Occupational health: the next decade

What the experts say

A panel of experts assembled for this special 100th edition of Occupational Health [at Work] *discuss the outlook for occupational health over the next 10 years.*

ISSUE one of *Occupational Health [at Work]* was published in June/July 2004. In the sixteen years since we've seen huge changes in occupational health (OH); not least the coming into force of the *Equality Act 2010*, Professor Dame Carol Black's 2008 review of the health of Britain's working-age population[1], Dr Steve Boorman's 2009 report on the health and wellbeing of the NHS workforce[2], the coming (and going) of the Fit for Work service, the fit note, the aborted merger of the Faculty of Occupational Medicine (FOM) and Society of Occupational Medicine (SOM), a new Faculty of Occupational Health Nursing (FOHN), the establishment of a national OH service accreditation scheme – the Safe Effective Quality Occupational Health Service (SEQOHS) – revalidation of doctors and nurses, legislation to prevent sharps and needlestick injuries, five UK governments, including one coalition, and Brexit. And then a pandemic as COVID-19 affected every industrial sector and millions of workers across the UK. But rather than ruminate on the past, for this special 100th issue of the journal, we asked 13 experts in workplace health to look forward and consider what we can expect in occupational health over the next decade.

How can we reinvigorate the concepts detailed in Carol Black's review of the health of Britain's working-age population, particularly in respect of making work a health outcome and improving access to OH across the workforce?

***Dame Professor Carol Black, chair of the Centre for Ageing Better and chair of the Health and Well-being Advisory Board NHS, and author of two independent reports on workplace health:* Working for a healthier tomorrow[1]*, and (with David Frost)* Health at work – an independent review of sickness absence[3]**

In 2008, I said that 'at the heart of my review is a recognition of, and a concern to remedy, the human, social and economic costs of impaired health and wellbeing in relation to working life in Britain'. The review aimed to identify the factors that stand in the way of good health, and to elicit interventions that could help overcome them. COVID-19 has given sharp relief to those words. It has exposed the close relationship between economics and good health. They are not separate entities – they go together: control the virus, control the economy; enable physical and mental health and wellbeing of the workforce and you improve the economy and increase productivity. We should see COVID-19 as an opportunity to accelerate change, to make it a high concern of CEOs, a boardroom issue, and a major key performance indicator for managers. Take public health into the workplace and make OH a central part of the answer, not an add-on.

Occupational health featured prominently in 2008. My review recommendations pointed to an expanded role for OH and its place within a broader collaborative and multidisciplinary service. I said: 'Ultimately I believe that such a service should be available to all,' whether they are entering work, seeking to stay in work, or trying to return in the wake of injury or illness.'

The OH community moved too slowly for my liking after 2008, but COVID-19 could be a great opportunity for development, not entirely an enemy. The pandemic has shown the need for, and value of, high-quality OH services, as evidenced in the NHS over the past eight months. For the future, what is needed is better central understanding of, and commitment to, the need for occupational medical input to strategic decision-making, both nationally and locally.

More OH expertise and leadership should be available to the population as we move into the new world of work, with its new risks, greater flexibility, home working, and greater challenges on mental health and wellbeing. During the pandemic OH services have shown that they can deliver the wider health and wellbeing agenda to good effect.

Finally, there is a need for the voice of OH to be heard at the boardroom table, and the 'corporate medical director' (CMD) role needs to be encouraged. A CMD brings great depth and breadth of knowledge to the business operations, to support a healthy, engaged and high-performing workforce. Much has been achieved, but there is so much more to do.

Do we need mandatory accreditation of occupational health services (eg to SEQOHS) to ensure quality OH delivery regardless of the model of delivery (in-house/outsources/mixed)? If so, how could this be achieved?

***Dr Steve Boorman, employee health consultant at Empactis, chair of the Council for Work and Health, and author of the* Boorman review of NHS health and wellbeing[2]**

OH is a clinical specialty and should therefore have clear standards for clinical governance and quality control. However, many commissioners of service are uninformed purchasers and have poor understanding of appropriate quality marks. Another issue lies in quality standards checking the process, but being weak on measuring outcomes of OH interventions. Clearly, our marketplace has inconsistent approaches and variable quality, so standards should be very important, but we have some way to go to establish trust in them. It was recommended over 10 years ago that large public organisations, such as the NHS, should mandate SEQOHS accreditation as a minimum. However, today we see the NHS People Plan[4] once again calling for such a requirement, but with no clear systematic means of checking or enforcing it. It may be a controversial stance, but perhaps we should use revalidation to ensure that practitioners only work in clinical services in which accreditation standards are in place and adhered to.

What should we prioritise in occupational health research over the next 10 years?

Professor Carel Hulshof, emeritus professor in occupational medicine at Amsterdam University Medical Centre, and Dr Jos Verbeek, coordinating editor of Cochrane Work at Amsterdam University Medical Centre

How do you forecast the future? According to Philip Tetlock, political science writer and author of *Superforecasting: the art and science of prediction*, you certainly don't ask two old men. So, this is our two cents. We see three key areas where research is needed: working life; COVID-19 and home working; and unsolved problems in occupational health.

Problems due to changes in working life – robotics, less manufacturing and more services, increased time at work and the 24-hour economy:

➤ research on the meaning of work and the amount and nature of work (see John Maynard Keynes or Bertrand Russell)

➤ research on cognitive workload – how to integrate physical activity with cognitive work, and the benefits and harms of so-called cognitive enhancing drugs (nootropics)

➤ research on sleep and shiftwork – sleep education and optimum shiftwork solutions

➤ research on mental wellbeing at work – eg peer support and the deployment of 'workplace champions'.

Covid-19 and working from home:

➤ research on work–life balance and recovery

➤ research on the effectiveness of personal protective equipment for infectious diseases.

Unsolved problems:

➤ research on how to maintain and share expertise on old and emerging chemical and physical factors – essentially, this means developing the knowledge infrastructure

➤ research on how to increase work participation for people with health problems.

Will the experience of the pandemic have focussed employers' minds on the mental and physical health of their employees, creating opportunities for OH to drive the work–health agenda over the next decade?

Rachel Suff, senior policy adviser employment relations at the CIPD

COVID-19 has pushed employee health and wellbeing to the top of the business agenda because it's now a crucial business continuity issue. The focus extends beyond managing the physical health risks: CIPD research shows 89% of employers are concerned about employee mental health. The challenge is to ensure organisations view employee health and wellbeing as a strategic imperative beyond the pandemic.

In March 2020, the CIPD launched its 20th annual health and wellbeing at work report[5]. Based on a survey of over 1,000 human resources (HR) professionals, and covering 4.5 million employees, its findings can help organisations to integrate employee health and wellbeing into their day-to-day operations during and after COVID-19.

The research reveals that an increasing number of employers were paying serious attention to health and wellbeing even before the pandemic. There's also evidence showing where employers need to step up their efforts. Organisations are still more likely to take a reactive, rather than a proactive, approach to employee health. Not all health conditions are preventable of course and employers should provide a range of support when needed, such as access to quality OH services and good rehabilitation practices. But we need to see more organisations taking stronger preventative action to manage the main risks to people's health, such as those related to musculoskeletal disorders and work-related stress.

Year on year, our research shows that HR professionals regard OH services as one of the most effective methods of addressing long-term health conditions and absence in their organisation. But it also indicates there could be clear benefits to involving OH in employee health issues at an earlier and more strategic stage of an organisation's approach. Most organisations say they use OH services primarily for referral in cases of long-term sickness absence; only a minority report that HR and OH work closely at a strategic level to help prevent ill health or develop health and wellbeing-related policies and practices.

Working together with HR, OH could provide organisations with a wealth of specialist expertise that could be invaluable in developing a health and wellbeing strategy and managing the main risks to people's health.

The strength of the working relationship between OH and HR practitioners will be pivotal in ensuring that the work–health agenda continues to receive the attention it deserves beyond COVID-19. The pandemic presents an opportunity for the two professions to work together to ensure this happens.

Does the OH profession need to do more to address race equality – both in terms of the provision of OH services and in ensuring equality for OH professionals from Black, Asian and Minority Ethnic (BAME) backgrounds?

Dr Sheetal Chavda, consultant occupational physician and chair of the Society of Occupational Medicine taskforce on Equality, Diversity and Inclusion

Absolutely, it does. The COVID-19 pandemic has exposed the wide-ranging inequalities from income to housing that have led to poorer outcomes amongst BAME groups. From an occupational point of view, BAME workers are more likely to work in occupations with higher risk of COVID-19 and to use public transport when travelling to work. These systemic inequalities have probably contributed to adverse health and work outcomes in many areas before the pandemic and will continue to do so unless we take urgent action. Investment in OH to promote universal access will help, but it is important that OH providers make education and training of OH clinicians a priority, so that we have more professionals working in the specialty to meet this need.

And more needs to be done to ensure that clinicians from BAME backgrounds are given the same opportunities as anyone else. We know from general research that clinicians from ethnic minorities are less likely to get shortlisted for senior positions and more likely to face bullying and disciplinary action. There is currently a lack of data within OH specifically, but it is very likely to be the same. I would urge organisations to start by acknowledging this issue and gathering data to identify areas where improvements can be made. It is vital that all organisations take proactive steps to ensure their senior leadership is diverse and inclusive, which undoubtedly will benefit society as a whole.

In the post-Brexit decade, which areas of OH law should we be most careful to protect as the UK withdraws from EU influence?

Professor Diana Kloss, barrister and expert in OH law

The three main areas of law heavily influenced by UK membership of the EU are as follows: criminal law of health and safety at work; civil laws prohibiting discrimination at work on the ground of a protected characteristic, including sex, race and disability; and data protection legislation laying down standards with which controllers of personal data must comply.

Health and safety at work

The *Health and Safety at Work etc Act 1974* was the product of a report by a Royal Commission chaired by Lord Robens. Although it came into force shortly after the UK joined the EU it was not materially influenced by EU membership and is therefore a 'home-grown' product. Until 1987, it was necessary for EU member states to be unanimous in order to pass health and safety directives, but the passage of the Single European Act in 1987 allowed such legislation to be passed by a qualified majority. Shortly after, a Framework Directive and five daughter directives were agreed in Europe and became UK law in the 'six-pack' regulations of 1992. They were followed by a number of other regulations dealing with various hazards. In 2011, an independent review conducted by Professor Lofstedt found that there was generally no case for radically altering the legislation. Fines were substantially increased in 2016 through recommendations of the Sentencing Council.

I suggest that the protection of workers and of the public remains a vital function of the state, and that all this legislation should remain and be strengthened by giving increased funds and powers to the enforcing bodies – the HSE and local authorities.

Discrimination at work

The UK created its own *Equal Pay Act* and *Sex Discrimination Act*, which came into force in 1975, but the main impetus towards equal pay and equal treatment at work of men and women came from the EU in a series of directives and European Court decisions. The drive towards equal pay continues. The UK created its own race relations and disability legislation, but they were expanded after the EU passed the Framework Directive of 2000 and the law is now in the *Equality Act 2010,* enforced through the civil courts and the tribunals.

I suggest that the fair treatment of workers is a core function of management and supports the health of the workforce, and that these laws should continue in force with minor amendments.

Data protection legislation

The *Data Protection Act 1998* was the product of an EU directive. In 2018 the EU issued a new Regulation – the General Data Protection Regulation – which automatically became law in the UK. The UK *Data Protection Act 2018* was passed at the same time to ensure that the EU principles continue after Brexit. Unfortunately, there is misunderstanding among employers of the effect of these laws on confidential OH records as the common law and the ethics of the healthcare professions remain in force in tandem.

My view is that the protection of personal data is a vital matter and should continue, but that more official guidance is needed from the Information Commissioner's Office about OH reports and records.

Does OH nursing in the UK have a healthy future? It's been through a period of uncertainty – the FOHN was launched in 2018, but it has not been the unifying voice it aspired to be, arguably facing increased competition from the Association of Occupational Health and Wellbeing Professionals (iOH) and SOM. Does OH nursing need a single voice?

Sandra Winters, OH nurse and clinical director at Organisational Wellbeing Ltd

The future of OH nursing in the UK is dependent on many factors – and the voice by which we may seek (individual, organisational or societal) endorsement or guidance to enhance our professional practice has a significant role to play. But rather than debating the benefits, or not, of specific allegiance to any 'single voice' – we should perhaps consider how we can fully unify a collective voice. Our future strength and value will be reliant on us demonstrating diversity of thought, embracing new technology and innovative practice, in addition to maintaining quality, standards and a professional organisational standing. Whether we opt as individuals to align to the SOM, iOH, or FOHN, we should expect as a minimum a collective strategic approach and collaborative agenda that fits the future needs of the OH nursing profession. Collaboration, not competition, is required to generate the most powerful collective voice. This does not mean an end to choice, or implementation of a monopoly forum, but an equal understanding and commitment to identify the gaps, to create the opportunities from across the various forums to strengthen and to showcase the leadership qualities that are plentiful amongst our wide and varied professional networks.

What is the market outlook for occupational health in the UK as the country endeavours to recover from the COVID-19 pandemic?

Lewis Cone, senior B2B analyst at Mintel

Following the COVID-19 outbreak, it has become clearer that employers need to be proactive to ensure their workforce is protected from risks to both their physical and mental health. The COVID-19 pandemic has demanded new ways of living, working, and changes to people's daily routines. With many people lacking a desk at home and having to work 'hunched' over coffee tables or on kitchen stools, more people are likely to be struggling with musculoskeletal conditions.

With working environments unlikely to reflect how they were pre-COVID-19 for some time, it will be vital that OH providers ensure that their services are still able to reach those working remotely. They must be able to provide assistance programmes and workplace checks remotely – whether through video calls or via a purpose-made app.

The lasting legacy of COVID-19 within this sector could well be the increased focus on programmes to support mental health. Under the *Health and Safety at Work etc Act 1974*, employers have a responsibility to support both health and wellbeing so they must consider mitigating the risks to employee mental health. This is likely to result in greater uptake of employee assistance programmes, which have come to the fore since the start of the pandemic.

Major opportunities are still available and occupational health marketing should be focused on the proactive prevention of workplace ill health rather than on the reactive curing of ill health and wellbeing after it has already taken place – an aspect of occupational health which differentiates itself from other health services with this type of activity being a major attraction to employers wishing to reduce absenteeism costs.

Does OH need a higher profile within the NHS, and if so how can it be achieved?

Dr Anne de Bono, consultant occupational physician at University Hospitals of Leicester NHS Trust and president of the Faculty of Occupational Medicine

Unquestionably yes! A network of high-quality OH practitioners in clinical roles in NHS trusts throughout the UK could have a transformative effect across the health and societal landscape.

Historic exclusion of occupational medicine from mainstream NHS practice has limited national understanding of the two-way relationship between heath and work. Population access to occupational

medical and nursing expertise is almost entirely restricted to the minority whose employers fund OH service provision. In the NHS, OH practitioners are usually employed in non-clinical directorates, often regarded as a 'back office' function and have been vulnerable to repeated economic challenge.

2020 and the arrival of SARS-CoV-2 has shaken the old order. A new pathogen, and a potentially a serious workplace hazard for the NHS, has brought increased risks for staff, particularly those with vulnerabilities including older age and underlying health conditions. Risk assessment, management and reduction are crucial and OH in the NHS has been a key player. Strategic advice, individual assessments and testing programmes have all contributed to safer working and better patient care[6,7,8,9,10].

The NHS should build on these achievements, recognise occupational medicine and OH nursing as clinical disciplines that can contribute to healthcare beyond OH services for staff. Consultant OH posts could be sited within clinical directorates, include responsibilities for strategic advice on good work and good health, and engagement with other clinical services as a source of advice and referral, ideally including a referral service for primary care.

Such appointments would sit alongside and continue to contribute to occupational health service provision for NHS staff. They should not be a threat to employer-funded OH services elsewhere, but could be an important step towards making 'work as a health outcome' a reality in mainstream clinical practice. More occupational physicians and OH nurses would be required and training numbers should increase ... but that's another question!

How can we make OH an attractive career for nurses?

Dr Karen Coomer, OH nurse, chartered psychologist and director, KC business health

OH has many facets. Whilst we don't see sick people in a traditional sense we understand the work processes that can lead to ill health and how it can affect the psychological, physical, social and economic position of individual people and their wider families and communities.

How do we sell that to nurses looking from the outside in? We need to appeal and make the case that OH is about 'care' in a different way. We need to emphasise that the application of evidence-based clinical skills, science, psychology, research and wellbeing is just as applicable in the workplace as it is in a primary healthcare setting. That being curious about people, the nitty-gritty of what they do at work and how they fit into organisational systems can influence health in a different unique way. That professional confidence, objectivity and the values of nursing are just as relevant in a business setting as they are in healthcare. That the satisfaction of 'getting it right' in an OH context can be comparable to nursing patients back to full health. That the ability to be autonomous and have control over your own workload is achievable in OH, and a work–life balance isn't just words but can be reality. That a business head combined with soft skills is a successful combination so those with an entrepreneurial spirit or managerial ambitions have a place in OH. That multidisciplinary skill development is possible which in turn can result in a varied, interesting and transferable career path.

How can we convince employers of the value of targeted (evidence-based) investment in health at work?

Professor Stephen Bevan, head of HR research development at the Institute for Employment Studies

It seems strange, in the midst of a pandemic, to have to make a business case for investing in employee health and wellbeing. After all, for many organisations, the health of the workforce has been a critical factor for business survival in 2020. The big unknown is whether the priority being given to wellbeing will diminish when the pandemic fades. If it does, then a core argument for maintaining a focus on workforce health will be the impact it has on operational effectiveness. Some employers have found convincing ways of doing this. For example, the NHS knows that reducing absence can ensure that the equivalent of more 15,000 nurses are available each year. Royal Mail found that even a small fall in the use of agency staff prompted by staff absence could increase the number of parcels delivered on time by over 800,000 a year.

There are other 'hard' benefits of improved wellbeing, such as reduced accidents and improved customer retention, but now might be the time to emphasise other, less tangible advantages. In an increasingly 'knowledge-based' economy, for example, we should promote the links between emotional wellbeing on our ability to concentrate, collaborate and innovate. We should also convince more employers that 'patching up' employees who become unwell is less efficient than preventing their work contributing to poor health, and that efforts to improve access to early support and vocational rehabilitation are essential. I've become sceptical that simplistic and one-dimensional claims about the 'return on investment' of workplace health interventions carry much weight with employers. Looking forward, a legacy of COVID-19 may be that the moral arguments for investing in employee health will become at least as important as the business arguments.

CONCLUSIONS

- **COVID-19** has shown the need for, and value of, high-quality OH services
- **More** research is needed in three key areas of health and work: working life; COVID-19 and home working; and unsolved problems concerning physical and chemical risk factors and work participation
- **A radical** way of achieving quality control and clinical governance in OH could be to use revalidation as a mechanism to ensure OH practitioners only work in clinical services meeting accreditation standards
- **Employee** health and wellbeing is a crucial business continuity issue, but there is a need for greater involvement of OH at an earlier and more strategic stage of an organisation's approach
- **OH laws** protecting workers' health and safety, promoting equality and safeguarding health data should not be watered down after the UK leaves the EU
- **Systemic** inequalities have contributed to adverse health and work outcomes for BAME workers even before the COVID-19 pandemic, and will continue to do so unless we take urgent action; more effort is also needed to ensure equality for clinicians from BAME backgrounds
- **The lasting** legacy of COVID-19 on OH businesses could well be the increased focus on programmes to support mental health, but providers should also focus their marketing on proactive rather than reactive services
- **The three** professional bodies representing OH nursing can work together to offer a collective and collaborative approach to strengthen the voice of practitioners
- **The NHS** should recognise occupational medicine and OH nursing as clinical disciplines that can contribute to healthcare beyond OH services for staff
- **OH** nursing is a multifaceted discipline that can influence the health of the population as much as any 'clinical' specialism
- **The moral** arguments for investing in employee health – highlighted by COVID-19 – will become at least as important as the business arguments
- **Promoting** the 'cool stuff' carried out by OH practitioners will help persuade young doctors to aspire to a career in occupational medicine

How can we make OH an attractive career for young doctors?

Dr Paul McGovern, senior lead occupational physician, Transport for London

What did you want to be when you grew up? Doctor? Bus driver? Astronaut? Ice-cream seller? I bet when you were five, it wasn't occupational physician.

Children want to be doctors for the same reasons they want to be train drivers. Driving a train is cool. Selling ice cream is awesome. I'd be excited even to meet an astronaut. When people think of doctors, they imagine a heroic lifesaver with sexual magnetism, a healthy bank balance and lots of respect. Anyone who works with doctors in real life know the truth of course, but the image that pops into people's heads when they hear 'doctor' is positive, and it keeps students flocking to apply to medical schools.

If you Google 'what is occupational medicine?' what you get is reliably dry. Phrases like 'wide-ranging', 'preventing and managing', and 'workplace factors' yawn out at you from the screen, prompting a quick look for something more entertaining, like cats. People don't know how fantastic this specialty is. Since I first started in OH, I've been to factories and watched diggers, cars, hummus and hip replacements get made. I've watched massive bits of metal cleaved in two by plasma cutters, and been into a train station when it was still a hole in the ground. I've watched journalists make the news, and helped people get back to a job they love, that they never thought they'd be able to do again. This is routine in occupational health.

Whenever I ask people in OH about cool things they've done, they talk about going on bin lorries and designing evacuation plans and helping patients decide what they're going to do with their lives and companies how to avoid getting sued. They've worked at home and abroad and for huge companies and themselves. They do all clinical work, no clinical work and everything in between. They speak truth to power and stick up for people who have no one left to help them. And they enjoy their jobs.

Fighter pilots and ice cream sellers have drudgery and paperwork in their lives, but no five-year-old thinks about that. Nor does anyone who aspires to get into a great new line of work. How do we make OH an attractive career? We tell people about the cool stuff we do. They'll work the rest out themselves. ■

Questions by John Ballard

Notes

1 Black C. Working for a healthier tomorrow. London: Department for Work and Pensions, 2008. ohaw.co/BlackReview

2 Boorman S. NHS health and well-being. Final report. London: Department of Health, 2009.

3 Black C, Frost D. Health at work – an independent review of sickness absence. London: The Stationery Office, 2011.

4 We are the NHS: People Plan 2020/21 – action for us all. London: NHS England, 2020. ohaw.co/NHSPP (see: Occupational Health at Work 2020; 17(3): 6–7).

5 Health and well-being at work: survey report. London: CIPD, 2020. ohaw.co/CIPD2020

6 Walker-Bone K, Channa S et al. Occupational health: the thin line protecting the front line. Occupational Medicine 2020; 70 (5): 292. ohaw.co/Walker-Bone2020

7 Pattani S. An insight from a NHS occupational health physician during COVID-19. Occupational Medicine 2020; online first: kqaa137. ohaw.co/Pattani2020

8 First experience of COVID-19 screening of health-care workers in England. Hunter E, Price DA et al. The Lancet 2020; 395, (10234): e77–e78. ohaw.co/2JyRx7k

9 Boustead K, Kiera McDowall K et al. Establishing a healthcare worker screening programme for COVID-19. Occupational Medicine 2020; 70(7): 456–457. ohaw.co/3ewF4fP

10 Matthewson J, Tiplady A et al. Implementation and analysis of a telephone support service during COVID-19. Occupational Medicine 2020; 70(5): 375–381. ohaw.co/2I3OUK5

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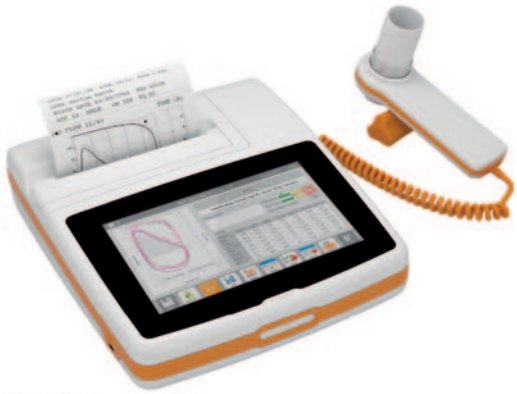

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