



Position Paper:
Occupational Health Nurse Education,
Funding and Regulation

The Faculty of Occupational Health Nursing

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1. Summary

This position paper has been prepared by the Faculty of Occupational Health Nursing (FOHN) Development Group (FDG) to consider the current position in relation to the availability of validated education courses, funding of education, regulated standards of practice, and revalidation for occupational health (OH) nursing in the United Kingdom (UK).

Our primary purpose in presenting the paper is to draw attention to the issues associated with these matters and to inform the Nursing & Midwifery Council (NMC) and professional bodies about the impact they have on OH nurses' ability to deliver safe and effective occupational health practice.

The FDG believes that the current system of nurse education, funding and regulation is failing employees, employers and nurses alike; and recognises that this may, in part, be due to a lack of knowledge about OH as a specialism. Consequently running through the paper, is an explanatory narrative that has been deliberately included to assist the reader in gaining insight into the unique characteristics and properties of OH nursing (and hence, why it is important that these are retained).

The paper begins by setting out the context in which OH Nurses (OHNs) operate, before moving on to consider the main issues and challenges currently facing the profession. It provides proposals for the future - taking account of the changes in the role of nursing as well as significant changes in employment, society, and health and wellbeing in the UK generally. Lastly, it explains why it is important that these issues are addressed, before making suggestions for next steps.

For completeness, Appendix 2 contains a high level impact analysis summarising the issues and suggested actions as described. In addition, and for information, Appendix 3 maps the contribution of OH nursing to public health and government strategy using a life course approach.

- **Education**

Currently, a number of different educational programmes exist across Higher Education Institutions (HEIs) in the UK. As a result, OHNs are graduating from courses with very mixed levels of experience, knowledge and skills. Within this context, there is also concern about the variation that exists between Specialist Community Public Health Nurse (SCPHN) Occupational Health (OH) courses, because some clearly do not include sufficient OH specific content. Although the range of tasks and duties assigned to an OHN will always vary because of sector specific and regulatory driven requirements (as well as the particular needs of the organisation e.g. culture and available budget), there are nonetheless a core set of technical skills and competencies required to undertake OHN job tasks. In the FDG's experience, too many OHNs are graduating from SCPHN (OH) courses having been inadequately prepared to work in the specialism. Through no fault of their own, and depending on the course undertaken, SCPHN educated nurses often appear to complete their course of study without the essential knowledge required for excellent OH practice. Some nurses are unable to undertake basic job tasks (and / or to perform these safely to the

standard required). A lowering of practice standards ensues unless their employer immediately steps in to remedy matters.

For the delivery of excellent and auditable nursing practice that offers effective public protection this situation needs to be addressed.

- **Funding**

Educational sponsorship for SCPHN courses is more readily available from the National Health Service (NHS) for health visitors and school nurses, than it is for nurses choosing to practice in OH. Likewise, in the private sector, obtaining financial support from employers is also difficult because it can be hard to justify the benefits of employing qualified OHNs versus non-OH qualified registered nurses for employers with limited resources. As a result, most OHN trainees self-fund which together with difficulties associated with securing practice placements, reduces the numbers enrolling on courses and has a consequential effect on the flow of practitioners into the field. Added to which, there is insufficient funding for practice teacher courses so most do not hold an OH qualification.

- **Regulation**

Deficiencies with SCPHN (OH) based education and funding are compounded by associated problems with OHN regulation, registration and the way in which OH qualifications are recorded in the UK. In combination, these issues marginalize good practitioners without the SCPHN qualification, and cause confusion over competence to practice amongst nurses and purchasers of services.

Appropriately qualified and supervised OHNs make a significant contribution to improving the health, wellbeing and productivity of the working population. But in the FDG's view the issues outlined here place employees, practitioners and their organisations at unnecessary risk, threatening to jeopardise public safety. Left unaddressed, there will be a gradual erosion of the professional standing of OH nursing and therefore, the FDG urges the regulator to take swift and effective action to remedy matters.

The FDG is calling for the NMC and other associated bodies to review the current system through which proficiency for practice is determined and specifically to ensure that in future there is increased consultation with senior nurse practitioners and decision makers in OH to ensure that:

- A robust framework is in place for OHN education and regulation.
- More content specific material is included in SCPHN (OH) courses or consideration given to a new way of educating OHN's e.g. with peer groups in the workplace such as occupational physicians, psychologists and physiotherapists.
- Appropriate skill set(s) and competencies are agreed for OHNs.
- An agreed national standard for OH nursing with appropriate alternative levels of qualification is in place for those not wishing to attain degree level.

- OHN accreditation is set at Advanced Practitioner level.
- A dedicated career pathway and preceptorship is available for newly qualified OHNs.
- A route is developed for existing (non SCPHN) qualified OHNs to attain the national accredited qualification in OH.

This is not the first time that these issues have been highlighted^{1,2,3}. In restating the position now, the FDG recognises that concerns about nurse education and regulation (in particular) have also been raised by other professionals, OH bodies and educationalists in the past. As a collective, these individuals and organisations have a wealth of experience of working with OHNs, and like the FDG, share a passionate interest in maintaining excellence and raising standards in education and OH practice.

The FDG aims to present its opinions within the context of a compelling argument for change. In doing so, we have also included suggestions for improvement and would welcome the opportunity of opening up a meaningful dialogue with key stakeholders to agree a joint way forward. The FDG wants to work collaboratively to ensure that occupational health nurse education and regulation is suitable for the needs of both the working population and employers in the future, making OH nursing a career of choice.

2. Background

In the UK, there are an estimated 3,439 OHNs on Part 3 of the NMC register⁴. However, by including nurses who are qualified but did not migrate to the specialist register, or who have not followed the approved path to qualification, or who are working in occupational health without an OH qualification, the true figure is more likely to be in the region of 9,000⁵. The data relating to exact OHN numbers are not reliable, but at the last count only approximately 1,200 nurses held positions in the NHS¹. The remainder (i.e. 87%) work elsewhere in the public sector, the military, 'in-house' for large private companies, with outsourced OH service providers, or as self-employed independent practitioners and so on. The diversity of employment in OH nursing and the fact that the majority of posts exist outside the NHS has long been misunderstood and has important implications for the nature and scope of OHN education.

Whilst the overall number of SCPHN OHNs is small in comparison to health visitors, they nevertheless represent the second largest group of SCPHN registrants⁴. Nurses working in OH have a wide sphere of influence over the health of adults at work. According to the Office of National Statistics 73.5% of people aged from 16 to 64 (equivalent to 31.05 million) are currently in work⁶. In the UK OH practitioners primarily provide services to large private, and public sector employees (i.e. approximately 5 - 6 million in number)⁷. Evidence from the Faculty of Occupational Medicine (FOM) indicates that over 25% of the UK workforce is now covered by SEQOSH (Safe, Effective, Quality Occupational Health Service) accredited services⁵ hence are likely to come into contact with an OHN. Typically this will happen during or after a period of sickness absence, or as part of a health assessment (pre-job placement, health surveillance or health screening). Given the popularity of providing services telephonically these encounters will not necessarily be face to face. In future, the

Fit for Work service⁸ could increase the reach of OHNs still further, extending into many small and medium sized enterprises (SMEs) who traditionally have had little or no access to OH. Working adults will also continue to benefit indirectly from OHN input e.g. through the design of organisational policies, shift patterns, risk management and work systems, as well as public health and wellness activities; or possibly as a result of purchasing decisions relating to health screening, monitoring or surveillance methods.

From a commercial perspective, OHNs represent the largest single professional group in a growing UK OH market – which is expected to reach £810 million by 2017⁹.

3. The Faculty of Occupational Health Nursing

The new FOHN is currently in development having been created in response to calls for OHNs to have a single, unified voice for the profession. It is expected to be fully operational by the end of 2018. The agreed vision for the FOHN is that it will exist to promote excellence in the education, research and evidence based practice of all OHNs for the benefit of the working population. It is envisaged that in future, the FOHN will be central to OHN standard setting for education, training and practice supervision; and that this should be undertaken in collaboration with the NMC and the National School of Occupational Health (NSOH). The mission for FOHN is to promote, preserve and protect the health of the working population.

The FOHN will achieve its' purpose by:

- Creating standards and providing guidance for the education and practice of OHNs in order to promote and sustain professional excellence and competency.
- Providing services that enhance confidence, competency and credibility to practice OH effectively and safely.
- Providing a framework and support for professional and regulatory standards.
- Promoting national and international research and evidence based practice for all concerned.
- Engaging at a local, national and international level with all key stakeholders and interested parties.

The stated values of the FOHN are: Professionalism, leadership, quality, collaboration, competence, and integrity. The group developing the FOHN (i.e. the FDG) is comprised of experienced nurse practitioners from the private sector, public sector and the NHS. The FDG is supported by a team of Special Advisors (including experts from nurse education in England, Scotland and Wales) and a Faculty Consulting Group (FCG) made up of senior stakeholders and multi-disciplinary practitioners from a range of occupational sectors. Details are available at www.fohn.org.uk.

In the following sections overleaf the issues relating to education, funding and regulation are set out as clearly and concisely as possible, giving explanations and examples to illustrate points where necessary (please see text in italics).

4. Education

As stated, the FDG is concerned about the number of newly qualified OHNs who graduate without the level of knowledge, technical skills and competencies required to do their job. A lack of preparedness for practice is noticed most often in students who have undertaken a SCPHN (OH) course, and the FDG believes that the way in which these courses are regulated, designed and delivered is not consistently fully fit for purpose. It has been documented that when the SCPHN register was originally established in 2004, generic standards of practice were deliberately set in order to accommodate the different nursing specialisms to be included. The Institute of Health Visiting has indicated that because standards were set at a high level of abstraction, Higher Education Institutions (HEIs) have been able to interpret them within their own regulations¹⁰. From the FDG's perspective, it is clear that uniting the different functions in this way has left each individually struggling to maintain its own professional identity. For OHNs, substantial problems arise from the requirement to be educated alongside other community public health specialists.

4.1. Standards of proficiency: The current standards of proficiency were developed from previous competencies for community healthcare nursing and health visiting and adapted for public health¹⁰. As a result they are generalised, broad in scope and heavily orientated towards public health (e.g. in the focus placed on work with groups, communities and families rather than with individuals; as well as the emphasis placed on health promotion rather than the management of work related health risks). Despite calls for a more strategic approach to the Health and Wellbeing of NHS Staff¹¹ and primary level intervention to facilitate workplace health management¹² for most OHN's, their primary focus remains at a secondary level of intervention with case management being the dominant service provided. The standards also support an approach that is modular to encourage flexibility and transferability between the specialist functions on the SCPHN register. Whilst intuitively appealing, unfortunately this 'one size fits all' approach does not work for OH nursing. In their present form, the standards fail in their stated aim of adequately preparing OH students for safe and effective practice. The way in which SCPHN education is currently organised dilutes and compromises the overall integrity of the profession – the FDG recognises this was never the intention.

4.2. Course curricula: The regulator does not stipulate the proportion of core to specialist course content required to prepare OH nurses appropriately for practice, so this is determined by the HEIs operating within a competitive market. To remain economically viable many HEIs aim to accommodate a mix of students (in which OHNs represent the minority) therefore courses contain differing amounts of pathway specific material. On these courses, preference is given to generic material and transferable learning that is applicable to all (e.g. communication skills, inter-professional working in the community, health promotion, wellbeing and addressing health inequalities instead of OH specific input). Whilst it is acknowledged that overlaps do exist between practitioners within the family of public health, it must be emphasized that the core purpose of OH practice is fundamentally different from that of other SCPHNs. In the FDG's opinion, this approach to blended learning disadvantages OHNs, and is out of step with what is actually required for excellent OH practice. Specifically, there is insufficient time allocated to activities such as health needs assessment, case management (especially for the management of psychological health

conditions), health risk management and the development of business related skills. This is important because:

- ❖ *A fundamental role for OHNs is to provide advice to businesses on the management of health risks and the interventions necessary to prevent, promote and maintain health in relation to those risks. Conducting a health needs assessment is a means of achieving this (and aligns OH practice with a public health approach). For successful interventions to properly match the identified needs of the working population, the use of an objective framework is necessary (identifying the requirements at primary, secondary and tertiary organisational levels). In the FDG's view, there is little focus on needs assessment within current course curricula and this represents an important gap. As part of their education, if OHN's are not adequately prepared to conduct this type of systematic assessment then there is a potential to overlook important priorities and rely on treatment based OH intervention instead (tertiary only). This may assuage an employee's immediate concerns, but ultimately it is to the detriment of other employee's wider health needs and does not constitute good OH practice. Within public health, the life course approach is also now promoted to reflect inter-generational work patterns. Since there can be up to 60 years difference between employees entering and exiting employment, the interaction between health and work is likely to be different and therefore needs to be understood from a bio-psychological perspective. A model bringing together these concepts is included in Appendix 3 which has been developed by the FDG to demonstrate the application of this approach from a practitioner's perspective. The FDG would like to see needs assessment receiving a greater profile in future education programmes using this type of model.*
- ❖ *In practice OHNs typically spend at least 75% of their total time assessing employee's fitness for work, and especially as part of case management for employees on or returning from sickness absence. Employers (and employees) need OH practitioners who are solution focused and skilled at assessing functional ability (in light of an employee's job tasks). Practitioners must be able to provide the robust intervention required to manage individuals with multiple presenting co-morbidities such as common psychological health conditions (e.g. stress, anxiety and depression) and musculoskeletal disorders; and to know how to proactively support return to work and rehabilitation programmes. If this is only variously addressed on courses (depending on the HEI), then the nurse will graduate without the proper knowledge and skills required to carry out a substantial part of their job.*
- ❖ *To underpin their work (especially in safety critical environments), OHNs must possess a deep knowledge of safety, environmental and health risk management at work (e.g. control of physical, biological, chemical and psychosocial hazards). They must properly understand the principles and legal basis of health surveillance, human factors and ergonomics, and be able to undertake basic risk assessments. Outside the NHS, these aspects of practice are equally (if not more) important as knowing about health screening or promoting lifestyle change. Notably, a recent RCN survey on Public Health Nursing identified that nurses were perceived rarely or never to be involved with radiation, chemicals, poisons and environmental health issues¹³. Whilst the authors have not specified the proportion of respondents that were OHNs, the fact that health protection is recognised as a public health issue in this survey is testament to the fact that it remains an important area of attention; thus ought appropriately to fall within the domain of OH and should be reflected as such in course curricula.*
- ❖ *Unlike other SCPHNs, in commercial settings OHNs work outside the 'traditional' clinical model of nursing care and this 'duality' of practice is frequently overlooked. If OHNs are really going to make a*

difference to the health and wellbeing of adults at work they need business as well as nursing and professional skills. To get things done in business, OHNs actually need to understand how organisation's function formally and informally (not just how organisational systems and products impact the health of employees). They must know how to present and market themselves effectively – communicate in the language of business as well as using professional and clinical vocabulary. They must have the ability to make a business case, manage resources, and effectively handle sceptics who are vociferous in expressing doubt about the value of OH intervention. They must be able to persuade and influence senior decision makers to invest in health and wellness generally and compile compelling cost benefit analyses. They must work confidently and reciprocally with unions and employee representatives. Compared to community settings, in a commercial environment clinicians stand out because they are in the minority, and so are more quickly judged in relation to their expertise. Going forward, if OHNs are to remain relevant, nurse education must accept and embrace the business related aspects of OH practice more readily and wholeheartedly.

- ❖ *Ethical requirements of practice such as confidentiality are more likely to be challenged outside a clinical health care setting. OHNs are frequently asked to release confidential information to managers, human resources (HR) and legal professionals. This can be intimidating, and requires a comprehensive knowledge of the ethical and legal obligations associated with nurse practice, as well as professional confidence and courage to stand firm whilst simultaneously maintaining good working relationships (if possible). The case of *Cooke v West Yorkshire Probation Board (2004)* is an example of an OHN who was unfairly dismissed following Cooke's refusal to disclose confidential information without employee consent¹⁴. Aside from demonstrating why it is so important for OHNs to have a sound knowledge base, this case also shows the difference in 'visibility' that exists between OHNs and community practitioners – and hence why OHNs must be adequately prepared for their role.*
- ❖ *OHN job roles are often assigned at a relatively junior level in organisations where the practitioners' power of influence comes solely from what they know, rather than the rank they hold – their knowledge is what differentiates them and is what enables them to present a confident and experienced image of themselves (e.g. to demonstrate to their employer how they contribute to optimising health and performance). Professional credibility is essential in making a difference to public health in the workplace because employers will readily dispense with practitioners services if this is lacking.*
- ❖ *Because there is no pre-determined career pathway for OHNs, relatively inexperienced practitioners can quickly move into a job or start their own businesses with considerable responsibility and limited (if any) professional supervision. This has obvious implications for public protection, and the fact that this is common practice places an onus on the regulator to take account of it.*
- ❖ *Recently, on certain HEI websites and in the nursing press, FDG members have seen OHNs described as fulfilling an 'employee advocacy' role by other community health nurses - this requires explanation. Like Occupational Physicians, OHNs act as independent and impartial advisors to both the employee and to the employer (who typically pays for their services). Whilst there is a professional duty of care owed to the employee, there is also a responsibility to the employer e.g. to provide appropriate and actionable fitness for work advice. In OH, the tri-partite nature of the 'clinician – employee – employer' relationship means that whilst employee advocacy is important, it is not the only consideration for the practitioner. Unlike hospital or primary care settings, in OH, if employee advocacy is not to be construed by the employer as a lack of independence, it should*

accompany the provision of a professional opinion and advice (e.g. in fitness for work reports). Unduly cautious advice giving or simply supporting an employee's point of view is not in the employees' best interests and is not good OH practice. For example, a baker who has developed occupational asthma because he has become sensitized to flour dust should not be permitted to continue in his role despite the fact that he might want to. In this situation, whilst the OHN would undoubtedly advocate that he is re-deployed to an alternative role to prevent further exposure, s/he would not concur with the employee's desire to remain in the bakery, because doing so would be detrimental to his health – even if ultimately it meant a loss of his employment. OHN recommendations should not be based on the employee's opinion alone simply because of their professional relationship. In this example, a seemingly innocuous comment relating to employee advocacy gives the impression that OHNs primarily act on behalf of the employee. This represents a fundamental misunderstanding of the nature and purpose of OH and illustrates the importance of ensuring that sufficient qualified OH practitioner input is incorporated on courses and that students are taught sound OH principles.

When OHNs graduate from courses having been inadequately prepared, they need further support and in these circumstances employers complain that they are effectively being made to 'pay for training twice'. But without the employers' ongoing goodwill and financial support there is a knock-on detrimental effect on nursing standards. Decisive intervention is required to halt the educational shortfall and residual longer-term reputational damage that will persist if the current situation regarding OH education remains unchanged.

4.3. OHN competencies: Problems associated with the generic nature of SCPHN education are complicated by the fact that within the NMC standards of proficiency there are no agreed skill clusters or competencies to underpin OHN practice. Building on work that was carried out by senior OHNs some years ago at the Royal College of Nursing (RCN)¹⁵, the FOHN is committed to working with the regulator and other key stakeholders to address this gap in future.

4.4. Practice orientation: SCPHN practice is required to reflect collaborative working with other health and social care workers. Whilst the FDG endorses the principle of shared learning, we are clear that it is only of value if the shared learning is relevant to practice (the importance of contextual learning for knowledge acquisition and skills development is well documented in the literature¹⁶). OHNs are more likely to work with multidisciplinary workers such as human resources (HR), health and safety practitioners, occupational physicians, physiotherapists and hygienists than they are other community health nursing practitioners, so the value of exposure to community nurses is limited. OHN education must adapt. In the near future, as the scope of OH services change to accommodate the requirements of an ageing workforce and potentially those who are economically inactive due to poor health or disability¹⁷ there will be an even greater demand for course curricula to reflect appropriate multi-disciplinary working (as well as providing targeted in-depth education and training relating to assessment of fitness for work after long term absence, rehabilitation and return to work strategies). SCPHN course curricula must better reflect the rapidly changing landscape of work as well as UK OH strategy and societal needs more generally.

- ❖ *With very few notable exceptions, the most likely scenario in which an OHN would work with a community health practitioner is when a request is made for a medical report as part of case*

management. But even then, for a good practitioner, this typically only applies in less than 10% of sickness absence cases (e.g. if an OHN has a typical caseload of approximately 100 cases or less this might only equate to one per month each year). OHNs work within the 'biopsychosocial' model of care which recognises that many of the obstacles to a successful return to work are not medical in origin and therefore require non-medical solutions¹⁸. These solutions come as a result of intervention from the OHN in tandem with the aforesaid multidisciplinary colleagues i.e. practitioners who understand the work environment. Promoting a model of OH that favours intervention from community practitioners above these occupational specialists may encourage 'medicalisation' of non-medical problems which contributes to the development of erroneous health beliefs, leading to long term sickness absence, chronic disability, and potentially, a loss of employment. Student OHNs must have exposure to the practitioners they routinely work with and can learn from in order to understand how different roles compliment and contrast with their own. More relevant multidisciplinary content and delivery at an advanced level regionally will also contribute to the NMC's goal of supporting regulation closer to the frontline - allowing professional leaders to provide a consistent, standardised approach to education thus promoting patient safety, professional standards and confidence in the profession¹⁹.

- ❖ To assist an employer in controlling job related health risks (as opposed to helping individual's control the health effects of a poor lifestyle) requires that OHNs can recognise and negotiate appropriate inter- professional boundaries e.g. when interpreting outcomes from environmental monitoring. Effective team work in organisations necessitates a good appreciation of the meanings associated with the professional and technical narratives inside the organisation as well as out. This is especially important when facilitating appropriate onward referral e.g. to investigate abnormal results or when seeking treatment, or as part of case management. 'Signposting' constitutes a big part of the OHN role and practitioners must understand when and to whom to escalate and refer. Much like General Practitioners (G.Ps) in the community, OHNs often represent a central point of reference in organisations and they fulfil a coordinating role. To do this they need a deep knowledge of their own specialism and a working knowledge of how appropriate others can benefit the management of the case. Inadequate preparation can lead to errors, as well as inappropriate referral and / or 'defensive' practice. A tendency towards indiscriminate referrals can result in inconvenience and unnecessary hardship for employees. It may also increase the overall cost of an OH service (e.g. if provided by a vendor who charges the client on a per-capita basis for additional services such as G.P or treating specialist reports). This de-values the practitioner in the employer's eyes and also has the unwitting effect of diminishing the OHNs potential to participate with peers on an equal footing. In our experience students from SCHPHN (OH) courses who do not have sufficient access to these practitioners are demonstrably less confident and technically proficient as a result.
- ❖ There may be a perception amongst policy makers that the inherent nature of OH nursing carries less risk to the public than that of other SCPHN nurses? For OH, arguably the nature of what constitutes a 'risk to the public' needs to be better understood. Risks to employees arise not just from clinical interventions, but also from exposure to the multiple hazards that exist in the workplace and the surrounding environment - the impact of not managing the health risks arising from occupations such as train or bus drivers and other safety critical roles can be catastrophic to public safety. In this sense, within a life course public health approach, OHNs have unique educational needs that are not being consistently met. The consequences of inadequate preparation for practice extend beyond the immediate employee or their family to the employing organisation, the employee's work colleagues, the wider community and the practitioner themselves. These include: a loss of income, loss of

employment, reduced profitability and reputational damage, environmental damage from noxious substances, litigation, long term ill-health and disability and so on.

4.5. Differing OH qualifications: The FDG agrees that entry level SCPHN programmes should be set at degree level. However, at present OHNs face a dilemma between choosing to enrol onto a degree level generalist SCPHN (OH) course of study (conferring NMC validation), or attending one of several excellent bespoke but non-validated OH courses. The fact that a choice exists in the first place is, in part, a consequence of the long-standing frustration felt by many OH practitioners and educators around the efficacy of SCPHN courses generally. However, the discrepancy is becoming more problematic because employers are increasingly stipulating a requirement for inclusion on Part 3 of the register. In deciding which route to take, nurses are effectively being asked to make a 'life-choice' between a perceived higher quality learning experience and the attainment of career goals (with the associated maximum earning potential). It is a dilemma that is keenly felt and it would not arise at all if SCPHN education was fully fit for purpose. Yet, until changes are made, if a nurse wishes to be included on Part 3 of the register, s/he has no alternative but to comply with the set pathway. Meanwhile, those nurses *without* a SCPHN qualification find themselves increasingly marginalised within the labour market. This situation is inequitable and cannot be justified - all the more so given it comes at a time when OH skills are in demand. It also has significant implications for the availability of OH courses in future as well as for workforce planning (and so the delivery of public health goals). Lastly, it causes confusion amongst less informed employers and purchasers of services, some of whom opt to recruit less qualified staff instead. As a profession, OH nursing does not relish the prospect of having a 'two-tier' registration situation in future where excellent practitioners from non-validated courses find themselves forced to record their qualifications onto an alternative register to gain recognition (e.g. the Professional Standards Authority UK Public Health Register²⁰). In terms of quality assurance and for the longevity of the profession, a more inclusive solution must be found.

4.6. Course teachers: In HEIs SCPHN (OH) courses can be taught by educators without an occupational health qualification (albeit under the directorship of an OHN). However, we know that on some courses OH educators are only employed on a part-time basis – perhaps only teaching one module. At the undergraduate level of study, the SCPHN (OH) course should not be considered as ongoing professional development in the sense of building on pre-existing skills obtained during specialist OH training. Rather, it *is* the specialist training, so it ideally needs to be taught by a specialist with the appropriate credentials (who can also support the generation of relevant research to build on the evidence base for OH practice and standards). It is inevitable that SCPHN students on generically oriented courses, with limited access to OH qualified educators will be less likely to acquire the rich grounding in OH that peers from non-validated courses with specific OH content, taught by OH qualified teachers will gain. It has been the experience of FDG members that generalist SCPHN (OH) courses give nurses a broader knowledge of the theory underpinning public health nursing and a more superficial knowledge of OH theories and concepts. This poses a barrier to good practice in employment because the theories are harder to apply. The FDG is calling for HEIs to make more regular and detailed declarations to the regulator to ensure that the standards to support learning and assessment in practice²¹ are being met appropriately and that every SCPHN

(OH) student has unlimited access to an appropriately qualified practitioner whilst in education. If this would require a change in the law to enable the NMC to act the FDG would support that.

4.7. Practice teachers: The requirement for practice teachers to have attended an NMC approved teaching preparation programme²¹ in combination with the difficulties associated with obtaining funding for this type of training in the private sector means that numbers of OH qualified practice teachers are low. In 2004 there were only an estimated 11 OH qualified practice teachers available to support the needs of students graduating from HEIs annually¹. Unfortunately more recent data are not available, but anecdotally the FDG understands that the number remains low (unlikely to exceed 40 at the very most). It is estimated that 1,245 graduates have registered as SCPHN since the register was established²².

Those OHNs working outside the NHS are rarely able to ring fence time or funding for this course which leaves a significant gap. The FDG does not wish to see a lowering of practice standards, and the inflexibility with which this requirement is regulated is having the opposite effect to what was originally intended i.e. to guarantee quality and competence. It should be reviewed.

- ❖ *FDG members regularly see potential OH students advertising for practice teachers and placements on social media, some report that due to the lack of success of finding a practice teacher they are unable to commence with the course.*

4.8. Practice placements: The requirement to ensure a 50-50% balance of classroom based to practical learning is sensible academically – the FDG supports the consolidation of theory to practice. However, using this method of assessment alone is difficult for employers to support. The practicalities of sustaining a student on a supernumerary basis in the diverse OH employment scenarios that exist makes this difficult – even in the NHS. This requirement discourages many nurses from pursuing a career in OH and results in organisations recruiting non-qualified nurses or technicians instead. Whilst a good technician is likely to perform specific tasks very efficiently, OHN (and occupational physician) supervision is required to interpret results and determine next steps, otherwise the employer risks providing negligent health surveillance²³. Given the emphasis on practice based learning, there is a considerable responsibility placed on practice teachers to ensure that they only pass students as competent if they really are. Plus it is critical that placement learning outcomes are appropriate and suitable for the assessment of OH nurses. The existence of generic practice based learning outcomes would only exacerbate the educational problems described. The way in which practice placements are currently regulated should be reviewed and serious consideration given to introducing a more flexible method of assessment as an alternative.

5. Funding

5.1. Availability of funding: There is a lack of available funding opportunities for nurses who wish to pursue a career in OH. Training for all student health visitors and school nurses is funded by the NHS (in Wales it is funded by the Welsh Government), but it can be difficult to find employers outside the NHS who are willing to support a nurse through such specialist training. As a result, and as stated earlier many trainees in OH nursing self-fund, but this means numbers on courses are very

low making it difficult for some HEIs to offer dedicated courses. The FDG believes that there should be parity with other SCPHN nurses and more research undertaken to support the benefits of intervention by qualified OHNs. The workplace represents an ideal environment in which to improve the health and wellbeing of working adults and deliver the programme of work set out by Public Health England (PHE)²⁴ therefore it is essential that funding issues be addressed. This would increase numbers into the profession. The FDG maintains that there should be an urgent review of public and private sector OHN funding, and as part of this, alternative funding streams should be explored (but to make this work issues relating to nurse education must first be resolved).

6. Regulation

6.1. Protection of title. As a discipline, OH nursing is encompassed into the framework of professional nursing regulation, currently legislated under the Nursing and Midwifery Order 2001 ('the order') and established under the NMC²⁵. As stated, OHNs are primarily (but not exclusively) registered on Part 3 of the Register as Specialist Community Public Health Nurses (SCPHN). The FDG recognises that 'Registered Nurse' and 'Specialist Community Public Health Nurse' are protected titles. However, for service users outside the NHS, the title of SCPHN is not meaningful at all. Firstly it relates to different nursing functions operating under the same qualification. Secondly nurses in organisations are more commonly referred to as an 'occupational health nurse' or 'occupational health advisor' - the protected title is not routinely used. The FDG is of the view that satisfactory completion of appropriate training should always be recognized by a clearly identifiable qualification that is appropriate to the job it represents.

6.2. Recording of qualifications: The current arrangements for accreditation of OHNs in the UK do not meet the needs of such a diverse group of professional practitioners. As stated, the restrictive way in which SCPHN OHNs are required to record their qualification on the register disadvantages many good OHNs holding equivalent degrees from non-validated HEIs. Despite being extremely proficient these nurses remain ineligible to enter Part 3 of the register. This 'blanket' exclusion is overly punitive, out of step with the requirements of the commercial OH market and blocks essential recruitment into the profession. There should be a meaningful agreed national standard for OH (at both under graduate and post graduate levels) with appropriate alternative different levels of qualification for those nurses who are already qualified but do not wish study to degree level.

6.3. Flexibility of the SCPHN qualification: SCPHN registered nurses can transfer into other areas of SCPHN practice after having only completed a ten week transitional module at a validated HEI (and submitting a professional portfolio). Since the majority of OHNs self-fund education (unlike health visitors and school nurses), some will favour this option on economic grounds. Given the serious concerns about the suitability of SCPHN (OH) education in the first place, the ease with which a nurse can potentially transfer into the specialism under the current system of regulation is alarming. It is wholly inadequate to assume that such a shortcut prepares a nurse to practice appropriately, safely and competently in OH. Perhaps this model would be more feasible if the nurse were working as part of a health care team, managed or supervised by a fellow clinician? But

many OHNs work in isolation of professional peers and report into a line manager who is either another workplace professional (non-clinician) or a lay person. Line managers are less equipped to differentiate between what constitutes acceptable and unacceptable practice, and are entirely reliant on the integrity of the health professional to act appropriately. If the practitioner is wanting for whatever reason, the employer could be held liable for any errors or omissions that might result. FDG members have come across several examples of nurses holding a 'dual SCPHN qualification' and have been shocked at their lack of basic OH knowledge. This transitional arrangement is completely inappropriate professionally (and arbitrary anyway since nurses do not need a qualification to work in OH). It should not be recommended as a route into OH because it immediately compromises standards and is misleading as a way of determining standards of competence for service users.

6.4. Advanced practitioner status: Although OH nurses are public health practitioners, OH nursing also incorporates advanced clinical practice status as defined by the Department of Health²⁶. In principle, the FDG supports the closure of the SCPHN register, but *only* if there is an alternative recognition of the specialist occupational health qualification at both Practitioner and Advanced Practitioner level status²⁶. Until an Advanced Practice register is established, OHNs should be recognised with a specialist practitioner status annotation on the NMC nursing register (as was previously the case with the English National Board [ENB] validated recordable qualification programmes and the special practitioner annotation on the United Kingdom Central Council [UKCC] for Nursing, Midwifery and Health Visiting register²⁷).

6.5 .Career pathway and preceptorship: Because of the nature of work in OH outside the NHS, there is a need for any revised regulatory arrangements to integrate with a formal agreed career pathway for OHNs – this should reflect the progress of an OHN from junior to a senior level. The OHN's career journey should be more specified with a clear 'line of sight' accompanied by corresponding educational input that is supported throughout by a system of preceptorship providing informal and/ or formal supervision to nurses who have newly qualified (and also for those who are not working at advanced level but who want to raise and maintain standards). Some nurses also undertake leadership roles as managers of OH services. These positions demand a high level of responsibility and a capacity to make important decisions independently. As such they accord with the concept of Advanced Practice. If the NMC develops this, the FDG believes that graduates of OHN programmes must have the opportunity to be registered as such (this would be akin to the membership and fellowship model outlined in the Shape of Caring Review²⁸). The FDG is interested in developing membership categories for the FOHN that reflects this in our future work. It is also interested in supporting professional supervision requirements.

6.6. Revalidation: Revalidation is welcomed by the OH profession, but the process must take account of the needs of OHNs working in both the private and the public sectors. For example not all OHNs in the private sector have an annual NHS style appraisal – and as stated many work as lone practitioners without peer support, or supervision. As with OHN education, a homogenous approach does not work. The FDG is concerned that one outcome arising from the inadequacies of current SCPHN education and regulation is that the quality of OHNs reflective practice will be compromised (how does an OHN know what they do not know?). The FDG is pleased that the

Association of Occupational Health Nurse Practitioners UK (AOHNP) was included as one of the bodies piloting the proposed system and welcomed the assurances made by the NMC to the Select Health Committee that they would take account of revalidation pilot outcomes²⁹. As revalidation is embedded, the FDG is committed to working collaboratively with the NMC and the AOHNP to support the wider implementation of revalidation within the diverse field of OH.

6.7. Renewal: As part of revalidation, NMC registrants are required to renew their registration every three years having declared that they have undertaken a minimum of 450 hours practice and 35 hours CPD over the preceding three years. However, the content of this is not specified or regulated. The FDG believes that the FOHN will have a role to play in providing guidance for OHNs on the interpretation of this requirement, which should include content of ongoing OH professional development as being relevant and specific to the specialism and the role they are performing (using different competencies for different organisations and at different levels).

The FDG supports the present changes to the Nursing and Midwifery Order 2001 with regard to Fitness to Practice and Registration Rules as it will free up funding to achieve better public protection through improved education and practice standards.

Please see Appendix 2 for an Impact Analysis of sections 4-6.

7. Why Are These Issues Important?

OHNs who are appropriately educated (and suitably qualified) offer employers a unique mix of skills and competencies to enable intervention at primary, secondary and tertiary levels. But this means that OHNs must graduate with a comprehensive understanding of the interaction between health and work, i.e. how individual health impacts work but also how work can affect an individual's health. Being fully conversant with *both* reciprocal pathways within this theoretical construct (the basis of OH intervention) and what each means for practice is what differentiates qualified OHNs from non-OH qualified nurses. But in the FDG's experience (although always difficult to generalise) another clear distinction exists. And that is that SCPHN (OH) qualified nurses tend to be more comfortable dealing with the 'impact of an individual's health on work' than they are with the 'impact of work on health'. Understandably, if nurses are not taught how to carry out needs assessments, case management (especially for psychological health disorders) and risk assessments to the appropriate level (and they do not appreciate the functional workings and dynamics of organisations) they cannot fully engage with the health-work dynamic. This means that they graduate without the attributes which make them unique in the first place and so, arguably, why would an employer justify the additional expenditure required to employ them? For the reasons set out, it is vital that going forward all OHNs graduate having been properly equipped to make a tangible difference to the health of the workforce across the full depth and breadth of OH practice - in terms of both individual *and* organisational outcomes. Otherwise, there will be a consequential diminution of standards within the profession as more nurses pass through the educational system. This forms the basis of the FDG's concern about public protection.

The issues outlined arise at a time when the nature of work is changing. Information technology and globalisation have intensified the experience of work for many people. There are now four generations of workers co-existing in a workforce with different needs and expectations of employment. There is an ageing population which brings particular challenges for the study and practice of OH (e.g. relating to disease management). The UK needs a productive and economically active workforce. Yet in 2014, the National Office for Statistics revealed that output per hour worked was 21% below average compared to other G7 countries³⁰ - health, wellbeing and engagement related factors play a part in this and are primary concerns for employers.

Given the amount of time employees spend at work each day, the role of the workplace as a vehicle for improving health and wellbeing remains under-utilized and so a huge opportunity exists to make a difference. If adequately prepared OHNs can make a unique contribution to the sustainable development, improved competitiveness, job security and increased profitability of enterprises and communities by addressing those factors which are related to the health of the working population. In doing so, they promote a successful UK economy which, in turn enables investment to reduce health inequalities in people across the demographic spectrum.

In the UK, OH nurses have worked in organisations for at least 140 years since Philippa Flowerday was first employed at J&J Coleman of Norwich³¹. Nowadays, OHN numbers are dwindling and, as with the changing demographics nationally, those with embedded knowledge and experience are also an ageing group, so new talent must be attracted into the profession. However, the issues outlined preclude this. It is clear that if OHNs are to contribute properly to meeting the demands of future workplaces and ensure a legacy for generations to come, as well as maintaining excellent standards of practice, the profession needs a better educational and regulatory framework that moves with the times (and this adaptation need not be at the expense of quality).

The OH nursing role represents a unique resource for the workforce, employers (and potentially in future) those who are economically inactive to help improve the health of the nation. No equivalent practitioner group exists with the same knowledge, expertise and profile within organisations to carry out this work *more cost effectively*. It is therefore incumbent upon us to work together to preserve it as a flourishing specialism within public health, and to ensure that it remains safe and relevant to the needs of the working population.

8. Recommendations

8.1 Education

It is acknowledged that Part 3 of the SCPHN register is currently under scrutiny and there is an ongoing debate about whether or not it will provide an appropriate framework for practice going forward⁴. Recommendations in respect of nurse education are therefore set out here in two sections.

Section A: lists recommendations aimed at improving the *existing* SCPHN arrangements for education whereas **Section B:** outlines thoughts in terms of *proposed* changes that could replace Part 3 and the requirement for the SCPHN course.

Section A: OHN education - existing SCPHN (OH) model

- SCPHN (OH) courses must be more closely aligned with the needs of future OH strategy and evidence based provision (e.g. as identified by the work of the Council for Work and Health) in their workforce planning project³².
- Current SCPHN (OH) courses must be adapted to include more directly relevant and specific OH content as described. The current standards of proficiency and course content must be re-written to more accurately reflect specific learning outcomes in the form of essential skill sets or skills clusters.
- Competencies must be agreed and more closely aligned with both the theory and practice of OH to match the key competencies that OHNs need across the depth and breadth of practice. The FDG supports (in principle) the Royal College of Nursing (RCN) Occupational Health Nursing: Career and Competence Development¹⁵ document but would recommend that this guidance be updated to be more specific with regard to OH evidence based practice, standards and guidance.
- A formal regulatory mechanism must be adopted whereby senior OHNs in the profession can input feedback into standards for OHN education. Otherwise the NMC needs to develop more active relationships with stakeholder groups.
- Shared learning with other SCPHNs is useful but must not be mandatory. Shared learning with other relevant multi-disciplinary groups and professionals must be mandated as it is an essential pre-requisite for OH practice, as well as an evidence based model of learning.
- Differences between validated and non-validated courses must be addressed, with appropriate consistent standards and a high quality, standard qualification for both.
- Consideration must be given to the possibility of OHNs obtaining a recognised qualification through a flexible modular programme with core and specific training requirements.
- Standards for successful completion of courses must be more congruent between HEIs and a quality assurance process developed to demonstrate this for potential employers.
- There must be more robust and regular detailed declarations by HEIs confirming that the standards for the preparation of teachers of nursing and midwifery are being met in full and that students have unlimited access to an appropriately qualified practitioner whilst in education.

- As compliance with NMC standards for provision of practice teachers is difficult, an agreement with course providers to seek alternatives to NMC validation for post-registration programmes preparing OHNs for practice must be considered by the regulator.
- The requirement for OHNs to assume supernumerary status needs to be re-addressed and alternative options found that better align with the practicalities of what is reasonable due to the different employment situations in which OHN's work.
- To raise the profile of OH nursing, the FOHN should hold a dialogue with the Chief Nursing Officer (Department of Health) to ensure that careers within OH nursing are appropriately reflected in documents or models associated with Department of Health strategy for modernising nursing careers.

Section B: OHN education - proposed future changes

A collaborative approach between the NMC, FOHN and NSOH to define a more relevant model of OHN education is a key recommendation.

- Centres of excellence should be identified throughout the country as a standard base for occupational health education. Potentially, the NSOH and the FOHN should provide the 'gold standard' stamp of approval for courses based on relevant multidisciplinary learning as identified by a competency skills assessment. This would provide an evidenced based learning experience which is affordable and more relevant to the needs of the working population.
- OH courses should be developed on the principles of Advanced Practice, with an OH strategic reference group (to include designated members of the FOHN). A post qualification period of professional supervision should be mandated for those SCPHN (OH) registrants not qualified to Advanced Practitioner level.
- Designated members of the FOHN should play an important role as preceptors, providing informal and formal supervision to nurses who have newly qualified and / or are not working at an advanced level but who want to raise and maintain standards. The FOHN should also explore the development of membership and fellowship standards as proposed by Lord Willis²⁸ as part of a career framework model.
- There should be incentives to generate more qualified course teachers and practice teachers and if this is not possible, as a minimum, there should be more structured input from senior practitioners in the field of OH.

8.2. Funding

- The FOHN should work jointly with the FOM, the NSOH and Government Departments to ensure that the rationale for intervention by qualified OHNs is more visible to employers.

- There should be an urgent review of public and private sector OHN educational funding in order to identify the best solutions to the problem and options to improve numbers entering the field of OH nursing.
- In the NHS, bursaries should be set up to assist students with funding for courses.
- Within their budgets for work health and wellbeing, The Department of Health and the devolved UK Governments should consider offering bursaries for non-NHS nurses who wish to study or qualify as OHNs or OHN Practice Teachers.

8.3. Regulation

- There should be a protected title for those who have completed an approved programme of education with a tiered route through to recognition as an Advanced Practitioner. For example, a newly qualified practitioner would have a protected title, others with more experience of practice would be designated at a higher level and those with the highest qualifications in the speciality (and / or who are already on Part 3 of the register would become an Advanced Practitioner).
- The FDG would not support the removal of the SCPHN annotation until the establishment of an Advanced Practice register for OH is complete and agreement has been reached regarding the appropriate post nominal allocated by an external professional body such as the FOHN.
- In conjunction with representatives from OH nursing, the current transitional arrangement for SCPHN nurses to move into OH nursing after only ten weeks training must be urgently reviewed and withdrawn until such time as the current SCPHN (OH) educational issues are resolved.
- A clear career pathway for newly qualified OHNs should be introduced starting with junior nurses and progressing through defined stages to a senior leadership position (it should also incorporate provision for those who may not want to progress to a senior level). The pathway should be supported by a system of preceptorship as provided by senior OHN personnel in both the public, private and independent sectors. As part of the work entailed in developing a career pathway, the FDG could consider defining the difference between the work of an occupational health nurse and that of an occupational health advisor.
- Revalidation must incorporate guidance for OHNs working across a wide range of practice settings i.e. professional development (reviewed by another OH registrant), reflective practice that drives public protection and practice development.

9. Next Steps

The FDG has produced this position paper as an initial means of highlighting the issues currently facing the OH nursing profession as well as way of generating debate and feedback. It will be made available on the FOHN website (please see www.fohn.org.uk).

In the spirit of 'partnership and collaboration' which forms part of the values and principles of the NMC strategy 2015-2020,¹⁹ the FDG is keen to develop a more evolved and consultative way of working with the regulator and professional bodies in future. The omission of the Law Commission Bill in the recent Queen's speech was disappointing, but the FDG believes it is still possible to fine tune the bill or section 60 order to change some rules in the interim. The FDG points to the NMC briefing to modernise health professional regulation. In light of the Select Health Committee advice to the NMC to do '*what you can do within the existing arrangements*'²⁹ the regulator is urged to consider the issues outlined in this paper and take action before the end of another parliamentary year.

As part of the FOHN Operating Plan (and by way of follow up to this document), in 2016 the FDG will carry out a survey seeking feedback from the OH nursing community in the UK. The aim is to obtain accurate data about the profession itself; the requirements for education and standard setting; and to gather information about the structure and functions of a FOHN going forward (to ensure that it delivers maximum value to members at the same time as improving the experience of recipients of OH services). The findings from this survey will be incorporated into an updated position paper to be made available on the FOHN website before mid-2017. It is hoped that use of this dynamic methodology will provide a much needed demographic view of practitioners and practice in the UK, captured as part of a 'living' document that engages the OH community in the process of building the FOHN, as well as helping the organisation itself to develop as an entity.

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Appendix 2: Impact Analysis

Issue	Impact (H, M, L)	Recommendation
OHN education – existing model	High	SCPHN (OH) courses must be more closely aligned with the needs of future OH strategy and evidence based provision (e.g. as identified by the work of the Council for Work and Health) in their workforce planning project.
		Current SCPHN (OH) courses must be adapted to include more directly relevant and specific OH content as described. The current standards of proficiency and course content must be re-written to more accurately reflect specific learning outcomes in the form of essential skill sets or skills clusters.
		Competencies must be agreed and more closely aligned with both the theory and practice of OH to match the key competencies that OHNs need across the depth and breadth of practice. The Royal College of Nursing (RCN) Occupational Health Nursing: Career and Competence Development document should be updated to be more specific with regard to OH evidence based practice, standards and guidance.
		A formal regulatory mechanism must be adopted whereby senior OHNs in the profession can input feedback into standards for OHN education. Otherwise the NMC needs to develop more active relationships with stakeholder groups.
		Shared learning with other SCPHNs is useful but must not be mandatory. Shared learning with other relevant multi-disciplinary groups and professionals must be mandated as it is an essential pre-requisite for OH practice, as well as an evidence based model of learning.
		Differences between validated and non-validated courses must be addressed, with appropriate consistent standards and a high quality, standard qualification for both.
		Consideration must be given to the possibility of OHNs obtaining a recognised qualification through a flexible modular programme with core and specific training requirements.
		Standards for successful completion of courses must be more congruent between HEIs and a quality assurance process developed to demonstrate this for potential employers.
		There must be more robust and regular detailed declarations by HEIs confirming that the standards for the preparation of teachers of nursing and midwifery are being met in full and that students have unlimited access to an appropriately qualified practitioner whilst in education.
		As compliance with NMC standards for provision of practice teachers is difficult, an agreement with course providers to seek alternatives to NMC validation for post-registration programmes preparing OHNs for practice must be considered by the regulator.
The requirement for OHNs to assume supernumerary status needs to be re-addressed and alternative options found that better align with the practicalities of what is reasonable due to the different employment situations in which OHN's work.		

Position Paper on Occupational Health Nurse Education, Funding and Regulation




Issue	Impact (H, M, L)	Recommendation
	Low	To raise the profile of OH nursing, the FOHN should hold a dialogue with the Chief Nursing Officer (Department of Health) to ensure that careers within OH nursing are appropriately reflected in documents or models associated with Department of Health strategy for modernising nursing careers.
OHN education – proposed future changes	Medium	Centres of excellence should be identified throughout the country as a standard base for occupational health education. Potentially, the NSOH and the FOHN should provide the ‘gold standard’ stamp of approval for courses based on relevant multidisciplinary learning as identified by a competency skills assessment. This would provide an evidenced based learning experience which is affordable and more relevant to the needs of the working population.
		OH courses should be developed on the principles of Advanced Practice, with an OH strategic reference group (to include designated members of the FOHN). A post qualification period of professional supervision should be mandated for those SCPHN (OH) registrants not qualified to Advanced Practitioner level.
		Designated members of the FOHN should play an important role as preceptors, providing informal and formal supervision to nurses who have newly qualified and / or are not working at an advanced level but who want to raise and maintain standards. The FOHN should also explore the development of membership and fellowship standards as part of a career framework model.
	High	There should be incentives to generate more qualified course teachers and practice teachers and if this is not possible, as a minimum, there should be more structured input from senior practitioners in the field of OH.
Funding	High	The FOHN should work jointly with the FOM, the NSOH and Government Departments to ensure that the rationale for intervention by qualified OHNs is more visible to employers.
		There should be an urgent review of public and private sector OHN educational funding in order to identify the best solutions to the problem and options to improve numbers entering the field of OH nursing.
		In the NHS, bursaries should be set up to assist students with funding for courses.
		Within their budgets for work health and wellbeing, The Department of Health and the devolved UK Governments should consider offering bursaries for non-NHS nurses who wish to study or qualify as OHNs or OHN Practice Teachers.
Regulation	High	There should be a protected title for those who have completed an approved programme of education with a tiered route through to recognition as an Advanced Practitioner. For example, a newly qualified practitioner would have a protected title, others with more experience of practice would be designated at a higher level and those with the highest qualifications in the speciality (and / or who are already on Part 3 of the register would become an Advanced Practitioner).




Issue	Impact (H, M, L)	Recommendation
		<p>The FDG would not support the removal of the SCPHN annotation until the establishment of an Advanced Practice register for OH is complete and agreement has been reached regarding the appropriate post nominal allocated by an external professional body such as the FOHN.</p> <p>In conjunction with representatives from OH nursing, the current transitional arrangement for SCPHN nurses to move into OH nursing after only ten weeks training must be urgently reviewed and withdrawn until such time as the current SCPHN (OH) educational issues are resolved.</p> <p>A clear career pathway for newly qualified OHNs should be introduced starting with junior nurses and progressing through defined stages to a senior leadership position (it should also incorporate provision for those who may not want to progress to a senior level). The pathway should be supported by a system of preceptorship as provided by senior OHN personnel in both the public, private and independent sectors. As part of the work entailed in developing a career pathway, the FDG could consider defining the difference between the work of an occupational health nurse and that of an occupational health advisor.</p> <p>Revalidation must incorporate guidance for OHNs working across a wide range of practice settings i.e. professional development (reviewed by another OH registrant), reflective practice that drives public protection and practice development.</p>


Appendix 3: Contribution of Occupational Health Nursing to Public Health and Government Strategy: A life course approach

Terms of reference:

1. **A life course approach** considers the identification of biopsychosocial and behavioural pathways during gestation, adolescence, young adulthood and later adult life that operate across an individual's life span to influence the development of chronic diseases³³.
2. **Primary intervention:** Population based intervention to identify and prevent risk.
Secondary intervention: Group or individual intervention for identified population risk or pre-symptomatic risk of developing ill health or injury.
Tertiary intervention: Intervention for those that have experienced loss to health; largely therapeutic and curative in nature³⁴.

	Public Health & Government Strategy		Occupational Health
Definition	The 'science and art of promoting health, preventing disease, and prolonging life through the organised efforts of society' ³⁵ .		The 'promotion and maintenance of the highest degree of physical, mental and social wellbeing of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risk resulting from factors adverse to health; the placing and maintenance of workers in an environment adapted to their physiological and psychological capabilities' ³⁶ .
Pregnancy	'Through partnership working midwives will seek to meet the challenges of reducing health inequalities through improving maternal and population health, ensuring the best start in life, thus contributing to a healthy life expectancy' ³⁷ .		<ul style="list-style-type: none"> • Workplace assessments/epidemiological research to determine reproductive hazards to men and women. • Work population risk assessments to determine risks to mother and/or foetus. Examples include: chemicals, pesticides, heavy metals, solvents, radiation, heavy workload, heat, awkward/sedentary postures, shift work, infections, and psychosocial stress. • Individual assessment and support at work if risk factors are identified.
Childhood	'Ensuring every child has the best start in life' ³⁸ .		<ul style="list-style-type: none"> • No direct occupational health contribution.

	Public Health & Government Strategy		Occupational Health
Adolescents & young adults	<p>‘To promote health, prevent disease; develop resilience and foster equality starting before birth through childhood and the teenage years and into young adulthood’³⁹.</p>		<ul style="list-style-type: none"> • Apprenticeship/internship/placement schemes – baseline biological/physical health surveillance based on workplace risk and job design. • <i>Inclusion in all OH adulthood services</i> 
Adulthood	<p>‘We recommend that all NHS organisations provide staff health and wellbeing services that are centred on prevention (of both work-related and lifestyle-influenced ill-health), are fully aligned with wider public health policies and initiatives, and are seen as a real and tangible benefit of working in the NHS’¹¹.</p> <p>‘Wellbeing – a positive physical, social and mental state – is an important part of our health. Good wellbeing does not just mean the absence of mental illness – it brings a wide range of benefits, including reduced health risk behaviour (such as smoking), reduced mortality, improved educational outcomes and increased productivity at work’⁴¹.</p> <p>‘Create fair employment and good work for all’⁴².</p> <p>‘Improving the health of the working age population is critically important for everyone, in order to secure both higher economic growth and increased social justice’¹⁷.</p>	Primary	<ul style="list-style-type: none"> • Health needs risk management assessments, hazard identification (based on demographic profile and risks in the environment and workplace). • Wellness and health audits. • Psychosocial risk assessments and management. • Research/assessment into emerging risks such as nanotechnology, pandemics, waste management⁴⁰. 
		Secondary	<ul style="list-style-type: none"> • Development of strategic plans and policies for prevention, protection and promotion of health in the workplace considering health and safety legislation, employment law, business productivity objectives and industry risk. • Contribution to organisational job design, ergonomics and engineering controls to prevent ill health, e.g., shift patterns, musculoskeletal disorders, elimination of respiratory sensitisers and psychosocial risks. <hr/> <ul style="list-style-type: none"> • Pre-placement assessments. • Functional assessments e.g., impact of disability and chronic ill health on work, advice on adjustments. • Case management – fitness for work, return to work advice, rehabilitation, retention at work, signposting to other agencies. • Capability and fitness assessments e.g., safety critical roles, food industry. • Design and delivery of health surveillance programmes (based on workplace health risk). • Design and implementation of workplace healthy lifestyle initiatives e.g., smoking/alcohol/diet and exercise. • Delivery of occupational health promotion training e.g., hearing, skin, stress management, infection control. • Provision of mental health support, e.g., counselling, resilience training, job design. • Provision of travel health services. • Provision of occupational vaccination programmes e.g., Hepatitis B, Flu vaccinations. <hr/>
		Tertiary	<ul style="list-style-type: none"> • First aid provision to industries identified as high risk, e.g., construction projects. • Identification of symptoms and referral to other professionals for diagnosis of occupational health disease.

	Public Health & Government Strategy		Occupational Health
Older adults	<p>'Enabling people to stay in work in their 50s and early 60s and, if they wish, after State Pension age can help support the financial, health and social wellbeing of individuals into later life. It is important for our economy, for employers and for individuals to make sure we can continue to afford pensions'⁴³.</p> <p>'Recruit one million dementia friends, in partnership with the Alzheimer's Society, by March 2015'²⁴.</p>	➔	 <i>Inclusion in all of the above to promote active ageing and employability but more specifically:</i> <ul style="list-style-type: none"> • Evidence based practice on the science of age, disease and work processes, e.g., occupational gerontology⁴⁴. • Focus on work ability – assessment of work demands, individual health conditions and mental health conditions^{44, 45}. • Contribution to redeployment/job design e.g., job analysis, work adjustments, retraining and job matching. • Promotion of dementia friendly workplaces⁴⁶.

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