

Well-being and Performance



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Looking into the future – where next for occupational health?

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Over the past 10-15 years, the world of work has drastically changed. Traditional occupational health was initially slow to understand these changes, but a new approach to employee health and well-being is emerging in the United Kingdom, led by forward thinking occupational health physicians and nurses.

The introduction of the Health and Safety at Work Act and the success of risk based health and safety practices have reduced and almost eliminated exposure to physical, chemical and biological harmful agents at work. Common mental health problems and musculoskeletal disorders now dominate work related ill health, and psychological problems and unhappiness generally appear to have increased. As technology continues to advance at apace and communication is based around talking with our fingers by text and e-mail, we need to have a clear understanding of work style health. We also need to address the needs of the ageing population, with older workers dominating the employment market place and remaining in work for much longer.

Employers have started to recognise the role of occupational health as an integral part of the human resources jigsaw and

to develop a strategic approach to well-being. Some organisations' strategic models of well-being include defined roles for HR, occupational health and health and safety. Other organisations are developing a split team approach – a Well-being team and an Occupational Health team, using different players with different expertise. There is therefore a need for professionals to work far more closely with one another to ensure the well-being of the working population.

Recent research has shown that 'Work is Healthy' and we need to help people who are healthy stay healthy. We must transfer health spend from treatment/illness management to the preventative, health and well-being improvement end of the scale.

To take all of these changes into account, I believe that occupational health practice needs to develop a new model to guide its practice and to adapt to significant shifts in the coming years – this article addresses each of these in turn.

Developing a new occupational health model

So what model of occupational health do we need for the future? I believe it must

introduce new concepts relating to well-being, without losing traditional occupational health approaches.

Well-being can be understood by the way that five areas in our lives need to be in harmony as shown in the Well-being Model:

Well-being Model



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All of these areas need to be in balance – if any part is out of balance, well-being is affected. Health and well-being programmes need to include a means of addressing these physical, psychological, social, economic, and environmental factors which effect well-being both at work and increasingly away from work.

Simple definitions are:

- **Physical** ('the healthiness of our body systems') – our heart and cardiovascular, endocrine, gastrointestinal, immune and musculoskeletal systems. Focuses on the prevention of the metabolic syndrome, diabetes, heart disease and cancer.
- **Psychological** – our mental health status, common mental health problems, behaviours, emotions and happiness.
- **Social** – interactions and relationships with other people, family, friends.
- **Environment** – where we live and where we work.
- **Economic** – disposable income, financial problems and debt.

In addition, occupational health models must not lose the traditional risk-based core occupational health services, to ensure the management of risk and prevention of classical work related illnesses and injuries, legal compliance, business reputation and business risk protection. The traditional Occupational Health Model consists of managing the five workplace hazards, as follows:

Occupational Health Model



The Combined Well-being and Occupational Health Model

Well-being	Work on Health	Health on work
Physical	Work style health <ul style="list-style-type: none"> • (Commuting, travel, sedentary work, unhealthy diet, caffeine excess, lack of physical activity, sleep disturbance) • 'E-mail Hell' • Mobile phones • Musculoskeletal disorders(MSD's) • RSI Back pain • Poor ergonomics 	Lifestyle health <ul style="list-style-type: none"> • Lack of physical activity • Risk of metabolic syndrome, heart disease, cancer, diabetes • The obesity epidemic • Common minor health problems • Major illnesses and diseases • Headaches and migraine • Irritable bowel syndrome
Psychological	<ul style="list-style-type: none"> • Pressure and stress 	<ul style="list-style-type: none"> • Common mental health problems (eg anxiety, depression)
Social	<ul style="list-style-type: none"> • Bullying, interpersonal conflict • Behavioural issues, dignity and diversity • The organisational culture • Work life balance, flexi-working 	<ul style="list-style-type: none"> • Family, relationship problems, childcare, eldercare • Legal issues • Drugs/alcohol addiction
Environment	<ul style="list-style-type: none"> • The 'culture' of the workplace • Travel to and from work • Noise, vibration, radiation, chemicals, dusts, biological agents – (Need for risk assessments) 	<ul style="list-style-type: none"> • Home problems • Local disputes • Neighbours • Housing problems
Economic	<ul style="list-style-type: none"> • Reward and recognition • Flexible benefits • Disposable income 	<ul style="list-style-type: none"> • Financial difficulties • Credit card debt • Gambling

This model simply takes the five hazards, physical, chemical, psychological, biological and ergonomic, and combines a workplace risk assessment with an individual health risk analysis to give a total overall risk assessment. This then is used to define what Health Assessments (health check), if any, are needed. These might include Health/Medical surveillance (eg for Hand Arm Vibration Syndrome, noise, occupational asthma) or job related risk

management (eg for working at heights, vocational driving, working alone).

We also have to remember the basics of traditional occupational health, defined as: 'the effects of work on health' and the 'effects of health on work capability and performance'. We can then combine the Well-being Model and Occupational Health Model and come up with the above combined model.

Preparing for shifts in occupational health

Looking into the future, I foresee the following shifts to which occupational health practice will need to adapt:

1. Attendance management must always enable managerial ownership of attendance, but will need to include a much higher level of support by occupational health practitioners. This role will therefore become an increasing part of the occupational health practitioner's remit and, with the introduction of the Biopsychosocial Model replacing the Medical Model, new training and education is needed for all stakeholders, including managers and HR, involved with attendance management and rehabilitation. The key is early active professional intervention, case management and effective rehabilitation programmes thereby breaking down the barriers that delay or prevent recovery and return to work. In larger employers this, inevitably, will include the private health sector with increasing use of PMI and funded early referral investigation as well as treatment to physiotherapists and psychologists trained in Cognitive Behaviour Therapy (CBT) in particular.

2. In view of the shortage of occupational health personnel and the huge costs of sickness absence, remote call centre services using high tech databases and first day intervention with real-time sickness, absence information for line managers will continue to develop. Employee and manager Occupational Health help lines are already being introduced to enable appropriate advice to be given by skilled occupational health professionals. Will this signal a shift to remote delivery of occupational health by call centre operators using video conferencing in case management?

3. Occupational health advisers are moving to a managerial role and outside their original nursing comfort zone. Their role in physiological measurements and health assessments will shift increasingly to a supervisory role as occupational health technicians take over occupational health assessments previously undertaken by the nurse. This will enable the occupational health nurse to become more active in

strategy development, case management and rehabilitation. But will they be happy to lose this personal, preventative, patient contact, the reason most doctors and nurses enter the medical profession?

4. Many occupational physicians presently work as, what I term, a 'doc in a box' – they sit in a room seeing endless employees/patients with mainly psychosocial well-being issues, they are fed coffee and biscuits, allowed to go to the toilet and after writing reports are released from the box. Occupational health advisers are increasingly taking on this role in attendance case management: so inevitably they will become the 'nurse in a box' and the role of occupational health physicians will also have to be reviewed. However, doctors are trained in total patient care from diagnosis, undertaking investigations, to treatment so they will always be the key decision maker in case management. Their therapeutic skills will become the key driver to breaking down the individual obstacles that prevent recovery and return to work and will be far more utilised in the future.

5. Poor psychological well-being is increasing, and more large companies are employing psychologists for the early diagnosis and treatment of common mental health problems. Cognitive Behaviour Therapy (CBT) is recognised as the treatment of choice for many psychological problems including post traumatic stress disorder, anxiety, depression, emotional and behavioural issues at work, etc. However, there are a finite number of available psychologists and therefore we need to train more practitioners in this area. In my opinion, we should be training occupational physicians and nurses to take on this work.

6. Active case management to restore function and encourage earlier return to work will continue to evolve as the Biopsychosocial Model replaces the Medical Model. This will need a comprehensive educational programme for General Practitioners, in particular, and occupational health professionals. Doctors are trained to follow set diagnostic steps: history, examination, investigation, diagnose and treat. The problem is that patients now often present with a multiplicity of non-specific complaints, often caused by unhappiness and psychosocial issues which makes it difficult to pin down a true

diagnosis. Managed rehabilitation programmes will need to include a multi-disciplinary approach. Occupational therapists may work more closely with occupational health practitioners and physiotherapists, psychologists and fitness coaches will become more actively engaged in employee health and well-being.

7. Within the next 10 years we should at last be able to measure the link between health and well-being on the one hand, and productivity, performance and engagement at work on the other. On-line Health Risk Appraisal Questionnaires, giving individual and organisational health risk mapping, are being introduced more widely to enable accurate health metrics and so demonstrate positive behaviour change and reduced health risk factors. It is essential to have a means of health data collection and analysis, in order for activities related to well-being to be monitored and measured. This will enable cost-effective, comprehensive and integrated programmes to be evaluated and ultimately to demonstrate a bottom line pay-back for the investment made.

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New information on the business case for stress management

The HSE has added a new case study to its website stress pages. The study, looking at the experience of the Rullion Group, provides information on how to get directors to buy into the need for stress management when absence figures suggest that there isn't a problem. It shows how a range of data was presented to management to convince them of the need for a robust stress management approach, despite the company having better than average levels of absence.

Interestingly, one of the first things the Group Safety, Health and Environment manager did when presenting the information to senior managers was to drop the 'S' word. Instead of referring to 'stress management standards', she talked about 'good management standards'. The study can be accessed at: www.hse.gov.uk/stress/casestudies/rullion.htm

CIPD report on absence management reveals low levels of recording

The CIPD's latest annual Absence Management survey found that a quarter of UK employers do not record their annual employee absence rate. It also found that the average working time lost to employee absence increased to 3.7%, as compared to 3.5% in 2006, the first increase in two years.

The average cost of absence was found to be £659 per employee per year. The same survey found that 40% of respondents said that stress related absence had increased in the previous year, with only 9% reporting a decrease. A third of respondents suggested that high workloads were the main contributor to work-related stress, followed by management style (16%) and organisational change (14%).

A separate piece of CIPD research, produced in partnership with Active Health Partners, revealed that employees suffering from mental health problems, such as stress, depression and anxiety, are off work for an average of 21 days. This latter research warned employers to watch for early signs of mental health problems in the workforce in order to

avoid cases of long-term sickness absence. The CIPD Absence Management Survey 2007 can be downloaded at: www.cipd.co.uk/subjects/hrpract/absence/absmgmt.htm?lsSrchRes=1

Employers not caring about staff well-being is reducing productivity

Research commissioned by Business in The Community (BITC) has revealed that 31% of workers feel that their health is neglected at work and that 62% don't believe that their employer regards employees as worthy of investment. Importantly, almost half of respondents claim that employer apathy about employee well-being has taken a toll on workplace productivity.

Employees complained that they were:

- discouraged from taking sick days when unwell (44%)
- put under pressure to do unpaid overtime (44%)
- prevented from taking a full lunch hour (40%)
- suffering stress (55%), depression (38%) and panic attacks (22%).

In response, BITC has launched a national campaign, calling for at least 75% of all FTSE 100 companies to publicly report on employee well-being by 2011. It suggests that employers who do invest in employee health and well-being get a return of investment of 3:1. The Business Action on Health campaign provides a suite of tools for UK boards to measure bottom line impact of employee health and well-being investment for the first time. Organisations including Boots, National Grid, Standard Life Healthcare, Abbey, Aramark, and Danone Dairies have already made a three-year commitment to support the campaign. Materials can be accessed at: www.bitc.org.uk/take_action/in_the_workplace/healthy_workplaces/

'Work while you're sick' culture taking hold of businesses

A report by the Chartered Management Institute has revealed that one in three managers is afraid to take time off when ill. 'The Quality of Working Life 2007', based on the views of 1511 managers, reports that 42% of managers feel illness rates in their organisation have gone up

over the last 12 months. Only 53% feel they would be treated sympathetically if they were ill. The impact of this culture is seen through declining performance, waning enthusiasm and increasing levels of suspicion. Only 36% of respondents claim to be operating 'at or near peak productivity' and, with 67% claiming their productivity was reduced by ill-health, there is a clear indication of the extent to which health and productivity are linked. The report is available at: www.managers.org.uk/listing_1.aspx?id=10:106&id=10:9&doc=10:3691

Support for line managers in managing people with mental health problems

A new resource for line managers was published in October 2007 by Shift, a Department of Health funded initiative, with support from other agencies and organisations. It is a practical guide for managing and supporting people with mental health problems in the workplace. It is part of Shift's 'Action on Stigma' initiative, which aims to help employers in promoting good mental health and reducing discrimination. The Resource contains:

- advice for employers on the main areas of legislation that relate to mental well-being in the workplace
- information on recognising depression and anxiety, the most common forms of mental illness
- advice on various forms of counselling services.

It also covers a range of different aspects of managing mental health issues in the workplace, such as:

- promoting well-being and the value of a positive approach
- the recruitment process, advising managers on what to ask and what not to ask when recruiting
- monitoring staff well-being and taking early steps
- keeping in touch during sickness absence and managing return to work and
- managing an ongoing illness while at work.

The document is available to download for free from the Shift website: www.shift.org.uk