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The Black Report: key themes

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A watershed a once-in-a-generation opportunity - Dame Carol Black's review of workplace health and its potential effect on occupational health has been described as many things. But as the dust settles and we await the government's response with bated breath, it is clear there are many vital issues that will have to be thrashed out over the coming weeks and months. *Occupational Health* takes a look at some of the key issues that have been brought firmly into the spotlight. Nic Paton reports.

The capacity of OH to deliver

How occupational health - as a relatively small (and ageing) speciality - can physically meet Black's ambitious aspirations is set to be one of the key challenges going forward, and something that will need a lot of careful thought and debate, the profession and observers agree.

Dr Gordon Parker, president of the Society of Occupational Medicine (SOM), for example, suggests that any Fit for Work service will need at least a further 1,800 OH doctors if it is to have a "competent clinical lead".

So where are the extra numbers of OH physicians, nurses and even technicians going to come from?

At a basic level, there may need to be a fundamental rethink of training posts and their funding and, as Black identified, a requirement to bring OH into the health mainstream and to encourage more nurses and doctors to consider the profession at an earlier stage in their training and careers.

Nevertheless, Black's vision is one that OH should be leading, agrees former Royal College of Nursing professional occupational health nurse (OHN) adviser Sharon Horan. "There is a very big emphasis and acknowledgement that OH can be leading within the workplace," she says.

But increasing capacity is not something that can be achieved overnight, she cautions. "This is a long-term strategy, and we must not lose sight of that fact."

It will also, clearly, be a question of OH nurses in future working smarter, such as making more use of technicians, GPs, health and safety practitioners and other healthcare professionals.

Fit for Work teams

Perhaps unsurprisingly, virtually everyone - doctors, nurses, commercial providers, the private sector, health and safety practitioners - sees Fit for Work teams as an opportunity to be grasped.

But what is also clear is that there will need to be debate - much of which will probably emerge during the piloting process - on their structure, who leads them and the role of each practitioner group within them.

An instant-access Fit for Work/OH service that you could step into the moment you step out of your GP's surgery would be a logical and attractive step, but would also entail a fundamental change in how primary care cover is delivered, commissioned and organised, points out Dudley Lusted, head of healthcare development at health provider and insurer Axa.

Jenny Leeser, clinical director for occupational health at Bupa, agrees with Lusted that there are potential opportunities for private sector providers within the Fit for Work service. "We would be keen to play our part within it, although there could, of course, be commissioning and funding - issues that would have to be sorted out," she says.

Occupational physicians could play an important part in spearheading the multidisciplinary teams envisaged by Black as part of the service, argues Dr David Snashall, president of the Faculty of Occupational Medicine (www.facocmed.ac.uk). Physicians already offer some form of health and wellbeing consultancy within their own work and so would be familiar with Black's further idea of a consultancy service for smaller businesses, he adds.

Health and safety practitioners could also be a key part of the make-up of Fit for Work teams, stresses Ray Hurst, president of the Institution of Occupational Safety and Health (IOSH). "I think it has to be a multi-disciplinary approach. We as safety professionals have a key role to play in that.

"In the past there has not been quite so much close working between the medics and the safety practitioners, and sometimes there has been a clear dividing line. But this clearly has to be a close, collaborative effort," he adds. "That is the only way it could work."

The case management focus that would be required within any Fit for Work service is also potentially a step forward, argues Anne Harriss, OH course director at London South Bank University.

"I cannot see any reason why someone who is an experienced case manager could not work and work well within a Fit to Work team," she points out, although she added that teams would have to be able to demonstrate clinical effectiveness.

Fit/well notes and the role of GPs

British Medical Association (BMA) council chairman Dr Hamish Meldrum stresses GPs have long desired change on sicknotes and are not dragging their feet on this issue. However, he also sounds a cautionary note in that, ultimately, a GP's first loyalty will always be, and must be, to the patient sitting before them.

"GPs are often placed in a difficult position when issuing sicknotes to patients in the early stages of their illness and it is not always possible for them to confirm whether a patient is well enough to do their job," he says. "This is often determined by the nature of their job and working environment.

"A major, additional problem is that GPs can have huge difficulties in accessing physiotherapy and counselling services that would help patients to return to work more quickly," he adds. "The detail of

how a 'well note' system would operate needs to be carefully examined, including the workload implications and the avoidance of any conflict of interest," he continues.

What also needs to be recognised is that the UK's GP population is not a single body all thinking in the same way, says Horan. Some "get it" when it comes to workplace health, while others clearly do not and never will. Taking a stick therefore to the entire GP population and forcing them to engage with the workplace health agenda may be counter-productive.

"There has been a big exercise in enlisting the help of GPs and we have to acknowledge that some are more interested in this than others," she says. "We are flogging a dead horse in trying to make doctors get involved if they do not want to be."

There may also be the likelihood, as Parker pointed out in Occupational Health last month, that some GPs will simply write "suggest referral to OH" on any fit note so, again, batting the ball back into the employer's court, whether or not there is OH capacity to deal with the issue.

The role of line managers and employers

Just like taking a horse to water, you can only reduce sickness absence if managers want, listen to and act on the advice you give, argues Geoff Davies, a director of the Commercial Occupational Health Providers Association (Cohpa).

Black's focus on the failings, and importance, of line managers was therefore spot on, agrees Dr Les Smith, managing director of the consultancy Health and Wellbeing UK (www.hwbuk.com).

"One of the biggest barriers for fast return to work is the lack of knowledge of line managers," he says.

"Line managers are crucial. If they are not engaged or do not understand the policy it gets very difficult. The line manager sets the management style and the culture of the team, and that in turn drives the sickness absence," he adds.

This doesn't mean line managers need to become doctors. Rather, they need to have some working knowledge of common health conditions, particularly musculoskeletal disorders or psychological or mental health issues, he suggests.

This is in part to ensure they know when not to intervene themselves but call in the professionals and also to help them to understand when and how to act.

"Training for sickness absence programmes is often given by HR when they have never managed a case in their lives. So there is a case for doctors and nurses to be more involved, not in teaching managers about the medical conditions, but the effect of the medical conditions on things such as functionality or availability to work," Smith points out.

"Employers must take more responsibility for promoting the health and wellbeing of their staff, including much wider provision of proper OH services that specialise in health at work, rather than the patchy occupational illness services that we have at present," agrees Meldrum.

Harriss argues that Black also missed a trick by not recommending that the government make it mandatory for employers to provide access to some form of workplace or occupational health - service.

Standards and accreditation

On the issue of the need for a wider evidence base, the work of the Occupational Health Clinical Effectiveness Unit will, Horan says, become increasingly important over time. Similarly, ongoing work by the British Occupational Health Research Foundation and the National Institute for Clinical Effectiveness is beginning to build up an evidence base for workplace health intervention, although there is still a long way to go.

The Black-commissioned [research by PricewaterhouseCoopers \(PwC\), Building the Case for Wellness](#), also adds to this growing evidence base. PwC was asked by the review to consider the wider business case, and specifically the economic case, for employers to invest in wellness programmes for their staff. As Black concluded: "PwC found considerable evidence from literature reviews and more than 50 UK-based case studies that health and wellbeing programmes have a positive impact on intermediate and bottom-line benefits.

"Intermediate business benefits include reduced sickness absence, reduced staff turnover, reduced accidents and injuries, reduced resource allocation, increased employee satisfaction, a higher company profile, and higher productivity," she added.

But, as Horan stresses: "We definitely do need national standards. The review leads the way and it opens doors for us to move on."

From the educational perspective, one thing that may need to be looked at is whether there could be a greater emphasis on mental health and vocational rehabilitation, argues Harriss.

"I think it is an opportunity for OH practitioners to really take a lead on things like rehabilitation. Maybe, for example, we should be thinking carefully about OH practitioners doing specialist rehabilitation courses," she suggests.

When drawing up standards there needs to be recognition of commercial operating issues as well as medical ones, argues Davies. "For example, drawing up standards on how we do an audiogram is all fine and well, but then you also need to be looking at how do you do an audiogram on, say, a construction site? Do you need to do it in portable accommodation, or would a van be quiet enough? Do people need to take time off work, and should they be going off site?" he asks.

The evidence base does need to be built up, says Hurst. "There needs to be more evaluation of the efficacy of workplace intervention, and the findings need to be shared to strengthen good practice."

Funding, and getting the message to SMEs

The elephant in the room, as it were, and conspicuous in the review by its absence, was the Treasury, points out Lusted, and in particular, what sort of financial carrots will be able to be offered to SMEs. It's a moot point, for instance, whether employers will be happy to take the cost of a Fit for Work service on the chin or through higher insurance premiums, or whether tax rates will have to go up - surely a completely unpalatable political option for a government trailing in the polls and just a couple of years away (at most) from a general election. And in these more uncertain economic times, how likely is it that the purse strings will, or even can, be loosened enough to make Black's vision for healthcare a reality?

SMEs, agrees Davies, will be a key challenge, and getting them on board is closely interlinked with

the issue of funding. "As a small business, are you going to spend £250 on an OH report and then give someone the job of overseeing and monitoring that person's rehabilitation? No you are not," he says. "There is no financial benefit for a small business in going down the OH route and doing a return-to-work programme.

"Until the Treasury says there will be tax rebates for return-to-work programmes, it is not going to change. SMEs also, on the whole, don't pay sick pay. Therefore, there is no benefit for them whatsoever in doing occupational health.

"If you are a low-margin organisation employing just four or five people and you have to have someone covering return-to-work and checking they have access to occupational health, that is a complete nightmare," he adds.

Leeser agrees there is a clear need to do more to reach out to smaller and medium-sized enterprises. "I do think everyone is ready. Everyone is keen to be involved and it is just knowing what being involved will look like," she stresses.

Yet, while the key will clearly be the government response, which is expected over the summer, and with some suggestions that we could be looking at as soon as the end of May or early June, Horan, for one, remains cautiously optimistic. "Ministers seemed very happy with it at the launch and appear to have been very happy all the way along. There has been a lot of modelling going on at different levels all the way through the process," she says.

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