up.
- Designing practical strategies for health-related professions and employers to provide early interventions to support people to work – doing good work – to return to work and remain in work whilst supported.
- Incentivising employers to prioritise and provide a safe and healthy working environment, to take prevention first approaches to health (both physical and mental) and safety risks, work-life balance, health promotion and disease prevention, and support for work ability for employees through the employee life cycle.

The following overarching principles could be adopted to ensure prevention and control of NCDs:

- Increase awareness and training in public sector workers to enable them to identify occupational causation.
- The workplace should be supported through the provision of resources that enable the early identification and subsequent management of NCDs.
- Improved collaboration between HSCS and OHS, along with occupational safety and health professionals and HR professionals who all support workers. For example, occupational safety and health professionals can advise as part of the risk assessment process. Also, many workers do not seek health intervention early as a consequence of accessibility issues (including not given time off to attend appointments, work schedule and limited access to GP services) causing them to only seek intervention when organ damage has possibly occurred. Improved collaboration creates the opportunity to identify early onset NCDs with early treatment to manage disease progression.
- Better integration and application of existing systems (such as the ‘fit note’) to deliver on the potential identified when these systems were developed.
- Private sector OH staff should be included, at no charge, in HSCS NCD training programmes and capacity building so they have the insight and learnings to apply these in the workplace.
- Currently there is a lack of action on supporting people living with NCDs in their returning to and remaining in work. There is a need champions in the political and the workplace arena to drive health promotion and screening programmes to encourage a changed mindset where supporting a healthy workforce is viewed as an investment.
- When championing the agenda within the workplace, provide solution-focused options. Consider and identify routes where this can be applied within the workplace e.g., integration within occupational health and safety management systems where appropriate e.g., prevention and management of psychosocial risk factors, and health hazards through risk management and assessment, etc.

Additional remarks

Policy initiatives that provide continuity in addressing structural issues that vulnerable workforce might suffer have seen significant advances in some lines of work. Different option for enhancing employment support

for disabled people and people with health conditions, and how to encourage people to take up that support, were discussed back in 2021. Prior to the public health crisis, the DWP and Department of Health and Social Care's 'Health is everyone's business: proposals to reduce ill health-related job loss' encouraged tackling job loss through providing employers with access to good quality information and advice, supporting employers and employees during sickness absence, and enabling SMEs to reap the benefits of occupational health systems.

This consultation is part of wider exercise that previously looked at employment support as part of a Department for Work and Pensions (DWP) response to the coronavirus crisis, and more recently through the inquiry into DWP's 'Preparations for changes in the world of work' and the 'Disability Employment Gap'. Despite these developments, the agenda for helping people stay in their jobs, supporting them through returning to work or reintegration processes, or when faced with ill-health and disability, have not yet progressed sufficiently.

Concluding remarks

Good work is good for people and for their health, safety and wellbeing. Among other key elements, this means work that's safe, supportive and accommodates people's needs. Regulators and employers should prioritise targeted actions towards healthier and safer workplaces – considering the substantial evidence that proves the pivotal role that they play in protecting people's health – to tackle the toll of people off work due to long-term ill health, which has now hit 2.55 million[24]. It is time for the government to rethink approaches to improve employer and workers access to preventative OH support and OSH expertise and advice.

Occupational health systems and services can make important contributions to not only protect workers from occupational risks and promote workers' health in general but also by supporting employers and workers who have or develop conditions that require support or who are absent due to injury or ill health, so that they can sustainably remain in or safely return to work. IOSH support's the government's effort in addressing the barriers and opportunities for England to enjoy longer working life to support sustainable workforces and productivity. We also remain at the disposal of the DHSC to respond to any questions and participate in constructive debates that look at creating a safer working environment for all while contributing to the sustainability of the working population and organisations.

For further information, please contact:

- Ruth Wilkinson ruth.wilkinson@iosh.com
  Head of Policy

- Dr Karen Michell karen.michell@iosh.com
  Research Programme Lead (Occupational Health)

- Dr Ivan Williams Jimenez: ivan.williams@iosh.com
  Senior Policy and Public Affairs Manager

Institution of Occupational Safety and Health (IOSH), The Grange, Highfield Drive Wigston Leicestershire

United Kingdom, LE18 1NN Tel: 0116 257 3100

Email: consultations@iosh.com or publicaffairs@iosh.com

[24] Institute for Employment Studies. Labour Market Statistics, June 2023. https://www.employment-studies.co.uk/resource/labour-market-statistics-june-2023