OFFICIAL REPORT
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Social Justice and Social Security Committee

Thursday 16 November 2023

Session 6

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Thursday 16 November 2023

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SOCIAL JUSTICE AND SOCIAL SECURITY COMMITTEE
29th Meeting 2023, Session 6

CONVENER

*Collette Stevenson (East Kilbride) (SNP)

DEPUTY CONVENER

*Bob Doris (Glasgow Maryhill and Springburn) (SNP)

COMMITTEE MEMBERS

*Jeremy Balfour (Lothian) (Con)
*Katy Clark (West Scotland) (Lab)
*John Mason (Glasgow Shettleston) (SNP)
*Roz McCall (Mid Scotland and Fife) (Con)
*Marie McNair (Clydebank and Milngavie) (SNP)
*Paul O'Kane (West Scotland) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Lucy Kenyon (Association of Occupational Health and Wellbeing Professionals)
Professor Ewan Macdonald (Society of Occupational Medicine)

CLERK TO THE COMMITTEE

Claire Menzies

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Social Justice and Social Security Committee

Thursday 16 November 2023

[The Convener opened the meeting at 09:02]

Decision on Taking Business in Private

The Convener (Collette Stevenson): Good morning, and welcome to the 29th meeting in 2023 of the Social Justice and Social Security Committee. We have received no apologies for today's meeting.

Our first item of business is a decision on whether to take agenda items 3, 4 and 5 in private. Are we agreed to do so?

Members *indicated agreement.*

Scottish Employment Injuries Advisory Council Bill: Stage 1

09:03

The Convener: Our next agenda item is the second evidence session on the Scottish Employment Injuries Advisory Council Bill—the SEIAC bill for short. It is a member's bill that was introduced by Mark Griffin MSP on 8 June 2023. It is currently at stage 1. The bill would create a Scottish employment injuries advisory council to advise Scottish ministers on employment injuries assistance. It is proposed that the council have three functions: to report on draft regulations for employment injuries assistance, replacing the Scottish Commission on Social Security's role; to report to the Parliament and ministers on any matter that is relevant to employment injuries assistance; and to carry out, commission or support research into any matter that is relevant to employment injuries assistance.

I welcome our panel for today's evidence session on the bill. Lucy Kenyon is a non-executive director and past president of the Association of Occupational Health and Wellbeing Professionals, and she joins us online. Professor Ewan Macdonald is chair of the academic forum for work and health, which is hosted by the Society of Occupational Medicine, and he joins us in the room. I thank you both very much for accepting our invitation.

Before we start, there are a few points to mention about the meeting's format. Please wait until I say your name or the member who is asking the question says your name before speaking. Do not feel that you both have to answer every question. If you have nothing new to add to what has been said, that is okay. Please allow our broadcasting colleagues a few seconds to turn your microphone on before you start to speak. Lucy, as you are joining us online, you can indicate with an R in the chat box on Zoom if you wish to come in on any of the questions. I ask everyone to keep their questions and answers as concise as possible.

I will now invite members to ask questions in turn.

Jeremy Balfour (Lothian) (Con): Good morning to the panel and thank you for coming along today.

I have a question for both of you, and I will start with Professor Macdonald, if that is okay. What involvement, if any, do you have with the Industrial Injuries Advisory Council on matters that are related to industrial injuries disablement benefit?

Professor Ewan Macdonald (Society of Occupational Medicine): I have no formal involvement.

Jeremy Balfour: What about informal involvement?

Professor Macdonald: I know most of the people who are on it, and it is quite relevant to the job that I do. I was asked to consider joining it but I did not, because it has no infrastructure of support for research—they all do their research in their own time in the evenings—and it is my understanding that they do not even have an information technology base for what they do.

Jeremy Balfour: That is helpful. Lucy, do you want to answer that question as well?

Lucy Kenyon (Association of Occupational Health and Wellbeing Professionals): Yes. I do not have as much detailed knowledge as Ewan Macdonald in relation to the scientific interest, but I have had conversations with the University of Manchester team and the University of Birmingham about investigating industrial diseases, which is my area of expertise, as well as looking at the reporting structures and how we can make sure that diseases that could be occupationally related are reported through the health and occupation research network—THOR—and EPIDERM. I know that an awful lot of work is being done, but there does not yet seem to be a formal structure through which we can encourage reporting, including early symptom reporting, to prevent occupational disease, which is really important.

Jeremy Balfour: Thank you very much. That is helpful.

Roz McCall (Mid Scotland and Fife) (Con): Welcome, both. I will ask both of you this question, and, on the basis of the answers that you have just given, your answers will be very informative. I will start with you, Lucy, if that is all right.

Given the answer that you have just given us, and taking into consideration that there is no proactive way of looking at it, the Industrial Injuries Advisory Council recommends which conditions and occupations are included in the prescribed list for industrial injuries, which we have already alluded to. In your experience, does that have any wider influence on the extent to which employees are supported or on any preventative measures that are put in place for the workforce?

Lucy Kenyon: I have an independent practice and I look after small and medium-sized employers. In my very small practice, I have referred two people through the group of occupational respiratory disease specialists—GORDS—service. As a result of not having that kind of awareness of occupational diseases, those people came to me at quite a late stage, so we were then playing catch-up with the diagnostic process.

I would like to formally respond to this question in writing after the meeting so that I can give some specific information that is backed up by the evidence base. I have a concern around the ability to provide protection from, and to prevent and identify, occupational disease. We also have a serious lack of occupational physicians, which, obviously, impacts on the opportunity to diagnose people with diseases. From my correspondence with general practitioners and respiratory consultants, in particular, they do not appear to have the necessary awareness in relation to occupational disease being a possible cause of the symptoms that their patients are presenting with, although we have the GORDS network.

Roz McCall: Thank you. It would be fantastic if you could send in more information in relation to relevant evidence. I do not think that we would have any problem if you wanted to do that. Thank you very much.

Professor Macdonald, I know that you said that you do not have any formal arrangement with the IIAC, but can you give me an answer from your experience?

Professor Macdonald: Well, I am a clinician and an occupational physician—a professor of occupational medicine—so I still see workers. I do research on workers and their health. I agree entirely with what Lucy Kenyon said about the lack of provision. I could talk for hours on this, but I do not want to talk too long, so you can shut me up.

I chair the Scottish occupational health action group. To put things in perspective, the United Kingdom generally—and Scotland as well—probably has the lowest coverage of occupational health services for the workforce of any developed nation. For instance, Finland, which is the same size as us, has around 90 per cent coverage. All workers have access to occupational health and the kind of environmental services that Lucy represents. Therefore, there is a big lack of occupational health provision anyway, and then we have another gap: medical students get almost no training on health at work. Also, the national health service is very burdened, and they are all thinking about disease rather than health at work. As for referring people, I will not infrequently see people with hand-arm vibration syndrome, carpal tunnel syndrome, asbestosis or other dust-related disease of the lungs—the whole variety of occupational conditions—and we will advise them to apply. There is that fundamental underlying issue.

Earlier this month, the Scottish occupational health action group sent the First Minister a

proposal for a Scottish occupational health service provision. We did that because, informally, in London, there have been discussions with the Department for Work and Pensions and the Treasury about growing occupational health. There is an awareness of it, particularly with lots of people falling out of work and a large non-participating and ageing population who have work potential. They were talking informally about £300 million. That is hearsay, of course. I do not know whether the autumn statement has come out yet, but there may be something in it. If so, there may be resources here to correct, at last, the wrong of the lack of coverage and support for working people. Anticipating that, we sent a paper to the First Minister. It is now being discussed by the various civil servants so that there is a plan in place to do something. However, although you can have plans in place to do anything, it is hard to make them happen. I have been trying to do that for most of my life.

There is a lack of coverage, and occupational health practitioners see it. Probably around 35 to 40 per cent of the workforce may have some access to occupational health, which is very much a multidisciplinary thing. That might include safety professionals, occupational hygiene professionals and occupational health nurses, but there is certainly a lack of all of those. Part of the problem is that, when the NHS was established, occupational health was not included because industrial health was not really well established then. Occupational health is not provided as part of the NHS and never has been. It is provided by the NHS to its own staff. It is provided to public servants like you and to the public sector. Big employers will contract for it to private occupational health companies. The inverse care law applies here: the people who get occupational health are probably the people who least need it, although I am not suggesting that you do not need occupational health.

Roz McCall: That was a very interesting, full and informed answer. Certainly, both answers very much focused on support.

What are your opinions on preventative measures that are being used in the workplace? We will hear from you the other way around this time: Professor Macdonald and then Lucy Kenyon. Could you give me a brief answer, please? I will get shot in a minute.

09:15

Professor Macdonald: The Health and Safety Executive is aware, of course, of work-related ill health. The basic health and safety law, with which you are familiar, on the assessment and control of risk is, in essence, the control measure that applies to all employed people. That is where some kind of control measure comes in.

To touch on something that Lucy Kenyon said, the whole system is reactive. We wait until you have disease. You then present to the DWP or whatever committee it might be, and it makes a decision on whether you get benefits. We need a much more proactive system in Scotland, with an observatory looking at what is happening and at any changing trends. I can speak more about that, as well.

Roz McCall: Very briefly, Lucy, would you speak on the preventative side?

Lucy Kenyon: I have just been reminded that messages that I put in the chat are not on the record, so I will say that 55 per cent of UK workers do not have access to occupational health services. I picked up a late-stage hand-arm vibration case that had not been picked up by any of the person's previous employers. The NHS has one occupational disease service—GORDS—which is run by the Health and Safety Laboratory across five universities.

It is really important to know that, in 2021-22, 1.8 million workers were reported to be suffering from work-related ill health but only 17,000 made applications for industrial injuries disablement benefits. In a nutshell, we know that we are not getting sufficient applications to inform us and push the issue further up the agenda, because the financial burden is not there.

There is an opportunity for Scotland to be a herald and lead the way. There is a track record in Scotland of good universities when it comes to occupational health: the University of the West of Scotland, the University of Aberdeen, the University of Edinburgh and Robert Gordon University. There is massive potential to get this right, plug the gap and dovetail with what the rest of the UK is doing with the Industrial Injuries Advisory Council. There is a massive opportunity here.

Roz McCall: Thank you.

The Convener: That was helpful and really interesting.

Professor Macdonald: Could I just make a comment? Lucy unfortunately missed out the University of Glasgow, which has the only clinical occupational health academic group in Scotland.

Lucy Kenyon: Sorry, Ewan—it is good that you are here.

Professor Macdonald: And the only clinical group in the UK.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): I think that Professor Macdonald had Anton Muscatelli texting to prompt

him to put that on the record. That was helpful for completeness.

Good morning to both witnesses. The function of the Scottish employment injuries advisory council, as proposed, is to

"investigate and review emerging employment hazards that result in disease or injury".

That might duplicate activities of other organisations. Professor Macdonald helpfully mentioned the Health and Safety Executive, and it is imperative that it give evidence to the committee, given its crucial role. This should surely be its bread and butter, and, imperfect as occupational health might be in Scotland and across the UK, the data that you get should be used to inform the work of the HSE. Irrespective of whether it is the IIAC or the SEIAC—we love acronyms in this place—whatever the advisory board or council is, the information that occupational health gets from workplaces is vital, and it has to drive action.

I am conscious that employment law is reserved and that the HSE has a direct remit here. Is there the possibility of duplication when the SEIAC is in place? Can you say anything about your role and how we should use the vital data that you want to be collected to drive the change that you want to see? Perhaps we should take Lucy Kenyon first.

Lucy Kenyon: In a nutshell, the Industrial Injuries Advisory Council reports by itself. Research is done, as Ewan Macdonald has said, in people's spare time, but the reports are there and the data is robust. However, that does not seem to translate into a review. Last night, I did a last-minute review of what is on the IIAC list of prescribed diseases, and it does not reflect the reports that have been raised since 2017.

Duplication is unlikely because there is a needs gap in converting the evidence, particularly in relation to pilots and air crew, for example. The resource does not appear to be there to ask what that means in the sense of how we convert that to prescribed diseases and to have a rationale as to whether we do or do not.

Bob Doris: Before I move on to Professor Macdonald, I have a short follow-up question to Lucy Kenyon's reply.

I have no reason to doubt anything that you have said, Lucy, but, if the day job of the HSE is to look at emerging evidence and patterns in work-related deaths, injuries and ill health, are we legislating to fix the inadequacies of the HSE, or are we legislating to complement an existing mechanism? I will ask Lucy to respond to that, and then, Professor Macdonald, you can answer both of those questions. That would be really helpful.

Professor Macdonald: Okay. You will have to remind me of which question.

Bob Doris: That is fine; of course. People often say that.

Lucy Kenyon: I think that the bill will be to complement what exists. Ewan Macdonald alluded to what I call silo working. The Health and Safety Executive is doing great work. It publishes really good and robust guidance to do its best to help employers to protect people, and employers seem to respond to the research reports. However, that does not then translate into what happens for people who become disabled as a result of a disease. Some of that is probably because diseases fluctuate and can be slow in their onset and duration, whereas, with an industrial injury, there is an immediate injury and the extent of that injury can be assessed. With an injury, there is an algorithm to work out what level of disability is involved, and, to some degree, we can predict and make a prognosis on rehabilitation and recovery. That is so much more difficult with disease. What has probably happened is that it has ticked the "Too difficult" box. I will hand over to Ewan.

Bob Doris: That is really helpful.

Professor Macdonald, to remind you, the question is about whether the bill might create duplication and whether the Health and Safety Executive has a primary role in properly delivering on work-related deaths, injuries and ill health that might also be covered by the bill.

Professor Macdonald: There is inevitably some duplication, but there is not much. The culture of what Lucy and I do is to pick up things very early and prevent. When it is very early, it is generally not a breach of law issue. If an employer who has access to an occupational health service thinks that somebody has a work-related disease and has been told, "You should think of reporting this under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013", that is the only way that the HSE will hear about something such as that, and it is estimated that only about 40 per cent of such cases are reported to the HSE. We need a system that does not rely just on the HSE. People do not always want to go to a policeman, and employers do not necessarily want to attract the attention of the HSE, which comes in like a policeman.

The HSE has a valuable role, but we need a system that perhaps allows us to raise awareness and pick up issues early. GPs and hospital consultants will never have heard of any of the UK legislation. We need to move much more along the prevention route. The aim of the system is prevention. It is not about, "Let them get damaged and get money." That is a failure of the whole system. We need to move to prevention, and that

can be done. It means research and having a mechanism to identify what is going on, so that we are not waiting until people are dying of mesothelioma; we are picking up on the exposures that are high risk.

We need an entirely different approach. It is not about beating up the HSE. It does its job well, but employers are not particularly keen on voluntarily contacting the HSE to tell it about their possible problems.

Bob Doris: That is very helpful.

The Convener: Lucy Kenyon wants to come back in.

Lucy Kenyon: I want to follow up on that, because it brings me back to my first point, which is about occupational disease reporting systems. They have not disappeared, but, back in about 2017, I was talking with the University of Manchester about how we could use non-medical multidisciplinary teams that see people at the early stages of symptoms. We are the ones who refer on to the Ewan Macdonalds of this world. We could provide early reporting of symptoms, so that we have a symptom-reporting system as well as a disease-reporting one. That is not being done anywhere else and would not be duplicating what is being done already. It very much comes from the proactive side of things.

As groups, because we all talk and our professional groups collaborate, we can look at that information and support emerging diseases. We now have good experience of working with emerging evidence, because we did that very effectively during the Covid-19 pandemic, in the turnaround of our health risk assessments for Covid-19 and identifying vulnerable people who were at high risk of exposure. Therefore, we have some really good learnings.

There is an opportunity to fund prevention, as Ewan has said, through payouts for disease to compensate people and ensure that they do not fall into housing and food poverty as a result of a long-term disease that has been caused by work. That is where there is a gap, and there will be no duplication, because that is not being done at the moment.

John Mason (Glasgow Shettleston) (SNP): Professor Macdonald, you have twice mentioned research. I think that you were a little bit critical of the budget that the IIAC has and the fact that its members have to do so much at night and that kind of thing. As I understand it, the bill proposes £30,000 a year as a research budget. I am new to this committee and the subject, but that strikes me as a very small amount. Do you have any thoughts on that?

Professor Macdonald: You can do very little research for £30,000 a year, because research involves employing staff, surveying, methodology, statistical analysis and all that sort of thing. It is grossly inadequate. The fact that there is some money is positive; at least someone is thinking about it.

I go back to one of my earlier comments about a proposal for Scotland's occupational health provision. The fact has been alluded to that we all operate and link quite well. The academic groups all speak to one another. However, because of the low number of experts, we need to harness them to work together. One of the proposals in the paper that has gone to the First Minister is to create a Scottish centre for health and work. It would be a semi-virtual one, hub and spoke, to link up what people do, so that we get a much more collaborative approach to harnessing the resources that we have. Part of the role of that Scottish centre would be to proactively do research on work related to ill health.

John Mason: Did you have a budget for the proposed centre?

Professor Macdonald: We do not have a budget, but we hear the gossip at Westminster, which I have been part of. [*Laughter*.] Chris Whitty, for example, is really on to this. No other chief medical officer has really been proactive about it. I represent Scotland on the Bevan Commission for Wales, so I am not being critical of any individual. They are talking about £300 million for this whole area.

09:30

John Mason: That is at UK level, then.

Professor Macdonald: That is at UK level, so it will be 10 per cent of that. It could be £30 million—I am an irrational optimist. That £30 million would not be for research; it would be for provision of services. Within that, however, there needs to be a place that does clinically focused research, using the existing resources with an approach to do early monitoring.

John Mason: It strikes me that we are looking at a few moving targets at the same time, so let us focus. Assuming that your centre does not go ahead—

Professor Macdonald: It is not my centre; it is your centre. You will create it. [*Laughter*.]

John Mason: —and assuming that research should be linked to the bill, if £30,000 is not enough, can you put a figure on what kind of budget it should be?

Professor Macdonald: To establish a centre where people are focused on looking at and

monitoring all the sources of data, collating all the data sets and doing analysis, you are probably looking at having two competent postdoctoral researchers, which would cost £100,000 a year.

John Mason: Each?

Professor Macdonald: No. With overheads of around £50,000, I would put the cost at around £150,000 a year.

John Mason: Right, okay. Thanks very much. That is helpful. Ms Kenyon, do you want to comment on any of that?

Lucy Kenyon: For an actual figure, it would probably be worth benchmarking with the University of Manchester's budget for occupational disease research.

John Mason: Can you give us a figure for that?

Lucy Kenyon: I do not know exactly what that is. I was just looking to see whether I have it in my notes, but I do not. I can go away and do some extra research on that, but I am sure that Ewan Macdonald is closer to that than I am.

Professor Macdonald: Martie Van Tongeren is the professor there who runs it. I was with him last week, so I can ask him.

John Mason: It would be helpful if one of you could give us that figure. That is great.

The Convener: Thanks very much. I now invite Marie McNair, who joins us online, to ask a question.

Marie McNair (Clydebank and Milngavie) (SNP): Good morning, panel. I want to go back to the issue of duplication. Professor Macdonald, your written submission states:

"A repeat of the IIAC in Scotland would duplicate resources and experts."

What is your view of SEIAC undertaking an investigation of the same issues as the IIAC? I know that you have covered a bit of that already, but it would be great if you could expand on what you have said.

Professor Macdonald: Are you asking about duplication? What I am talking about will be not duplication but expansion. If we are to do something different, we have to get better data; we have to pick things up earlier, which brings us back to what we were talking about previously; and we need early detection systems. We also need to be more agile.

Lucy Kenyon mentioned Covid. I am drifting a bit here, but it is still relevant. The IIAC has been reviewing Covid to see whether there was any occupational causation. In Glasgow, we published a study on Biobank that showed that, for causation to be regarded as occupational, there had to be a twofold increased risk. That is because a lot of occupational conditions occur naturally anyway. You have to know whether people have been doing the job, whether they have had exposure and whether they have, potentially, got the disease. The IIAC will give benefit only if it is absolutely certain that there is more than a two-times increased risk. That is its criterion.

With Covid, for example, our paper showed that some healthcare workers, particularly medical support workers, had a sevenfold increased risk in the early days. However, the IIAC is still equivocating on that. That is an extreme example involving one small group, but the fact is that there was a general increase in risk in quite a lot of occupations. The IIAC has still not made a decision about those for whom Covid might be compensated.

I might have drifted off your point, but we need that kind of proactive analysis to be going on all the time. The research that I talked about was funded by a research council—the National Institute for Health and Care Research or similar—and it would have cost at least £200,000.

Marie McNair: My question was specifically on your views of the value of SEIAC undertaking an investigation on the same issues as the IIAC.

Professor Macdonald: The law has been passed that you are going to have a SEIAC. Is that not right?

Marie McNair: No.

The Convener: No, not yet. That is why we are taking evidence.

Professor Macdonald: Oh, really? I thought that you had decided that.

In that case, there will be duplication. The IIAC has a very good track record and some very good scientists, at least one or two of whom are based in Scotland. There will be duplication of the research, which is wasteful, because the same diseases are occurring internationally. Why do we have to do everything ourselves? If we are to move to a slightly more proactive approach that links to prevention—which we have not really talked about—we need to have the research function to pick up on work-related ill health much earlier, when it is at its most subtle. The Office for National Statistics picks up on some of that already through regular workplace surveys. However, although that gives data, not much happens with it.

Marie McNair: Thank you for that.

The British Occupational and Hygiene Society has said in its written evidence:

"Scotland has a differing workplace demographic and industrial heritage from the rest of the countries in the UK."

Can you give us some views on the extent of Scotland-specific issues in the types and instances of industrial disease? I will go to Lucy Kenyon for that one. I am sorry, Lucy—I think that you also wanted to come in on the last question.

Lucy Kenyon: I will respond to it quickly.

HSE has a list of stakeholders on its website, of which the IIAC is not one, but if SEIAC were to become a formal stakeholder of HSE, that would be a good way of sharing information and would reduce any potential overlap or duplication of activity.

As for the specific Scottish demographic that you asked about, the NHS data says:

> "Musculoskeletal … disorders—such as muscle, back and joint problems—are the single biggest cause of work absence in Scotland."

It also says that over 1 million people visit their GP every year with a musculoskeletal disorder. Again, I have not been able to drill down into the data to see how many of those million people have work-related musculoskeletal disorders.

In the original paper, there was reference to the fact that the IIAC still appears to be very focused on male-dominated industries and male-dominated diseases. Ewan Macdonald mentioned carpal tunnel syndrome, which, of course, predominantly affects women; we also refer to golfer's elbow or tennis elbow, which are some of the lay terms for upper limb disorders. Women predominantly work in the processing industries, and although such injuries are mentioned in the IIAC document, it talks specifically about heavy industry, with a passing reference to processing. I have worked in food processing and with a number of those industries and I have not yet come across a case of upper limb disorders, as I call them, being referred for IIDB. You also have the massive oil and gas industry, with people working offshore, underwater and at sea.

I have not done the background research, but there is a very specific need to look at male-dominated diseases that probably affect women. We just do not have the data or that information, because it is not being captured. A lot of people go to their GP with such conditions rather than see an occupational health nurse and then a physician for a diagnosis. Diagnostics happen through the GP network, and, although the diploma in occupational medicine that the Faculty of Occupational Medicine runs is absolutely brilliant, I would say, again, that not enough GPs have even the basic Faculty of Occupational Medicine training to be able to identify, or at least eliminate, an occupational cause of somebody's disease.

The Convener: Thanks very much. Marie McNair, do you want to come back in?

Marie McNair: I just wanted to ask Professor Macdonald to comment briefly on the extent of the Scotland-specific issues. If he does not want to come in, though, that is okay.

Professor Macdonald: It is true that Scotland has a strong legacy of coal mining, steel production and other types of industrial revolution industries. Sadly, they are all in decline, and we now have more high-tech companies than we do the former. We do still have a legacy, however; we still have people getting mesothelioma from asbestos exposure 20 or 30 years ago in the shipyards on the Clyde. It is actually an epidemic. There is not much that we can do about it, either, although treatment is getting slightly better. The sort of issues that you have asked about, though, are passing, and Scotland is probably becoming more like the rest of the UK, because of the decline of our heavy industry.

On Lucy Kenyon's point, I will just say that musculoskeletal conditions and mental health are the two biggest areas of ill health that cause sickness absence across the UK. The problem is that most musculoskeletal conditions are degenerative, and that is why good clinicians, who know what they are talking about, are needed.

Some of you will end up with arthritis—not quite yet but eventually. You will all get arthritis eventually. I do not know whether it will be called "occupational", just because you got it from sitting too much in your Parliament office. It is about discriminating between whether it is occupational or not. At that point, you have to look at the epidemiology. Does the disease in question occur much more often in a certain occupational group? That needs to be researched. That is not an HSE function; it just measures the cases coming into the police station, if you like—it is not out there looking at what is happening in the general population. You need both systems.

Marie McNair: It is also concerning that mesothelioma is linked to the built environment. In my area of Clydebank, folk as young as 30 have been diagnosed with it. May I have your views on that?

Professor Macdonald: There has been a bit of a mesothelioma epidemic, but it is starting to reduce. There are two factors involved in a young person getting it. First of all, anyone who walks around the streets of Glasgow will get some asbestos bodies in their lungs, simply because asbestos contamination is in the general urban environment. That is the first thing to say. One paper, which was done 20-odd years ago, has suggested that 6 per cent of all lung cancers are in fact the result of neighbourhood asbestos exposure. Therefore, there is an environmental factor, as we are all exposed to low levels of environmental contamination in day-to-day life.

In Clydebank, there is still some of that asbestos contamination around. It is very unusual for a 30-year-old person to get mesothelioma, because the gestation period, if you like, of the tumour is usually 20 to 40 years. That is what we are seeing. People might have been exposed 40 years ago. One of the problems about the long time that it takes for such things to develop is that you will pick it up only if you take an occupational history and ask the person, "What job did you do when you left school?" When you go into the NHS, nobody asks "What job do you do?" or "What job did you do, historically?" unless it is an unusual condition of particular interest. In occupational health, however, the first thing that we ask is "What is your job history?" in order to make a link between the current disease and historical exposure.

That was a bit of a ramble, but I just wanted to give you the picture of the need for a system that is more alert to the issues that are arising and to the recognition of occupational disease, of which there is still a lot around. The aim is that, if you pick things up early, you can start preventative measures, and you can get the HSE to go in and carry out its policeman role. Better provision of occupational health leads to better health outcomes, too.

09:45

Marie McNair: Thank you, convener, for your indulgence. I think that Lucy Kenyon wants to come in.

Lucy Kenyon: Yes, I just wanted to add to that.

I have alluded to a similar case in the electronics industry. Respiratory diseases in that industry are linked to the fumes that are created in it. It is an emerging issue in Scotland, too, and it is linked to fumes from the making of circuit boards. The UK is doing technologically advanced stuff, rather than the high-volume stuff that is being done elsewhere in the world, but this is a respiratory concern waiting to happen. After all, people need to be able to breathe properly in order to function.

It comes back to the core purpose of the IIAC and IIDB. We are talking about people who are no longer able to function optimally and, therefore, are less likely to do good-quality work, to have good-quality health and to be able to support our infrastructure by becoming healthy elderly people in a society that requires elderly people to be able to function for longer, especially as we extend the retirement age.

I echo everything that has been said. We need to learn from the asbestos story, so that we do not get exposures emerging as the next asbestos.

The Convener: Thanks very much, Lucy.

Katy Clark (West Scotland) (Lab): I just wanted to pick up on the issue of duplication. The bill that we, as a committee, are scrutinising seeks to set up a Scotland-wide body. We want to do that, because the status quo is not good enough; we want to do something that is better than what is there already.

The witnesses have outlined quite clearly the scale of the problem in Scotland. Do you have any thoughts or pointers to give on recommendations that the committee might make on protecting the expertise in the current system that is drawn on across the UK to ensure that there is collaboration and to enable us to build on that? Do you have any thoughts on what the committee might want to consider in that respect? I will go to Professor Macdonald first.

Professor Macdonald: I will put on my research hat for this question.

Basically, you rely on research to identify a causal relationship with a condition that can occur commonly anyway or one that might be specifically occupational. For example, the fact that the occurrence of hip arthritis is nine times more common among farmers was discovered only when we looked at cases of arthritis by occupation. Suddenly farmers came up with hip arthritis, probably because they spend all their time in vibrating tractors and do very heavy manual work.

That is where you find a relationship between the two things, but it takes research. Generally, you rely on published research rather than anecdotal stuff, so you need to be monitoring the health of the population. That is a basic thing that needs to be done. We need to look not only at what people present with to their GP but at the GP data sets and the various data sets that you can monitor to see whether something is changing, whether there has been a rise in something or whether something new is happening.

As for the core of your question, I would just say that, when we do a study, the first thing that we all do is publish it. After all, that is the whole purpose—it is the output of research. The people who are focused on this area will hear about something very quickly; indeed, I am desperate to find some new disease that no one has ever discovered so that it can be called "Macdonald syndrome". That is the only way that your name lasts for ever, like Parkinson's. [*Laughter.*] That sharing of research on a UK-wide basis is important, because you do not want duplication of what is perhaps already being investigated.

Because it is a smallish community, we all know what everyone else is studying. That sort of informal system helps. For example, someone

could be an expert in cleaning fluids. Recently, the University of Manchester published a paper on cleaning fluids; some of the fluids that the cleaners use to clean this building can cause skin problems and asthma, and the data on that has been gathered by the THOR system. I am not suggesting that we replicate that, but the fact is that that system gets input only from the people who participate in it, and 90 per cent of people do not participate. A busy doctor might well see something, but few of them will think of the THOR system.

You need active survey techniques, too, in order to survey the population, which brings us back to the basic question of what happens in the workplace. For example, hygienists measure the environment and occupational physicians and occupational health nurses carry out health surveillance, if there is thought to be a potential risk, to see, for example, whether the lung functions of a particular group are lower than they should be. Do you see what I mean? The aim is to pick up early, subtle signs before they become disease.

That was a complicated answer. In short, my answer is yes, we should collaborate and yes, we should pool resources, but, instead of having all these people making a claim and reacting to whether they get it or not, we need to create a system that feeds prevention. That is where the additional resource has to be put. We want to stop people getting damaged from their work—that is what we are all about.

Katy Clark: Perhaps we, as a committee, can look at whether the bill is framed in a way that maximises collaboration and avoids duplication.

Lucy Kenyon: Just to add to that, I would point out that there are some pockets of symptom reporting. In the early 2000s, I was involved in one such pocket when we were looking at in-store bakeries. We discovered that some of the respiratory symptoms—the occupational asthma—were happening more in people who were using the machines that sealed the bags that the freshly baked products went into. That is an example of where, after monitoring symptoms, we have discovered a potential alternative source in an area where, according to conventional wisdom, we have known for decades about occupational asthma—in this case, baker's lung.

As for how Scotland spends its money to get meaningful information and protect the public, the first thing that we should do is strengthen the requirement for employees to report symptoms. Ewan Macdonald has been talking about the health surveillance model, and we have mentioned that, too. The HSE has taken a pragmatic approach in that respect, which is to carry out health surveillance every year with a 13-week window. Of course, in that time, people will get symptoms and then have forgotten about them, because they have ebbed, or their role might have changed slightly, as a result of which they do not get reported in that annual review. Therefore, it is necessary to require employees to report symptoms and to have a formal system for doing so.

Effectively, there needs to be something that works like THOR but that captures symptoms early to allow us to start to look at the trends. That is why I talked about having the multidisciplinary team on whatever information group you might set up; after all, we are the people on the ground who are seeing symptoms as they are reported. If we have a symptom-reporting system, employers will be less anxious about it, because it will not come under RIDDOR—that is, the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013—and they will not be thinking, "If I report this, the HSE will come in, and I'm already busy trying to get on with what I'm doing. My day job is busy enough, and I don't have the time to deal with the consequences. I'm just going to do my best to make sure that it doesn't happen again." Employers do have all of this good will; they want to do a good job, and they want to keep their people safe. However, we are still relying on the census for symptom reporting.

In my research on the data that we have on occupational symptoms and the actual functional and impairment impacts of occupational disease, I have found that it is being reported through other systems, but with a 10-year gap. As a result, we again have recall problems, which affect the reliability of that data, and there is, of course, the personal perspective to deal with. If I were spending the money, I would spend it on identifying the profile and the extent of the symptoms and where they were, so that I could look for hot spots. That would have an impact on preventing occupational disease across Scotland, in your context, but it would also set a best practice benchmark for the UK.

Bob Doris: This session has been helpful. The picture that is emerging shows that, although structures are in place in the Health and Safety Executive, as Lucy Kenyon mentioned, they may not be sufficient for the ambitions that Professor Macdonald has regarding the data that we should be collecting, for example. There are systems in place, but there appears to be a weakness regarding the jobs that they should be doing. The question is whether the bill is the way to plug that gap, or whether there are other ways to do so. That is something that we have to wrestle with as a committee.

What the bill is silent about—for some, it is the elephant in the room—is whether the new SEIAC

will, at some point, make recommendations on who should get industrial injuries benefits when the criteria for that are looked at again by the Scottish Government, or whether another body should do that.

My question is about the different approach that SEIAC might take in relation to those kinds of things compared with IIAC, which is, of course, looking at the same evidence and has the same experts deciding whether there is "reasonable certainty", which is a very general expression. I suppose that that is a long way of asking whether you think that SEIAC would necessarily take a different approach to IIAC when making decisions. I am not talking about data collection, Professor Macdonald—we are admitting that there is a gap in that—I am being more general. If SEIAC and IIAC are looking at the same data, would you expect them to come to different conclusions as to whether there was reasonable certainty?

Professor Macdonald: That is possible but not desirable. Generally, these systems exist across Europe and around the world. If you were to say, "We're going to call ingrowing toenail problems an occupational disease in Scotland," and no one else thought that that was anything to do with an occupation, that would be bad science and bad policy. That is a facetious example.

There will be situations in which the approach will need to be tailored. Women, for example, are not appearing much. That needs to be addressed, because women are more than 50 per cent of the workforce and are doing all sorts of jobs. Those areas need to be addressed, rather than something else that is new and a bit questionable being dreamt up.

I will illustrate this by going back to baker's asthma. The first description of asthma in bakers was by a professor of medicine in Padua, in Italy, in 1715. Some of you will have had a morning roll this morning, and some of those rolls will have been made in a big place such as Mortons Rolls, which will have an occupational health service, and some of your morning rolls will have been baked in a wee bakery where there is no surveillance of staff because there is no system to provide health surveillance. Today, in Scotland, some of the staff who baked your morning roll may be suffering from mild occupational asthma.

There should not be any differences in the conclusions reached if the science is good—unless the IIAC's science is wrong and our science is better. That is the more important area. All the European Union countries have parallel systems, so they have to have fairly consistent criteria on whether something is occupational. The issue is what we are doing to prevent problems. At the moment, among the workforce in Scotland, particularly in the smaller organisations that do not have the resources to bring in occupational health services—there are not enough in existence anyway—people are still being damaged, and that is preventable. That is the more important issue.

If we find a new disease—it might be called "Macdonald syndrome"—which is definitely occupational and has not been recognised anywhere else, that would be great, and we would recognise it. However, there has to be good evidence.

10:00

Bob Doris: Can I follow up on that briefly?

The Convener: We are very tight for time.

Bob Doris: If we have time constraints, I will bring Lucy Kenyon in, if she wants to say something. I can always follow up with the professor later.

Professor Macdonald: Certainly—any time. I am happy to discuss anything.

Lucy Kenyon: From listening to our conversation, it seems that the question is: do you need an equivalent of the IIAC or do you want something else? Is what you need different from what you want? That is coming across to me. Ewan Macdonald and I are coming from the same perspective: let us prevent occupational disease and prevent disability. We are not doing that well enough. By the time something gets to the IIDB, somebody is disabled. We do not want disability; the whole purpose of occupational health is to prevent disability. Ewan wants to do the research, and my colleagues and I in the multidisciplinary team—what I call the "non-medical multidisciplinary team"; we refer to doctors for the diagnostics, but we are on the ground—see the symptoms. We need more information and guidance. We need clinical protocols and reporting protocols, and we need to make sure that all our data is easily captured, which has to be possible in this day and age.

Paul O'Kane (West Scotland) (Lab): Good morning to the panel. I would like to understand the witnesses' views on the proposed membership of SEIAC. We have had a lot of submissions about who should be in and who should not be in. The bill sets out the balance between employees and employers and the types of expertise. In your view, is it the right mix or are there things missing from the proposal in the bill?

Professor Macdonald: I was part of the earlier discussions on that in the disability and carers benefits expert advisory group, but I do not have the exact mix in my head. I would need to look at that again, so I cannot really answer that, I am afraid.

Paul O'Kane: Lucy Kenyon, your submission mentioned the need to broaden the scope of the membership. Do you want to comment on that?

Lucy Kenyon: The reason why you need to broaden the scope is that you need representation from the people whom you want to do the detection, and those people need to be a multidisciplinary team. Yes, it absolutely needs to be an advisory council, as in the model that has been proposed, but the advisory council must have the voice or the ear of the people who are doing the work.

As an occupational health professional, I carry out my job to the best of my ability. I do my due diligence, I do my best to report and I do my best to share my findings among the community. However, as Ewan Macdonald said, neither he nor I have a direct line to the IIAC, even though we take an evidence-based approach. We look at our own data and trends, and we advise our customer employers—employers are our clients—on what to do to make sure that the rest of the workforce does not suffer when we see something happening early on with a member of staff.

We absolutely need the scientists. We absolutely need a feed-in mechanism to present the information to the IIAC, which will then review it. However, if we do not have anybody who can explain the context for the information that is being provided by people such as me, the IIAC will continue to do what it has always done, because there will not be that mechanism for the clinicians on the ground to feed in.

Paul O'Kane: I think that you are making an argument for that formal role within the SEIAC membership, but I wonder whether, more broadly, there is an opportunity to widen the scope via people or organisations having observer status and being able to share views, opinions and expertise. Although I take the point that you make about having a formal status, do you agree that there is opportunity beyond that?

Lucy Kenyon: Absolutely. You have just two of our membership organisations here today, but you have referred to the British Occupational Hygiene Society. We also have the Faculty of Occupational Medicine and the Royal College of Occupational Therapists, which are not represented here. We have physios and occupational therapists with their specialist sections as well, all of whom have informal links and can contribute and reflect on what the SEIAC does when there is the opportunity to do so. That is absolutely essential for all the multidisciplinary professional bodies that are involved in delivering occupational health on the ground.

Jeremy Balfour: We heard evidence last week that you need technical and scientific expertise to be able to advise the Scottish and UK bodies. Are there enough people out there to give that advice?

Professor Macdonald: Yes. I say that slowly because, in Scotland, we are thin on the ground. I think that we have enough people, but we would not replicate. If the IIAC does useful research and comes up with good evidence—it has top scientists as well—we would not repeat that. In Scotland, between the various institutes and research areas, there is a nucleus. However, the expertise is thin on the ground. It would have to be properly organised and funded, and there would have to be a background of research and people processing data to pick up things early.

The answer to your question is yes, but we could do with a lot more people in occupational health generally and in academic occupational health.

Jeremy Balfour: Thank you. Ms Kenyon, do you want to come in on this one?

Lucy Kenyon: I echo everything that Ewan Macdonald has said. I could not say it any better.

Jeremy Balfour: Excellent. I will stop there.

The Convener: Thank you very much, and thank you to Lucy and—sorry, do you want to come in, Bob? Please be quite quick.

Bob Doris: Sorry, convener. I will be brief.

It is my understanding—I am sorry if I have got this wrong—that the DWP has said that experts who sit on IIAC cannot also sit on any Scottish advisory board. I think that that might be the situation. Do you have any views on that? I would compare that with the National Institute for Health and Care Excellence and the Scottish Medicines Consortium—the bodies that deal with UK health approval and Scottish health approval—which have something called multiple technology appraisals, through which they do things jointly from time to time.

There appears to be a barrier there. Do you have any thoughts in relation to that barrier? Please be brief, or the convener really will give me a hard time.

Professor Macdonald: There should not be a barrier. Scotland may be a separate country, but we are on the same island, we speak the same language and we all know each other. We should feed off each other.

Bob Doris: Thank you very much, professor. That was very brief.

Lucy Kenyon: We have cross-border working within the UK. Therefore, it is essential that we are all singing from the same hymn sheet, so we absolutely need to be talking and coming to a joint decision. That echoes what Ewan Macdonald said.

The Convener: I thank our witnesses very much for taking part and sharing their expertise. I found it very interesting and helpful, as did all the members. We will continue to take evidence on the bill next week. Thank you once again.

That concludes our public business. We will now move into private session to consider the remaining items on the agenda.

10:10

Meeting continued in private until 11:33.

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