PREFERRED MODEL OF CARE FOR OCCUPATIONAL MEDICINE IN IRELAND
Report of the Expert Advisory Group
August 2019

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Recommendations

**Recommendation 1:** Appropriate qualifications and competence of the occupational physician(s) delivering care is the key factor behind a preferred model. The EAG agreed unanimously that qualifications, competence and, where appropriate, skill-mix were the primary factors in the safe and effective delivery of occupational medical services. It is contingent on all occupational physicians to be appropriately qualified and certified as competent in order that all current models of care meet the diverse needs of industry. However, it is the EAG’s recommendation that specialist occupational physician provision of occupational medicine services is the standard that the faculty should promote and endorse. All current models of care meet the diverse needs of Irish industry therefore no single model of care supersedes the others.

Having recognised the workforce planning demands in the context of development of occupational medicine on a national basis we have also made the following recommendations:

**Recommendation 2:** All levels of physicians practising occupational medicine must engage in the RCPI Faculty of Occupational Medicine Professional Competency Programme and must maintain adequate CPD points specific to the occupational medicine specialty. The established Professional Competency Programme in occupational medicine is available to specialists and MFOMs. However, it was the opinion of the EAG that the system should be extended to any physician practising in occupational medicine, with a requirement for a quota of occupational medicine CPD points commensurate with the proportion of their work undertaken in occupational medicine.

**Recommendation 3:** Given the critical mass of LFOMs delivering OH services in Ireland, a formal competency framework for LFOMs should be established as a priority to identify ongoing training requirements and to ensure high-quality service delivery.

**Recommendation 4:** Once established, the required skillset and competencies of specialists, specialist registrars and non-specialists should be considered in future workforce planning to ensure the most appropriate use of resources (given the current shortfall) for service delivery.

**Recommendation 5:** Occupational medical services should be specialist-led. Where this is not possible/practicable, non-specialist providers must have confirmed access to an accredited specialist for advice as required, especially in the more complicated cases. There should be a clear process on how and when to access that specialist advice.

**Recommendation 6:** The Faculty should actively engage with key stakeholders (primarily employers, but also trades’ unions and employer representative bodies (e.g. Ibec, ISME, SFA) in order to: a) promote the value of occupational health and occupational medicine, b) keep abreast of changes in the world of work that may affect the current and future models of care; and c) educate employers to make informed decisions on the most appropriate model of care for their needs.

**Recommendation 7:** The EAG proposes creation of a project officer role. The project officer would act as a Faculty-Industry liaison and would manage employer engagement on behalf of the Faculty, using a range of tools including web-site development and stakeholder events. Such a position currently exists in the National Office of Traffic Medicine in RCPI and has proved a major success in its advocacy role.

**Recommendation 8:** In order to secure the development of occupational medicine in Ireland, the Faculty should engage with the Government to establish a statutory requirement for occupational health service provision in Ireland.
1. Introduction

The Board of the Faculty of Occupational Medicine (FOM), Royal College of Physicians of Ireland (RCPI), convened an Expert Advisory group (EAG) to review all options and make recommendations to the Board about a preferred model of care (MOC) for occupational medicine (OM) in Ireland. The EAG reports directly to the Faculty of Occupational Medicine Board.

1.1 Expert advisory group

- Professor Anne Drummond, University College Dublin (Chair and external Irish academic)
- Dr Declan Whelan, Faculty of Occupational Medicine, RCPI, Past Dean
- Dr Ovo Oghuvbu, Faculty of Occupational Medicine, RCPI
- Dr Paul Gueret, Faculty of Occupational Medicine, RCPI, Past Dean
- Dr Sheelagh O’Brien, Faculty of Occupational Medicine, RCPI
- Dr Drushca Lalloo, University of Glasgow (external international academic)
- Project Lead: Dr Norfazween Ibrahim (SpR)
- Administrative Support: Ms Rita Dolan (RCPI).

1.2 Terms of reference

1. To review the current models of care in the Faculty of Occupational Medicine (FOM)
2. To review alternative models of care, both nationally and internationally, for occupational medicine
3. To receive written submissions from Board members on this issue
4. To highlight the risks and benefits of different options of Models of Care
5. To consider the role of the Licentiates of Occupational Medicine (LFOM) in these options
6. To consider the role of the Membership of Occupational Medicine (MFOM) in these options
7. To consider the role of the Higher Specialist Training Scheme in these options
8. To consider the development of the speciality of occupational medicine in these options
9. To make a recommendation on a preferred model of care.

1.3 Meetings

The Expert Advisory Group met four times in 2019: 31 January; 08 March; 18 April; and 10 May.

1.4 Overview

This report provides a background and context to the task (section 2), a review of occupational medicine expertise in Ireland (section 3), a description of the current models of care (section 4) including the benefits and risks (section 5), taking into consideration the roles of training, qualifications and development of the speciality of occupational medicine. In section 6 the key discussion points are highlighted and in section 7 the recommendations of the group are provided.
2. Background and context

The background to the work of the Expert Advisory Group was described in the report on Workforce Planning for Occupational Physicians in the Health Service, Ireland (Sisson and Carolan, 2018).

Occupational medicine is a clinical medical speciality that deals with the interface between health and work. In 1976 a Faculty of Occupational Medicine (FOM) was established at the RCPI. Occupational medicine involves a broad range of activities including prevention/reduction of occupational diseases and injuries, fitness for work assessments, sickness absence and disability management, and vaccinations. A 4-year specialist training scheme in occupational medicine commenced in 2000. Prior to that there was no formal training scheme in Ireland.

The provision of high-quality occupational medicine services depends on having sufficient numbers of, and appropriately trained occupational physicians at national, regional and local levels. A shortage of trained and qualified physicians will impact adversely on the service and the speciality. At present there are several models of care for occupational medicine operating in Ireland and these are described in section 3. A recent review of workforce planning (carried out by the Faculty) identified several drivers of change, shown below.

In this context it was considered timely to review the current models of care and to make a recommendation on a preferred model.

2.1 Drivers of change

Changes in the nature of industry in Ireland include decreases in heavy industry and manufacturing and an increase in service industries. At a FOM, RCPI, Occupational Medical Workforce Planning Meeting in October 2018, the following drivers of change in Ireland were identified (Wallis, 2018)

- “Key macro-forces alongside a growing and aging population is driving an increased need for services
- Based on current employment figures, we are significantly behind the UK and Germany in the provision of specialist occupational physicians across public and private sectors.
- Supply of graduates does not match workforce attrition rate according to the latest report from National Doctors Training and Planning (NDTP)\(^1\)
- It is thought that the current gender balance of SpRs (8 of 11 trainees are females, entering potential family life-stage) means a strong likelihood of losing some to maternity leave during the next 5 years, with some likely to continue on a part-time basis only thereafter.”

Additional drivers of change at global level include recent predictions on the future of work and on extension of the predicted length of working lives, highlighting six already-visible megatrends that are shaping work and raising occupational health and safety issues (Horton et al, 2018)\(^2\). The six ‘mega-trends’ are:

1. The extending reach of automated systems and robotics
2. Rising workplace stress and mental health issues

3. Rising screen time, sedentary behaviour and chronic illness
4. Blurring the boundaries between work and home
5. The gig and entrepreneurial economy, and
6. An ageing workforce.

All of these trends imply a rise in the need for occupational health services, particularly prevention and risk management of related occupational hazards and optimisation of employee health and functional capacity, as well as workplace wellbeing programmes. The rise in the working age will bring with it a rise in prevalence of chronic disease in workplaces for which accommodations may be needed. The implications of these trends and the rapidity of the pace of change in work, strongly suggests a potential rise in demand for occupational medical services, but where new forms of work are concerned, makes opportunities for first, or any, contact with an occupational medical service less clear.

2.2 The value of occupational health

Recent reports published by the UK Society of Occupational Medicine (Nicholson, 2017 and Steel et al, 2018) have clearly outlined the value of occupational health professional expertise in a number of contexts, in reducing the economic burden of fatal and non-fatal injuries and illnesses, and the benefits to stakeholders across society through health gain. The benefits of OH interventions, while influenced by the social security system in different countries, are consistently relevant to all stakeholders (including employees, employers and society) and show a good return on investment at all levels. Moreover, many countries are taking occupational health beyond the statutory requirement and broadening the scope beyond traditional occupational medicine into workplace wellness, as well as corporate social responsibility.
3. Occupational medicine expertise in Ireland

3.1 Registration

All physicians must be registered to practice, however there is no statutory obligation for a physician in occupational medicine practice to be trained or qualified in the discipline. Moreover, a physician doesn’t have to be qualified in occupational medicine to use the title ‘Occupational Physician’. The practical risk of a lack of a statutory requirement for occupational medicine practice, is that an employer could not be expected to be able to make this distinction or to make an informed assessment of the expertise requirements for the services they wish to contract. Occupational physicians may be specialists or non-specialists (associated qualifications are shown in figure 1).

Figure 1: Qualification categories for specialisation status

Current physician levels / grades providing occupational medical care in Ireland have been described as follows:

- Specialist Occupational Physicians
- Specialist Registrars (SpR), working on placement, i.e. in training
- Occupational Physicians (OPs), physicians with a post-graduate qualification in occupational medicine (LFOM, MFOM)
- Physicians with or without formal training or post-graduate qualifications in occupational medicine
- Physicians in self-directed training schemes.

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3 Document provided by member of the Board of the Faculty

4 Any Medical Doctor may take a non-mandatory course for doctors interested in Occupational Medicine in the ICGP; this course prepares them for the LFOM
Irish Medical Council General Division

a) Medical Doctor with no occupational medical training (MB)

b) Medical Doctor with Licentiate of the Faculty of Occupational Medicine (LFOM)

c) Medical Doctor with Membership of the Faculty of Occupational Medicine (MFOM) ± LFOM

Irish Medical Council Specialist Division:

- Medical Doctor with a Certificate of Completion of Specialist Training (CCST)
- Medical Doctor who has undergone Evaluation of Existing Training and Experience (EETE)
  
  i. First time applicants who completed CCST-equivalent training in a non-EU or EEA country
  
  ii. Applicants whose qualifications are not eligible for automatic recognition, but have training and experience in an EU or EEA country

Irish Medical Council Training Specialist Division:

RCPI Higher Specialist trainee (Specialist Registrar SpR)

https://www.medicalcouncil.ie/Existing-Registrants-/Professional-Competence/Contact-Information-on-Schemes/

3.2 Specialisation

There are two pathways to specialisation (shown graphically in Appendix 3).

In pathway 1, qualified doctors who have carried out Basic Specialist Training in any branch of Medicine may enter a 4-year occupational medicine Higher Specialist Training (HST) and graduate with a Certificate of Completion of Specialist Training (CCST) and be registered as a Specialist.

Trainees are known as Specialist Registrars (SpRs). The Health Service Executive (HSE) funds all occupational medicine Specialist Registrar positions, and currently (2018-2019) funds 11 in the Faculty of Occupational Medicine’s Higher Specialist Training. Training comprises a 4-year programme from which 1-2 persons graduate each year. Graduates from the training programme who remain in Ireland may be recruited to the public service or the private sector.

Pathway 2 is an alternative pathway to specialisation and is available to qualified doctors with MFOM (or equivalent qualification) in addition to significant occupational medicine experience and education. In this route specialist registration is achieved through Evaluation of Existing Training and Experience (EETE); this is also known as the Self-Directed Route (SDR). The Medical Council requests the Faculty to assess the application and trained assessors within the Faculty (Fellows) carry out the assessment on behalf of the Faculty and make a recommendation. The Medical Council decides whether a Specialist registration is granted based on the recommendation.

There is a third pathway - those from overseas who have trained in occupational medicine within the EU may be entered on the Specialist Register by the Medical Council of Ireland.

3.3 Capacity

While there is no single source that enumerates all physicians that provide occupational medical services in Ireland, data is available from a number of sources.
• Just over 700 physicians are members at various grades in the RCPI Faculty of Occupational Medicine (information from RCPI, May 2019). This includes international members who are not practising in Ireland. Breakdown by grade and geography is provided in table 1 below.

Table 1: Licentiates, Members and Fellows in the Faculty of Occupational Medicine (May 2019)

<table>
<thead>
<tr>
<th></th>
<th>ROI / NI</th>
<th>Other</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>LFOM</td>
<td>169</td>
<td>188</td>
<td>6</td>
<td>363</td>
</tr>
<tr>
<td>MFOM</td>
<td>35</td>
<td>95</td>
<td>5</td>
<td>135</td>
</tr>
<tr>
<td>FFOM</td>
<td>93</td>
<td>106</td>
<td>4</td>
<td>203</td>
</tr>
</tbody>
</table>

Note: Figures never 100% correct as changes of address may not always be notified

• In 2014 the specialty-specific review of occupational medicine, carried out by the NDTP\(^5\), identified 72 specialists registered in the specialist division of the professional competence scheme in occupational medicine; but noted that no more than 65 were in active practice, that some work part-time and that attrition was forecast in the foreseeable future due to the age profile. The ratio per 100,000 employees was calculated to be 3.4 (noting that best advice recommends 14 per 100,000 employees), and projected to be unchanged in 2024, accounting for population growth and an unchanged ratio of specialists. At that time the training provision was not considered sufficient to meet anticipated demand. This problem is not unique to Ireland with similar challenges facing the profession in the UK (Nicholson, 2017).

• The RCPI Professional Competence Scheme (PCS) is a formal scheme for keeping a record of the professional activity undertaken by doctors (following basic training) in order to maintain their competency for practice. In January 2019, 87 doctors were registered to the RCPI Faculty of Occupational Medicine Professional Competence Scheme, of which 73 were registered to the Specialist Division Scheme and 14 to the General Division Scheme (Director of Professional Competence update to the Board of the Faculty of Occupational Medicine Document, January 2019).

In this report the term ‘Occupational Physician’ (OP) is used as a generic term, for simplicity, and specific grades are mentioned only where relevant. The term occupational physician is used widely in industry and an employer or employee is unlikely to be aware of the distinctions between the different levels or grades.

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\(^5\) [https://www.hse.ie/eng/staff/leadership-education-development/met/plan/specialty-specific-reviews/specialty-specific-reviews.html](https://www.hse.ie/eng/staff/leadership-education-development/met/plan/specialty-specific-reviews/specialty-specific-reviews.html)
4. Models of care

4.1 Occupational medicine services

Occupational medicine services are wide ranging and include the following:
1. Prevention – of ill health caused or exacerbated by work
2. Timely intervention - easy and early treatment for the main causes of sickness absence;
3. Rehabilitation – to help staff stay at work or return to work after illness
4. Health Assessments for work- to help manage attendance, retirement and related matters
5. Assessment of fitness for work, especially safety critical work
6. Promotion of health and well-being – using work as a means to improve health and well-being and using the workplace to promote health
7. Teaching and training – encouraging staff and managers to support staff health and well-being
8. Advisory – new company set-ups, advice associated with legal proceedings, e.g. court cases, tribunals etc.

These services are achieved using a wide range of specialised activities and are provided through a variety of Models of Care. Article 7 of ILO Convention No. 161 provides that “occupational health services may be organized as a service for a single undertaking or as a service common to a number of undertakings” or, “in accordance with national conditions and practice, occupational health services may be organized by the undertakings or groups of undertakings concerned, public authorities or official services, social security institutions, any other bodies authorized by the competent authority, or any combination of the above”.

4.2 Models of care in occupational medicine

In the ILO Encyclopaedia Rantanen and Fedatov (2011) describe the models of care in occupational medicine as follows:

a) In-plant or in-company model; an integrated, comprehensive occupational health service on the company premises, that includes nurse-led models
b) group or inter-enterprise model
c) industry-oriented model
d) hospital out-patient clinics
e) private health centres [private companies]
f) primary health care units, and
g) the social security model.

According to the ILO the primary decision on whether or not to have a service in an organisation is often determined by legislation, or management concerns about health and safety. In Ireland legislation requires employers to carry out risk assessment and to implement controls appropriate to the risk in the context of the hazards, but it does not specify provision of an occupational health service or occupational medical service.

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4.2.1 Models of care in Ireland

The approach taken by the Expert Advisory Group to describe the models of care in this report is based on the three ILO-described models that are predominantly used in Ireland.

- **In-company model**: the OP is an employee of, or contracted on a sessional basis to, the organisation receiving the service (the client) and is normally based on company premises. In Ireland the OP is likely to be a specialist or to have a post-graduate qualification in occupational medicine. In some cases, services may be provided by a local GP (with or without occupational medicine qualifications). Normally, the employee visits the OP at a location in their workplace or a place associated with the employee’s work, which in some cases (e.g. large multi-location organisations) may require an employee to travel in order to access the service. For the purposes of this report, this model includes externally contracted OPs, from a private health centre, whose in-company presence is considerable.

- **Private health centre model**: The main feature of the model is that care is delivered by a group of physicians or a private entrepreneurial organisation that employs them. The OP is contracted to the client whose employees are receiving the service, but the client’s employees normally travel to the OPs private premises. The ILO include in this category models that operate from hospitals (similar to recent UK NHS model).

- **Primary health care units**: In some countries such units are organised by municipal or local health authorities. In Ireland GP-provided occupational medical care may be provided alongside primary health care. In this model employees may travel to the GP practice or the GP may provide sessional services in-company.

- **Hybrid models of care** also exist and comprise some combination of the above.

Depending on the size and nature of the hazards and of the service, the in-company and the private health centre models of care can include a range of multi-disciplinary allied health professionals as part of the team, most commonly occupational health nurses (OHNs), but may include occupational hygienists, physiotherapists, counsellors and / or psychologists, ergonomists and others. Safety services are normally a separate activity to occupational health services but close liaison between safety personnel and relevant occupational health personnel is the norm.

According to the Rantanen and Fedatov (2011), the factors determining the model selected are:

a) The size of the workforce and demographic characteristics  
b) The work carried out and the workplace hazards  
c) The location of the worksite  
d) The kind and quantity of health services available in the community, and  
e) The affluence of the enterprise.

When considered from an enterprise perspective, this could be taken to mean that different models will be appropriate for different organisations, depending on the factors listed. It can also be viewed from a national perspective as shown below.

4.2.1a The size of the workforce and demographic characteristics

The workforce in Ireland has been growing steadily in recent years. In Q4 2018, there were 3.9 million persons aged 15 or over, with 2.4 million at work, of which 1.3 million were men (54%) and 1.1 million

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8 In Ireland this model is referred to as Private Health Provider
(46%) were women (CSO, 2019). Population demographics and predictions and increases in the retirement age will result in an ageing workforce, with a likely rise in demand for occupational health services as more people of working age will have chronic diseases (HSE and NDTP, 2014).

Figure 3: Employment in Ireland 2014-2018

4.2.1b Workplace hazards

While hazards and risks vary by the nature of the work being carried out, current key challenges identified by the Health and Safety Authority (HSA) in its 2019-21 Strategy Statement include new business models, pressure to perform, safety in agriculture, and long-term occupational health risks such as stress, manual handling and occupational cancer (HSA, 2019). The HSA strategy includes promoting active engagement in managing occupational health and wellbeing by employers, and increased awareness on the risks to health arising from chemicals.

The recent combined rate of injury and illness causing more than four days’ absence from work, peaked at 24.4 per 1,000 workers in 2012. Since then the rate has fallen to 15 per 1,000 in 2016 (most recent data available). The (self-reported via Labour Force Survey) illness rates in the same period peaked in 2012 at 14.8 per 1,000, and since then has fallen to 8.5 per 1,000 in 2016.

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9 https://www.cso.ie/en/releasesandpublications/er/lfs/labourforcesurveyquarter42018/
4.2.1c The location of the worksite

While worksite locations are diverse, it is known that specialist occupational physicians are concentrated in the greater Dublin and greater Cork areas (HSE and NDPT, 2014). Organisations located in geographically remote locations may have limited access to specialist services.

4.2.1d Health services available in the community

In some European countries, occupational medicine / health is addressed under community public health systems and a variety of models of care exist. In Ireland public health services are provided locally and nationally, including health protection services, advocating and contributing to health improvement and participating in health service development. While occupational medicine does not come under the remit of community or public health services, some recent public health policies have focused on the health needs of the working age population, particularly in the areas of health and wellbeing, including:

a) the HSA Workplace Health and Wellbeing Strategy, Report of Expert Group (2008),
b) the Healthy Ireland framework (2014), for which proposed legislation includes public but not private sector workplaces in the strategy, and
c) the more recent consultation and work on a Healthy Workplace Framework, which is in a very advanced stage of development (April 2019) and included consultation with all relevant work-related stakeholders including the Faculty.

4.2.1e The affluence of the enterprise

Under the framework Safety, Health and Welfare at Work Act, 2005 and associated Regulations, the employer is obliged to ensure the safety, health and welfare at work of his or her employees. While it is implied, it is not specified whether or how occupational health services should be provided. In practice, with the exception of cases of illness not recognised as occupational that are addressed through the public health system, the employer must carry out a risk assessment and decide whether or not an occupational medical service is required and must bear the cost. An editorial in BMJ (Torrence and Heron, 2017) (suggesting that occupational medicine in the UK should be part of the National Health Service) noted that many large businesses see a benefit from providing occupational medicine, but that employees in small and medium enterprises have limited access. While the exact coverage of professional occupational medicine service provision in Ireland is not known, it is more likely to be available in the public sector and in larger more affluent high-risk private sector enterprises. What is certain is that large sections of the workforce have no access, and at least one of the reasons for this is likely to be financial.

4.2.2 Summary

Depending on the nature of the hazards, the sector of industry, the size of the enterprise and the occupational needs of the company, in Ireland occupational medical services may be provided by physicians, exclusively, or in association with a combination of nurses and/or other relevant occupational health professionals. The provider may be a) directly employed, either full-time or part-time, by employers (in-company model), b) privately contracted on a sessional basis, which can range from full-time to part-time to ad hoc (private health centre model), or c) provided by a GP practice with an occupational medical service (primary health care model) or by other GPs.

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11 https://www.hse.ie/eng/services/list/5/publichealth/publichealthdepts/about/aboutus.html accessed 01/04/2019
12 https://www.hsa.ie/eng/Publications_and_Forms/Publications/Occupational_Health/Workplace_Health_and_Well-Being_Strategy.html accessed 01/04/2019
The predominant models of care used currently in Ireland are described in Tables 2 - 5, along with potential benefits and risks for each. It should be noted however, that potential benefits and risks for any model will be influenced at organisational level by the size, nature and culture of the industry and the associated health and safety risks.

Models of care in occupational medicine reflect the occupational medical needs of enterprises; the starting point is the enterprise. However, a private company may provide occupational medical services using one or more of the models to meet the needs of different clients. Models of care are influenced by political, social and health systems. For example, in many European countries, provision of an occupational health service is compulsory. In the Netherlands, which has a compulsory system, OHS provision was > 90% (Nicholson, 2004). While many of the models of care used in Ireland are used elsewhere, the ILO also describes models of care that are not used in Ireland and these are shown in Tables 6 – 10.

The current models of care (as received by the enterprise), which can be broadly described as internal or external services, are shown graphically in Figure 4.

**Figure 4: Overview of Models of Care (MoC) currently used in Ireland**

![Diagram of Models of Care](image)

The benefits and risks of these models are elaborated in Section 5.
5. Benefits and risks of the models

The benefits and risks of these models are provided in Tables 2 to 5. A selection of predominant models not used in Ireland is provided in Tables 6 to 11.

Table 2: Model of care 1: In-company model

<table>
<thead>
<tr>
<th>Description of the model of care and likely qualifications of OPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• OMS is provided full-time or part-time in-company by:</td>
</tr>
<tr>
<td>o OP(s) employed by the company or</td>
</tr>
<tr>
<td>o OP(s) from a private health centre.</td>
</tr>
<tr>
<td>• The key differentiating factor in this model is that the service is easily accessible to employees, from both time and location perspectives.</td>
</tr>
<tr>
<td>• The model is most commonly used in large companies.</td>
</tr>
<tr>
<td>• OHS is provided by OP(s) as direct employee(s) of the organisation, or OHS is provided by OP(s) employed by an external private health centre.</td>
</tr>
<tr>
<td>• The service is likely to be supported by OHNs ± other Allied Health Professionals (AHPs)</td>
</tr>
<tr>
<td>• In-house administrative support is usually provided.</td>
</tr>
<tr>
<td>• OPs are likely to be specialists (who may be supervising trainees) or MFOM or LFOM</td>
</tr>
</tbody>
</table>

Benefits of the model

Benefits where OP is a member of staff or a regular consistent external provider:

a) OP and employer likely to have shared objectives and values
b) OP can develop a deep understanding of the organisation’s culture and requirements.
c) In-service OPHs and OHNs likely to develop role and employment sector-specific skills
d) Service may be multidisciplinary
e) OP is likely to develop a relationship with allied OSH services that may be bought in or in-house (e.g. Occupational Hygiene) allowing for collaborative multidisciplinary OH team approach.
f) OP can play a role in preventing legal proceedings and is likely to develop medico-legal expertise bespoke to the organisation
g) Skills-match to business needs can be maximised over time.

Additional benefits where OP is a member of staff:

h) As a member of staff, the OP is likely to be on key company committees relating to employee health and welfare, can identify patterns and trends and propose, negotiate and design appropriate OH interventions as required
i) As a member of staff, the OP is likely to be in a position to identify and use opportunities to educate management and staff about OSH
j) As a member of staff OP is often part of the decision-making process and can influence organisational culture and strategic direction, with maximum impact at senior management level
k) As a member of staff OP is likely to have a lot of control over own professional activities and input to line management and senior management decisions
l) Tenure and loyalty of OP as a member of staff is likely to result in longer service with benefits for continuity of care.

This model is likely to be most suitable for large and public sector organisations. It is financially more cost-effective for large organisations that need more, and a wider range of, care.
**Model of care 1 - continued**

**Risks of the model**

a) OP as an employee is bound by the employer’s service needs and opportunity to negotiate some decisions and OH recommendations may be difficult.

b) A physician without occupational medicine training may be employed by the organisation bringing a clinical risk.

c) Clinical risks may arise in cases where the service leader is not part of a recognised occupational medicine Competency Scheme.

d) Expertise and experience of directly employed OPs or regular consistent provider OPs may become limited to a single industry.

e) Service may not be multidisciplinary.

f) In organisations with multiple locations and in-house OP(s), employees may have to travel distances to access one-to-one aspects of the service with risk of non-attendance.

g) Many benefits of the model may be lost if service provision (in the case of sessional service by private health centre) has no consistency of personnel providing the service.

h) In GP-provided in-house services there is a risk of clinical isolation, lack of occupational medicine peer support and lack of pathway for CPD if the GP is not a member of the Professional Competency Scheme in occupational medicine.

i) This model may be expensive for SME employers and financially likely to be feasible only in large organisations.

This model is not suitable for SMEs and is unlikely to reach new and emerging forms of work (e.g. gig economy, self-employed and sole traders, etc.) and hard to access populations (agriculture).

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**Table 3: Model of care 2: Hybrid of In-company model and private health centre model**

**Description of the occupational medical service model of care and likely qualifications of OPs**

- This is a combination model of internal and external services.
- The service is under the clinical governance of OP(s) from a private health centre, usually contracted by the employer.
- The key differentiating factor for this model is that the company primarily receives an in-company service, but some services may be off-site.
- The OHS is bought-in from a private health centre which provides in-house OHS services to the organisation.
- OHN(s) are located in-company, however they may be employed by the company or by the private health centre.
- The OP service may be received either in-company and/or in a private health centre premises.
- Administrative support is likely to be provided by the private health centre as opposed to being funded by the client but may be a combination model.
- In many cases this is a nurse-led model.
- OPs are likely to be specialists, who may be supervising trainees, or MFOM.
Benefits of the model

a) A bespoke service is negotiated and agreed between client and OHS provider.
b) Client can select from a menu of service options.
c) Ad hoc consultations are possible.
d) OPs attached to the service are likely to be qualified and experienced in occupational medicine.
e) Service is likely to be multidisciplinary.
f) Likely to be more cost-effective for most SME employers and more likely to be purchased vis-a-vis having an In-house service.
g) Employer is likely to seek regular service review which can ensure service is relevant and up-to-date and cost-effective.
h) OHS with regular sessional OPs can develop an understanding of the organisation’s culture, can have input to the decision-making process and may influence organisational culture and strategic direction, with maximum impact.
i) OHS with sessional OPs can agree shared objectives and values with employer.
j) Sessional OP may play a role in preventing legal proceedings.
k) Skills-match to business needs can be negotiated and maximised due to a potential range of expertise among a team of OP plus or minus allied health professionals.
l) OP may negotiate input to line management and senior management decisions.
m) OHNs within OHS may develop sector specific skills.
n) OHS sessions can provide support to OHN-led services.
o) Accessibility to multiple and non-traditional sectors of industry is possible, where OPs are not traditionally employed.
p) Accessibility to remote areas is possible, e.g. OHS may employ local GPs (qualified in occupational medicine) in remote areas, who may see patients in-company, in a third-party location or in the GP surgery.

Risks of the model

a) Employers may choose not to purchase some necessary services despite being advised to do so by the occupational health service provider.
b) Beneficial additional occupational health services may not be purchased by the employer.
c) If additional services bought-in by the employer are not from the main OHS provider, communication issues may arise.
d) Continuity of sessional staff may not be optimum; relationship-building and other benefits may be compromised.
e) In organisations with multiple locations, employees may have to travel to access one-to-one aspects of the service.
Table 4: Model of care 3: Private health centre model

<table>
<thead>
<tr>
<th>Description of the occupational medical service model of care and likely qualifications of OPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• This is a combination model of internal and external services.</td>
</tr>
<tr>
<td>• The service is under the clinical governance of OP(s) from a private health centre, usually contracted by the employer.</td>
</tr>
<tr>
<td>• The key differentiating factor for this model is that the company primarily receives an in-company service, but some services may be off-site.</td>
</tr>
<tr>
<td>• OHS is provided by a private health centre. OP(s) own, or are employed by, the private health centre.</td>
</tr>
<tr>
<td>• The service is likely to employ OHN(s) and other relevant allied health professional staff.</td>
</tr>
<tr>
<td>• In-company administrative support and practice management is usually provided by the private health centre.</td>
</tr>
<tr>
<td>• OPs likely to be specialist, who may be supervising trainees, or MFOM or LFOM.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits of the model</th>
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</thead>
<tbody>
<tr>
<td>a) A wide range of staff and expertise may be possible.</td>
</tr>
<tr>
<td>b) Skill and experience mix can be built-up.</td>
</tr>
<tr>
<td>c) The practice can build up a range of equipment and expertise that may not be feasible for an in-house service.</td>
</tr>
<tr>
<td>d) Company’s resources can benefit multiple companies (clients).</td>
</tr>
<tr>
<td>e) A multidisciplinary team is likely.</td>
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<tr>
<td>f) Panels can sub-contract work to local GPs with a qualification in occupational medicine, who will have access to specialist advice.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of the model</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Employer may choose not to purchase some necessary services despite being advised to do so by the OHS.</td>
</tr>
<tr>
<td>b) Beneficial additional OSH services may not be purchased by the employer.</td>
</tr>
<tr>
<td>c) If additional OSH services bought-in by the employer are not from the main OHS provider, communication issues may arise.</td>
</tr>
<tr>
<td>d) Continuity of sessional staff may not be optimum; relationship-building and other benefits may be compromised.</td>
</tr>
<tr>
<td>e) In organisations with multiple locations, employees may have to travel to access one-to-one aspects of the service.</td>
</tr>
<tr>
<td>f) Potential for lack of continuity of care to service users because attending OP can change from time to time.</td>
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<tr>
<td>g) The provider-client relationship with participating enterprises may hinder implementation of the principle of employer and worker involvement in formulating policies and procedures.</td>
</tr>
<tr>
<td>h) There may be a lack of understanding of the workplace on the part of the provider (e.g. occasional referrals and poor knowledge of the site).</td>
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</table>
Table 5: Model of care 4: Primary health care model

**Description of the occupational medical service model of care and likely qualifications of OPs**

- OHS is provided through an individual or group GP practice.
- The key differentiating factor in this model is that it can provide access to services in geographically remote areas.
- A GP or a GP group-service provides OHS to one or more local companies.
- The GP practice is not solely an OHS provider; GP is their primary role.
- Clients attend the premises of the GP practice.
- OP is likely to be LFOM or exceptionally MFOM.
- SpRs cannot work in this model.

**Benefits of the model**

a) Can support local companies, and may be a good model for providing access to services for SMEs
b) Can provide access to OHS in geographically remote areas where there is no access to MFOMs or Specialists.

c) Can work in collaboration with specialist services.

**Risks of the model**

a) GP may not be qualified in occupational medicine.
b) If the GP has LFOM, they may not carry out GP-related CPD and may not access occupational medicine CPD.
c) The GP may know the workplace but may not have a deep understanding of the risks associated with the hazards.
d) Specialist services unlikely in this model.
e) Risk of not being able to access CPD in occupational medicine if GP is not a member of the Faculty of Occupational Medicine Professional Competence Scheme.
f) Completion of the LFOM examination only addresses the education part of training, but not the experiential part.

A selection of the models of care offered in countries other than the Republic of Ireland (included in the ILO Encyclopaedia, updated in 2011), are described individually below, including benefits and risks where provided by the ILO. It should be noted that in the majority of these models the service is funded by the state, whereas in Ireland, the service is funded by the employer.
Table 6: Model of care 5: Case management model

**Description of the occupational medical service model of care**

- The *Fit for Work* scheme was introduced in the United Kingdom in circa 2010.
- Based on the premise that offering personalised case-managed and multidisciplinary services to persons in the early stage of illness would provide help address both social concerns, such as financial and housing issues, and clinical needs, and as a consequence would keep people in work.

**Benefits of the model**

a) Service models varied, but all provided clinical and non-clinical support to help workers experiencing a period of ill-health to keep attending work or to resume work after a period of absence.

b) The services were well-liked by clients and stakeholders and appeared to be meeting a genuine need for this type of service.

c) The scheme provided two core functions for employers, employees and GPs.
   i. Free, expert and impartial work-related health advice via website and telephone line.
   ii. Allowed employees on long-term sick leave to be referred to an occupational physician by their GP or employer for creation of a return to work plan.

**Risks of the model**

a) The volume and profile of clients were not in line with expectations.

b) The scheme was discontinued in 2018, due to perceived lack of efficacy by GPs who were required to certify which duties their patients were fit to perform rather than certify their being unfit for work. Most GPs had insufficient knowledge of their patient's workplace to give such advice.

Table 7: Model of care 6: Group or sector inter-enterprise model

**Description of the occupational medical service model of care**

- Used in the Netherlands, Denmark, Sweden and other countries in Europe.
- Sharing of services by (geographic or sector) groups of SMEs.

**Benefits of the model**

a) Multidisciplinary.

b) Very suitable for groups of SMEs too small to have their own service.

**Risks of the model**

a) Distance from company premises to the OM service premises.

b) Cannot provide first aid via OHS.
Table 8: Model of care 7: Primary health care units

**Description of the occupational medical service model of care**
- Organised by municipal or local authorities or by the National Health Service and provide both preventive and primary health care.

**Benefits of the model**
- a) Can reach SMEs, and the informal sector, including agriculture. Usually good country coverage.
- b) This is the model strongly recommended by the WHO.

**Risks of the model**
- a) Unless physicians and nurses have specialist training (e.g. Finland), there may be limited ability to carry out surveillance of the work environment.

Table 9: Model of care 8: Social security model

**Description of the occupational medical service model of care**
- Used in Israel, Mexico, Spain and some African countries.
- Organised by the social security organisation responsible for workers’ compensation for occupational injuries and diseases.

**Benefits of the model**
- a) Curative and rehabilitative services provided but focus is on prevention due to emphasis on controlling costs.

**Risks of the model**
- a) The emphasis can be on controlling costs.

Table 10: Model of care 9: Hospital out-patient clinics

**Description of the occupational medical service model of care**
- A hospital out-patient location is used as a site from which to provide OM services

Table 11: Model of care 10: Middle East model

**Description of the occupational medical service model of care**
- Public and occupational medical services are integrated.
- GP service in-company.
6. Discussion

6.1 Current models of care

The different models of Occupational Medical Service currently available in Ireland were graphically illustrated in figure 4 and described, alongside benefits and risks of each, in tables 2 to 5. The EAG reviewed the potential benefits and risks of all current models and considered that all models are suitable for one or more of the different circumstances described, and that such diversity may be necessary to meet the needs of companies of different sizes, with different hazards and risks, in addition to the geographical pattern of industry locations – mostly concentrated in cities.

6.2 Role of LFOM, MFOM and Specialist Registrars

The EAG agreed that focusing on the quality of the care being delivered, in terms of the qualifications, experience and competencies of OPs and the skill-mix within the OPs providing the service, and where relevant with OHNs and allied health professionals, was the most important factor regardless of the model in use.

Regarding the contribution of allied health professionals, it was noted that the National Doctors’ Training Specialty Review for Occupational Medicine (2014) highlighted that “some of the tasks being done by physicians could be done by nurses, and some of the tasks being done by occupational health nurses could be done by staff nurses or administrators” and skill-mix should also be considered. Complex cases should always be overseen by Specialists and referral to Specialists would be good practice in many cases, however, this option may not be available, or considered, in the GP (primary health care) model.

- The role of physicians, often GPs, with the LFOM qualification is very important, especially in geographically remote areas, where an LFOM may be required to provide a service to one or more companies. However, the LFOM in itself is a knowledge-based qualification, and any physician practising in occupational medicine should gain experience in occupational medicine to be competent. The LFOM is not envisaged as a qualification for independent occupational medicine practice. Moreover, it is essential, and ideally mandatory, that LFOMs maintain competency by engaging in CPD that is specific to occupational medicine. There is also a risk that physicians with LFOM, practising in occupational medicine, may not be Members of the Faculty and may only have access to GP-related, but not occupational medicine-related CPD. In addition, they may not always have access to specialists for complex cases. It should be noted that LFOMs may apply to the Faculty to be a member of any professional competence scheme in the General Medical Register, but it may not be practical to achieve the competency requirements for more than one scheme.
- The MFOM, or equivalent, is a benchmark of excellence and is a requirement in one of the pathways to specialisation (Appendix 3). MFOMs must maintain occupational medicine CPD to enhance their practical experience. MFOMs may access Specialist advice when necessary.
- The second pathway to specialisation as Specialist Registrars (SpRs) provides a cohort of specialists-in training, with a small number graduating annually. SpRs receive a wide range of experience and exposure in different settings during their training, and networking opportunities are optimised.
- The Specialist is the highest level of occupational medical practitioner recognised by the Medical Council of Ireland and is a protected title. A Specialist may be the only physician in an occupational
medical service, one of a team, or the leader of a service. Specialists are in a position where they can supervise trainees, and other less experienced staff.

The competencies of, and the number of members at, each of the different levels of occupational medicine qualification should be considered in future workforce planning as it would allow skill-mix to be considered in order to achieve an optimum service for clients. Skill-mix can be considered, a) within the profession (planning the most suitable skill-mix between levels of qualification among OPs) and b) between professions (OPs and OHNs and other allied health professionals). Recent work has been carried out in the UK comparing OP and OHN competencies, and priorities and opportunities to strengthen collaboration, including common core training within multidisciplinary teams, were identified (Lalloo et al, 2017).

6.3 Development of the specialty

Development of the specialty of occupational medicine is particularly important during the current period of existing and predicted changes to labour market demographics (ageing workforce and people working longer), a growth in the labour market exceeding pre-recession numbers, changes in the diversity of industry (e.g. gig economy), the nature of risks (recent increase in the prevalence of musculo-skeletal disorders and stress) and emerging and as yet unknown risks associated with new ways of working and new technology (Horton et al, 2018).

It is clear that many employers (e.g. SMEs) don’t seek or secure the services of an occupational physician, and some occupations that would benefit from advice don’t have the opportunity to access occupational medicine services (e.g. gig economy, farmers). Many employers would not be familiar with the limitations of the different levels of occupational medicine qualification (section 3.1) and may not understand when specialist advice is needed (e.g. in managing complex cases). Moreover, employers may not realise the diversity and spectrum of occupational medical services that are possible (from full-time in house, to ad hoc advisory services) or understand the risks and benefits of different models of care. Currently employers have no source of advice or guidance in a) deciding on the level of occupational health service they need, or b) selecting an appropriate model for their needs. The work required to achieve this could be addressed by creation of a project officer position to act as a Faculty-Industry liaison and to engage with employers for education and promotion purposes on behalf of the Faculty. This model has proven effective in the National Office for Traffic Medicine in the RCPI.

In keeping with a global trend, there has been an increase in demand in recent years in Ireland for in-company health promoting activity and health and wellbeing services. This is associated with a growing public health focus on the health of the working age population under the Healthy Ireland (workplace framework) which is currently (May 2019) at an advanced stage of development. The potential level of involvement of occupational physicians or occupational health nurses in this development has not yet been established.

Such demographic changes combined with changes in the nature of work has been identified in the UK as a major challenge, with an occupational medical workforce crisis, and a need for employers, those in work and those applying for work to have access to multidisciplinary occupational health services (All Party Parliamentary Group [UK] on Occupational Safety and Health, 2016). This report cites a survey published in 2011 by the Department of Work and Pensions, which found that only 38% of UK employees have access to an occupational health service, and that only 13% of workers can access a physician. No such information is currently available for Ireland. Harrison and Dawson (2016)
predict that the future strategic direction for occupational health in the UK (a move towards health and well-being) will be informed by a needs' analysis and a review of the competence and capacity of the total occupational health workforce.

In Ireland, it has already been established in one of the largest organisations (the Health Service Executive) that the demand for occupational physicians is increasing (Sisson and Carolan, 2017) and there is similar work taking place relating to occupational health nurse resources. It is likely that, overall, the demand for occupational health services and associated professionals will increase across Irish industry. The number of occupational physicians graduating through the different routes to qualification needs to be balanced with the number of anticipated retirements and the Faculty of Occupational Medicine, RCPI, has already commenced workforce planning. Any workforce planning is likely to look at the future role of the occupational physician in the context of the global trends to widen the scope of occupational health identified by Nicholson (2017) and Steel et al (2018), beyond occupational medicine to health and wellbeing.

6.4 Conclusions

The different models of occupational medical service available in Ireland were graphically illustrated in figure 4 and detailed in tables 2 to 5. The EAG considered the benefits and risks of the models and concluded that all of the existing models are suitable in one or more of the different circumstances described, and that such diversity is necessary to meet the different demands of industry, and the geographical nature of the country. Therefore, as such, the EAG would not suggest focusing on any one model of delivery, rather that the focus should be on the quality of occupational medical services being delivered and the competencies and continuing professional development (CPD) of the occupational physician(s) providing the services.

Thus, it was the view of the EAG that notwithstanding the model of care, the most important factor to ensure and maintain high quality occupational medical services is that physicians practicing in occupational medicine must be competent in their practice (i.e. appropriately qualified for the complexity of care they are providing, and CPD compliant). In a larger service, it is anticipated that there will be a skill-mix with physicians at different qualification and experience levels. Although experience is an important factor, at the highest level of training and expertise there are a number of key activities where the specialist is anticipated to play a key role. These include:

- Clinical governance responsibility for occupational health service delivery;
- Direct management or oversight of complex clinical cases and complex occupational and environmental hazards or exposures;
- Education, training and clinical supervision of OH staff, importantly non-specialists working in isolation or remote geographical areas;
- Development and oversight of OH policies;
- Medico-legal and Ill health retirement cases.

While the required competencies of specialists in occupational medicine have been established, as have mandatory annual occupational medicine CPD requirements, this has not been the case for LFOMs. Established competencies and formal CPD processes are an essential component in identifying ongoing training requirements and for clinical governance to continuously improve and maintain high standards of care.
7. Recommendations of the Expert Advisory Group

**Recommendation 1:** Appropriate qualifications and competence of the occupational physician(s) delivering care is the key factor behind a preferred model. The EAG agreed unanimously that qualifications, competence and, where appropriate, skill-mix were the primary factors in the safe and effective delivery of occupational medical services. It is contingent on all occupational physicians to be appropriately qualified and certified as competent in order that all current models of care meet the diverse needs of industry. However, it is the EAG’s recommendation that specialist occupational physician provision of occupational medicine services is the standard that the Faculty should promote and endorse. All current models of care meet the diverse needs of Irish industry therefore no single model of care supersedes the others.

Having recognised the workforce planning demands in the context of development of occupational medicine on a national basis we have also made the following recommendations:

**Recommendation 2:** All levels of physicians practising occupational medicine must engage in the RCPI Faculty of Occupational Medicine Professional Competency Programme and must maintain adequate CPD points specific to the occupational medicine specialty. The established Professional Competency Programme in occupational medicine is available to specialists and MFOMs. However, it was the opinion of the EAG that the system should be extended to any physician practising in occupational medicine, with a requirement for a quota of occupational medicine CPD points commensurate with the proportion of their work undertaken in occupational medicine.

**Recommendation 3:** Given the critical mass of LFOMs delivering OH services in Ireland, a formal competency framework for LFOMs should be established as a priority to identify ongoing training requirements and to ensure high-quality service delivery.

**Recommendation 4:** Once established, the required skillset and competencies of specialists, specialist registrars and non-specialists should be considered in future workforce planning to ensure the most appropriate use of resources (given the current shortfall) for service delivery.

**Recommendation 5:** Occupational medical services should be specialist-led. Where this is not possible/practicable, non-specialist providers must have confirmed access to an accredited specialist for advice as required, especially in the more complicated cases. There should be a clear process on how and when to access that specialist advice.

**Recommendation 6:** The Faculty should actively engage with key stakeholders (primarily employers, but also trades’ unions and employer representative bodies (e.g. Ibec, ISME, SFA) in order to: a) promote the value of occupational health and occupational medicine, b) keep abreast of changes in the world of work that may affect the current and future models of care; and c) educate employers to make informed decisions on the most appropriate model of care for their needs.

**Recommendation 7:** The EAG proposes creation of a project officer role. The project officer would act as a Faculty-Industry liaison and would manage employer engagement on behalf of the Faculty, using a range of tools including web-site development and stakeholder events. Such a position currently exists in the National Office of Traffic Medicine in RCPI and has proved a major success in its advocacy role.

**Recommendation 8:** In order to secure the development of occupational medicine in Ireland, the Faculty should engage with the Government to establish a statutory requirement for occupational health service provision in Ireland.
Bibliography


### Appendix 1: Glossary of acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term</th>
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<tbody>
<tr>
<td>AHP</td>
<td>Allied Health Professionals</td>
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<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
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<tr>
<td>BST</td>
<td>Basic Specialist Training</td>
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<tr>
<td>CCST</td>
<td>Certificate of Completion of Specialist Training</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
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<tr>
<td>CSO</td>
<td>Central Statistics Office</td>
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<tr>
<td>EAG</td>
<td>Expert Advisory Group</td>
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<tr>
<td>EEA</td>
<td>European Economic Area</td>
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<tr>
<td>EETE</td>
<td>Evaluation of Existing Training and Experience</td>
</tr>
<tr>
<td>ER</td>
<td>Employer</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>FFOM</td>
<td>Fellow of the Faculty of Occupational Medicine</td>
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<tr>
<td>FFOM (Hon)</td>
<td>Fellows of the Faculty of Occupational Medicine (Honorary)</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HSA</td>
<td>Health and Safety Authority</td>
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<tr>
<td>HSE</td>
<td>Health Service Executive</td>
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<tr>
<td>HST</td>
<td>Higher Specialist Training</td>
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<tr>
<td>ICGP</td>
<td>Irish College of General Practitioners</td>
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<tr>
<td>ICHMT</td>
<td>Irish Committee of Higher Medical Training</td>
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<tr>
<td>ILO</td>
<td>International Labour Office</td>
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<tr>
<td>ISME</td>
<td>Irish SME Association</td>
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<tr>
<td>LFOM</td>
<td>Licentiate of the Faculty of Occupational Medicine</td>
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<tr>
<td>MB</td>
<td>Bachelor of Medicine</td>
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<tr>
<td>MFOM</td>
<td>Membership of the Faculty of Occupational Medicine</td>
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<tr>
<td>MOC</td>
<td>Model of Care</td>
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<tr>
<td>MRCGP</td>
<td>Membership of Royal College of General Practitioners (UK)</td>
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<td>MICGP</td>
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<tr>
<td>MRCP</td>
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<td>Acronym</td>
<td>Term</td>
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<tr>
<td>NDTP</td>
<td>National Doctors Training and Planning</td>
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<tr>
<td>NHS</td>
<td>National Health Service (UK)</td>
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<tr>
<td>OCPE</td>
<td>Out of Clinical Programme Experience</td>
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<td>OHN</td>
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<tr>
<td>RCSI</td>
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<tr>
<td>SDR</td>
<td>Self-Directed Route</td>
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<td>SFA</td>
<td>Small Firms Association</td>
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<td>SHO</td>
<td>Senior House Officer</td>
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<tr>
<td>SME</td>
<td>Small or Medium Enterprise</td>
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<td>SpR</td>
<td>Specialist Registrar</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Appendix 2: Qualifications and awards in the Faculty of Occupational Medicine, RCPI

The following summarises the information about qualifications on the FOM website (www.rcpi.ie/faculties/faculty-of-occupational-medicine/)

1. LFOM (Qualification)
   - Licentiate is the Faculty of Occupational Medicine of the Royal College of Physicians of Ireland (LFOM) is an internationally recognised qualification, valued by healthcare employers worldwide.
   - LFOM is achieved through examination and is accredited by the Medical Council of Ireland as a key knowledge-based assessment for Occupational Medicine in Ireland.
   - The qualification of LFOM shows potential employers that the holder can apply the principles of Occupational Medicine in a clinical setting and critically reflect on medical conditions in an occupational context.

2. MFOM (Qualification)
   - Membership of the Faculty of Occupational Medicine of the Royal College of Physicians of Ireland (MFOM) is an internationally recognised benchmark of excellence, valued by healthcare employers worldwide.
   - MFOM is achieved through examination and is accredited by the Medical Council of Ireland as a leading knowledge-based assessment for Occupational Medicine in Ireland.
   - MFOM is an essential component of Higher Specialist Training in Occupational Medicine, which is the final stage of training before independent practice. It proves an advanced knowledge of Occupational Medicine.
   - The qualification of MFOM shows potential employers that the holder has advanced knowledge of Occupational Medicine - can get to the bottom of complex cases, give decisive medical advice and explain this medical advice to both the employee and the employer.

3. FFOM (Award)
   - The Fellowship of the Faculty is an award that is given by the Faculty of Occupational Medicine to a distinguished person. The Standing Orders of the Faculty of Occupational Medicine (2015) specify four categories of gaining the fellowship award.

   3.1 Foundation Fellows
   - Elected to the Faculty prior to 01 October 1978

   3.2 Honorary Fellows
   - Persons recommended for Honorary Fellowship shall be outstanding in Occupational Medicine or a related science or shall have given significant service to that science or to the Faculty and do not need to be medically qualified.

   3.3 Fellows Ad Eundum
   - Persons holding Fellowship of other Occupational Medicine Faculties / Colleges or equivalent qualifications recognised by the Faculty or the College or who are in bona fide practice of their specialty.
3.4 Fellows by election

No person may be elected to Fellowship of the Faculty unless he/she:

- has been a Member of the Faculty for at least four years;
- are in good standing with respect to their annual subscription;
- have distinguished themselves in the practice of Occupational Medicine;
- can provide evidence of participating in a CME/CPD programme;
- have contributed to the Faculty.
Appendix 3: Specialist accreditation in occupational medicine

The qualifications required by the RCPI to permit a medical doctor to practise as a specialist in occupational medicine are described on the RCPI website. There are two entry pathways to specialisation in the FOM. Both require candidates to hold an undergraduate medical degree and to have completed an internship recognised by the Irish Medical Council.

Pathway 1: Higher Specialist Training with the RCPI

Figure 5: Pathway for entry to Higher Specialist Training highlighting pathways to Occupational Medicine Higher Specialist Training

Graduate with basic Medical degree

Irish Medical School

1-year internship

Basic Specialist Training (Surgery) (2 years)

Obtain Basic Specialist Training Certificate

Complete MRCSI examinations

Entry to 4-year Occupational Medicine Higher Specialist Training (HST)

Certificate of Completion of Specialist Training (CCST)

Non-Irish Medical School

X year(s) recognised internship

Basic Specialist Training (Medicine)

Obtain Basic Specialist Training Certificate (Medicine)

Complete MRCPI or equivalent examination

Contract SHO jobs (X years)

GP Training (4 years)

Obtain MICGP examination

Basic Specialist Training (Medicine)

Obtain Basic Specialist Training Certificate (Medicine)

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No Basic Specialist Training Certificate

May complete MRCPI or equivalent examination
The Higher Specialist Training in Occupational Medicine Handbook (2018) states that applicants must meet the criteria in Figure 2.

Figure 6: Criteria for entry to Higher Specialist Training in Occupational Medicine

"Either:

- completed a minimum of two years Basic Specialist Training (BST)*, which will include passing the MRCPI for intake from July 2013), in approved posts recognised by the RCPI. Other equivalent clinical post may be accepted subject to approval by the Faculty of Occupational Medicine RCPI (FOM) and Irish Committee of Higher Medical Training (ICHMT).

OR

- completed an approved Irish College of General Practitioner (ICGP) training course (or equivalent) in General Practice. Candidates who have completed BST in other specialities may also be considered.

AND

- MRCPI, MRCP UK or MICGP (or equivalent) is desirable, but not an essential requirement for entry to higher specialist training in the speciality. Applicants without MRCP/MICGP/MRCGP who compete for HST posts must provide evidence of appropriate knowledge, training and experience equivalent to MRCP/ MICGP/MRCGP standard.

Entry on the training programme is at year 1. Deferrals are not allowed on entry to Higher Specialist Training."

In Higher Specialist Training (HST) in occupational medicine the trainee is referred to as a Specialist Registrar (SpR). The duration of HST is four years full-time equivalent. According to the handbook, the four-year training programme should contain:

- A minimum of 18 months in an industrial sector (i.e. heavy and light industry, engineering, electronics, manufacturing, pharmaceutical, chemical, transport etc.).
- A minimum of 1 year in the service sector (i.e. healthcare, financial services, insurance, office environment etc) to include at least clinics in the health service.

Up to one year of research, or time spent in academic training, may be a constituent part of the programme, provided that the content is relevant to occupational medicine. Each post within the programme to which the trainee is appointed will have a named supervisor / trainer. HST programmes are under the supervision of the National Specialty Director for Occupational Medicine. In addition:

- “The occupational health units which provide training posts must be recognised by the Faculty of Occupational Medicine and the Committee of Higher Medical Training as suitable for HST.
- Trainees will be required to have work experience in units that offer a wide range of exposure to the various elements of the training curriculum for occupational medicine.
- Time spent in overseas training posts in Occupational Medicine outside Ireland may be recognised provided that such posts and the content of the training and level of supervision they provide meets the requirements for HST as required by the Faculty of Occupational Medicine and ICHMT and prospective approval has been sought to undertake such training.
- The Diploma of Membership of the Faculty of Occupational Medicine (MFOM) is an essential requirement for trainees enabling them to demonstrate that they have a broad understanding of occupational medical issues and their application in practice.
- Trainees must spend the first two years of training in programme before undertaking any period of research or Out of Clinical Programme Experience (OCPE) or equivalent.
At the end of the 4-year HST programme, if the trainee meets the criteria set out in the curriculum, a Certificate of Completion of Specialist Training (CCST) is awarded, which will allow the doctor to register as a specialist with the Irish Medical Council.

**Pathway 2: Specialist registration via Evaluation of Existing Training and Experience (EETE) (hereafter referred to as Self-Directed Route (SDR))**

According to the Irish Medical Council (arrangements for applying for Specialist Registration via Evaluation of Existing Training and Experience) “applicants who are not eligible for automatic recognition into the specialist division may have their existing training and experience evaluated by comparing the training and experience they received, to the training attained by a graduate of the relevant training programme in Ireland”.

Figure 7: Alternative pathways for specialisation in Occupational Medicine

- **Irish Medical Graduate**
- **EU/EEA Medical Graduate**
- **Non-EU/EEA Medical Graduate**

- MFOM or equivalent
  - In addition to:
    - Years of experience; and
    - Variety of Occupational Medicine experience; and
    - Completed required courses

- Has obtained a specialist registration in Occupational Medicine from a recognised regulatory body