THE **COUNCIL** FOR
WORK**&**HEALTH

Planning the future:

Delivering a vision of occupational health and its workforce for the UK for the next 5-20 years

"Good work is good for health, good for business and good for national prosperity"

FOREWORD

Through collaborative and partnership working this project aims to clearly articulate a vision of how occupational health should be delivered over the next 20 years and identify the medium and long-term workforce planning that is needed to support that vision.

The approach that we have taken and the planning process means that all stakeholders can become actively involved in shaping this vision. By working together we can influence what our future services will look like, the way they will be delivered and ensure that we effectively plan our services and the workforce needed to deliver those services.

Occupational health professionals improve the health of the UK's working population, increase the productivity of UK businesses and enable our public services to become more efficient and cost effective.

The professions, including those from a range of medical health specialities as well as associated professions[1] can play a major part in revitalising the UK's economy. It is a unique multidisciplinary approach that prevents work related illnesses; provides early interventions for those who develop a health condition, reduces sickness absence and uses the workplace to promote health and wellbeing. We are distinctive because we offer a holistic approach that focuses on the person, their work and the business rather than just the disease.

This report has been prepared for the members of the Council for Work and Health but the contents are relevant for a much wider group of stakeholders. There is a compelling case for change and this report sets out the first steps in making that change happen.

This is an opportunity for us to deliver a 'step change' for occupational health. It is vital that together we demonstrate and raise awareness of the pivotal role we can contribute and ensure we have an occupational health workforce that is fit for the future needs of all workers and employers in the UK.

Professor John Harrison
Chair, Project Working Group

[1]Throughout this report occupational health refers to the full range of healthcare professionals and other resources involved in improving health and work. A list of the main medical and other associated healthcare professionals involved in providing work and health services is provided in appendix 9.

CONTENTS

Appendices

1 EXECUTIVE SUMMARY

This paper presents the findings of a Project Working Group established by the Council for Work and Health Executive to take forward a project to develop a vision for occupational health practice and a consequent workforce plan to underpin the delivery of the vision.

The Working Group was established to;

- Define the UK population(s) to be addressed

- Consider the drivers for and constraints of provision of OH resources

- Conduct a review of the evolving UK health service and health education economies and the potential impact on provision and development of OH resources

- Map key stakeholders and the actions required to manage their expectations

- Provide a prospectus to secure support and future funding for the project

- Formulate the communications strategy in support of the outcomes of this work

The Working Group was chaired by Professor John Harrison and a list of members can be found at appendix 3.

The Working Group used *the Population-Centric Workforce Planning tool* (appendix 2) as the framework for their approach, with, particular focus upon defining the population(s) of concern for occupational health and conducting a strategic analysis of the environment.

A literature review, together with a series of structured telephone interviews was undertaken. A stakeholder workshop with 30 participants was then held in January 2013 to test some of the emerging ideas and hypotheses. Key to the methodology was the development of a series of case studies that bring the clients and markets of the future to life.

In considering our target population of the future, our strategic analysis suggested that the current scope of 'working age population' should be extended to include those who are most likely to consume or benefit from occupational health advice over the next 20 years.

We identified these particular groups as;

- Those in the age range 16 – 75 and in work

- Those with a higher risk of falling into worklessness

- Those with pre-existing conditions known to impact fitness for work

- Those with increased prevalence of chronic disease [e.g. age 50+]

- People working in SMEs

The strategic analysis also suggested that there would be three main driving forces for change in the organisation and delivery of occupational health services over the next 20 years;

- The economic situation and availability of funding

- Demographic shifts in the UK working population

- The pattern of chronic and long term conditions

These three main drivers are supplemented by increasing globalisation, technological change and changes in the education and training of healthcare professionals.

The ten case studies illustrate a range of client groups and reflect changes in the way that occupational health will be delivered in the future.

A compelling case for the development and repositioning of occupational health has been made. This centres on the strategic themes of using the workplace to improve health and wellbeing, preventing work-related illness, delivering integrated care - particularly to those with long-term conditions, and managing sickness absence. They meet the needs of government and business by contributing to prosperity and the public health agenda and they are consistent with the philosophy of occupational health that good work is good for health, good for business and good for national prosperity. The case studies give examples of occupational health interventions that are consistent with these themes; they depict target populations and markets with the strategic analysis to provide an evidence base for a model of occupational health practice and service delivery.

The Working Group recommends the following actions;

- This project has laid the foundations for taking forward stages 3 – 5 of the workforce planning approach (see appendix 2). We recommend that the Council for Work and Health lead the implementation of stages 3 – 5 to be completed within 12 – 24 months.

- The Council implements the communications plan which engages key stakeholders and aligns our messages to promote a consistent vision of occupational health.

- We recommend that the Council develop and implement a marketing campaign for occupational health which promotes the demand for occupational health and ensures there is sufficient capacity of suitably trained and competent practitioners to deliver the demanded evidence based interventions.

This report presents the findings of a working group established by the Council for Work and Health Executive to take forward a project to develop a vision for occupational health practice and a consequent workforce plan to underpin the delivery of the vision.

The changing demographics of the UK population, and in particular the working population bring the interface between work and health to the centre of political debate about how economic growth can be stimulated and maintained, as the demands for health care rise inexorably.

The Health and Social Care bill brings significant changes to the commissioning of services. Clinically led commissioners will require significant guidance from occupational health leaders regarding the needs of populations over the next 5 to 20 years if they are to make informed occupational health purchasing decisions.

Changes in public health (England) also present opportunities to shine a light on the demands placed on health budgets that are amenable to management in workplace settings. Workplaces are environments where most people spend most of their working age life. Work and the workplace are responsible for a number of chronic health conditions with around 450,000 new cases of occupational related ill health reported annually. They are also rapidly becoming places where the lifestyle factors that contribute to the future burden of health can be addressed as a sine qua non for keeping people economically active. Health and wellbeing boards will need evidence-based information to guide them towards sensible occupational health resource plans for their working age populations.

To meet these challenges and opportunities, considerations must extend beyond those currently in work and to those who are capable of being in work. The Marmot review, *Fair Society, Healthy Lives, 2010* reinforces the aphorism that "good work is good for health and that worklessness is not," acknowledging that "the more favoured people are, socially and economically, the better their health." As one of six policy objectives he called for "fair employment and good work for all,".

The ageing worker population means that the way long-term conditions are perceived and managed will become increasingly important determinants of employability. About 42% of 50-64 year olds, the bedrock of the productive workforce have at least one chronic disease or disability. While they may not fit the 1948 definition of health - "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" - most will be fit for work.

Occupational health professionals have a pivotal role in advising employers and employees of "what good work looks like," and creating the evidence base for defining what physical and mental capabilities are required to deliver it. They help describe the arrangements for preventing people from falling into worklessness, and rehabilitating them from worklessness. For employers they reduce costs by advising on mitigation of risks from the workplace or from work practices, minimising the impacts of health risks to the business in areas such as complying with the Equality Act, identifying work-related disease at the earliest point, facilitating early intervention and treatment, complying with health surveillance, and, where

required, advising on statutory reporting of work-related disease. Of no lesser importance is their contribution to productivity as they advise on optimum human and organisational factors to reduce work stress, ensure fitness for work, and the management competencies required to address worker attendance and sickness absence.

Just at the time when occupational health is becoming so important to so many, the specialists within the occupational health team are under threat - fewer physician trainees are entering the profession and there are similar challenges for nurses and the allied professions. The funding for training is unsustainable, the research base is diminishing and affordable access to comprehensive occupational health services for the majority of the UK's working age population is limited or non-existent.

Occupational health should be a mainstream speciality that is integral to protecting, maintaining and improving the health of the working age population. Long-term resource planning, and the underpinning training framework to deliver that resource over the next 5-20 years is as critical as the evidence-based pathways for managing work-health issues for the delivery of a healthy workforce, and a healthy economy.

In response to the challenges described, UK occupational health leaders are becoming a more coherent force for change and positive action. Since its formation in 2011 the Council for Work and Health has facilitated a joined-up approach to cross-functional occupational health planning by bringing together the voices of the key actors, with the competencies and will to design and articulate the multidisciplinary occupational health priorities, and to champion the work streams to deliver on them.

3 BACKGROUND

This project builds on outputs from workforce planning workshops held in 2012. Fundamental to the modus operandi of the project has been an agreed vision, philosophy and set of principles that have grounded the future-focused work and which were developed at a stakeholder workshop held on October 15th 2012 (appendix 1). If the philosophy "good work and workplaces are good for health, good for business and good for national prosperity" is to be more than a mere aspiration and the vision of universal access to occupational health to create better health and business productivity is to become a reality; the clear articulation of the occupational health workforce needed to deliver that vision for UK workers must be a priority.

Integral to that articulation is clarity regarding the most efficient and productive way of providing universal access to consistently high quality occupational health provision. This requires an exploration of potential models of provision to anticipate capability supply challenges, training needs, and seamlessly juxtapose options within the landscape of professional career development; occupational health must be an attractive career route for the different professional groups engaged in the delivery of occupational health leadership and service.

The framework that has been adopted to shape the project is called population centric workforce planning (appendix 2). A fundamental focus for the framework is on target populations – it starts with 'who' occupational health will need to help in the future. Case studies are used as a method to bring the planning process to life. A second key aspect of the framework is the recognition that workforce planning is a change management process. This project is concerned with transformational change of occupational health practice. Bevan states that 75% of change initiatives fail to achieve their objectives. Key determinants of success are duration of change, performance integrity (the right mix of team members to deliver change), commitment and effort. The framework recognises that effective transformational change is not quick. There are a total of six stages in the planning process; each stage may be subject to review before the final reality check and gap analysis. Commitment to change will require leadership from respective professional occupational health organisations as well as engagement with and support from grass roots practitioners. Finally, there must be a realistic appraisal of the time and resources required to sustain the change process.

The scope of the project to date has been stages one and two of the framework - defining the population(s) of concern for occupational health and conducting a strategic analysis of the environment that will influence workforce planning. The findings form the basis for moving forward to the remaining stages and make recommendations as to how this might be achieved.

Accordingly, and with the support of the Executive Committee of the Council for Work and Health, a working group (appendix 3) was convened to:

- Define the UK population(s) to be addressed

- Consider the drivers for and constraints of provision of occupational health resources

- Conduct a review of the evolving UK health service and health education economies and the potential impact on provision and development of occupational health resources

- Map key stakeholders and the actions required to manage their expectations

- Provide a prospectus to secure support and future funding for the project

- Formulate the communications strategy in support of the outcomes of this work

4 METHODS USED

A feature of this project has been the use of scenario generation to draw together diverse sources of information to highlight important aspects of occupational health delivery, describe the population of interest, engage stakeholders and secure funding for the subsequent stages of the workforce-planning project. A number of case studies have been developed to bring these issues and themes alive and 'make the case'. These are the personal representations of the 'essence of occupational health'. We are using them as symbols or to 'paint portraits' to show the real need of occupational health services in the future. They demonstrate the benefits we can bring if we effectively plan for the future. Key themes were identified via telephone interviews with members of the working group, further developed during a stakeholder workshop and finalised by a sub-group of the main working group.

A *literature review* was carried out by Adrian Baker. This involved a hand search of grey literature. To make the search more manageable it focused on key issues including:

- How the demographics of the UK population will change within the next 25 years

- How future health needs will change within the next 25 years, particularly around cardiovascular disease, obesity and diabetes, cancer, Alzheimer's and dementia, long-term conditions and infectious diseases

- How these changing demographics and future health needs will affect occupational health in the next 5, 10, 15 and 20 years

- How work will change

- How technology will change

- How the health system will change

- How workplace exposures and risks will change

- Whether, given all the above changes, occupational health can remain with the status quo.

Given the above questions and themes, a search of journal articles would not have been practical. As well as a Google search of key terms, reports and work from a number of think tanks were analysed. Pieces from the King's Fund, the Nuffield Trust and the Work Foundation were used as they had particularly relevant insight around the questions guiding the literature search. Whilst there was a plethora of articles on technological changes and medical miracles, the literature review sought to ground itself in the theory of change management; in that, changes to occupational health would emerge from areas where there is the most pressure for change. As such, the unequivocal force of demographic changes, the increasing proportion of long-term conditions (including preventable conditions arising from work), the rising numbers of those employed by SMEs and in self employment, and the financial pressures facing the NHS will influence the diffusion of innovation within occupational health and guide any potential strategy. Some long-term conditions may be caused by the conditions in workplaces, and so the prevention of exposures that could cause such health effects to occur would ease the future burden on the NHS, as well as preventing the suffering of those concerned and their families.

Telephone interviews were carried out by Carol Brooks of Prospect Business Consulting Ltd. Available members of the working group agreed to participate in semi-structured interviews

to assist with defining the population, defining the strategic environment and stakeholder management / engagement. Information was obtained from 6 interviewees. The questions and themes identified in the semi structure interviews were then used to inform the key issues considered in the literature review and as the basis for the themes to be discussed at the stakeholder workshop.

A *stakeholder workshop* was held on January 8th, 2013. There were 30 participants. Outputs from the workshop were:

- Future clients / markets
- PESTEL analysis
- Stakeholders
- Shaping the future
- How do we take things forward?

The themes were then fleshed out and expanded by developing case studies.

The *case studies* present a series of scenarios that describe clients and markets of the future. Thus, the following conditions and issues were identified as important drivers of the occupational health market:

- Long-term conditions, such as diabetes, cancer, Parkinson's disease and dementia
- Work-related illness such as cancer, COPD, asthma, musculoskeletal conditions such as work-related upper limb disorders and back pain, and noise induced hearing loss
- Mental ill health and co-morbidities (alcohol, smoking)
- Obesity
- Disability
- Integrated care
- People capable of work but not in work
- Rehabilitation back to work
- Infectious and emerging diseases and changes in risk profile (for example nano technology and new chemicals)
- Ethnicity and health
- Use of new technology and other innovative ways to deliver healthcare
- New ways of working and service delivery

5 POPULATION DEFINITION AND POTENTIAL MARKETS

The current scope of "working age population" could include all persons over 16 years that are potentially capable of paid work. It is appropriate to focus the attention of the working group on a narrower population in the first instance, say 16-65, noting that the UK population will have an increasing proportion of people over the age of 65 years over the ensuing decades who either wish to or have to work beyond this age. The age of pension entitlement is likely to increase accordingly, such that many more people will be at work in their 60s and 70s.

In addition, it was agreed to stratify the populations, identifying those who are most likely to consume or benefit from occupational health advice both now and in the next 5-20 years. For example;

- those with a higher risk of falling into worklessness
- those with pre-existing conditions known to impact fitness for work
- those with an increased prevalence of chronic disease (e.g. age 50+).

6 | CASE STUDIES

Where does occupational health need to focus its activities and the provision of services in the next 5-20 years? What is the future market of our services?

The following 10 case studies provide a 'pen portrait or profile' of some of the typical people we see the profession providing a service for and the benefit that occupational health in the broadest sense will be able to bring. These case studies are not 'real' people but are designed to bring the planning process to life. They illustrate a range of client groups and markets and reflect changes in the way that occupational health will need to be delivered in the future.

Occupational health is unique in that it addresses the wider questions of the health and wellbeing of the working population and provides holistic solutions. As the UK's workforce becomes older, more people will have multiple issues and conditions that will impact on work, we will need to think about 'working people' rather than 'diseases'.

Tracy, 32, baker has worked in a small bakery for 5 years. During the last year she has become aware of intermittent wheezing and shortness of breath, that disappears when she is away from work or when on holiday. She has had some time off work because of her symptoms, when they are particularly bad, but most of the time she puts up with them. Her GP has prescribed her an inhaler, which gives her short-lived respite from her symptoms but they have not gone away. She is worried that, as a young woman, she is becoming disabled.

One in six cases of asthma in people of working age is either caused or aggravated by preventable work-related factors. Certain industries and trades carry a much greater risk such as vehicle paint sprayers, bakers, laboratory workers, certain workers in the chemical industry and those carrying out electrical soldering. Work related asthma is preventable with provision of good multi-disciplinary occupational health services, including advice on risk assessment and on how to adequately control exposures to respiratory sensitisers such as flour dust, plus health surveillance on those who may be exposed. Many of the people exposed, like Tracy, work in SMEs with little or no access to occupational health. **SMEs currently account for 99.9% of all private sector businesses and employ 14.1 million people – only one in 10 small employers provide access to any occupational health provision, and even fewer have access to allied health professions.**

Work and the workplace are responsible for a range of chronic health conditions (including asthma) with around 450,000 new cases of occupational related ill health reported annually and it is estimated that at least 12,000 deaths each year are being caused by past exposure to working conditions.

We need to ensure that people like Tracy have access to good occupational health information and support. Tracy's employer should have training about occupational health conditions as part of the management of risk in the workplace. More importantly, employers like Tracy's should have access to appropriate occupational health specialists, to help assess and manage the risks to health in the bakery, and so prevent Tracy from becoming sensitised to the flour dust in the first place. Research indicates that up to 80% of GPs do not record their patient's occupation in their notes. Tracy's GP should have core skills in occupational health and then should be able to refer to a specialist if first line measures to control the symptoms are ineffective or to confirm the diagnosis. There should be accessible and reliable sources of occupational health information – for example by ensuring that NHS Choices includes occupational health advice for a range of conditions.

Matt, 60, is a postman with a bad back. His back has troubled him, on and off, for some years and he has had time off work because of it. His job involves driving around a picturesque rural community and he loves his job. He is worried about the prospect of retirement and he would like to keep working for as long as possible. However, he has been under increasing pressure from his boss, who says that he is becoming slow. As a result he feels quite stressed.

In the UK, one third of the population will be over 60 by 2033 – increasingly many people will have to work beyond current retirement ages either by choice or necessity. **80% of the adult population will suffer with back pain at some time in their working lives.** Back pain and other musculo-skeletal aches and pains are the single biggest cause of sickness absence. As well as the cost to the individual in terms of pain and discomfort, there is also a huge financial cost to employers resulting in lost working days, increased sick pay and reduced productivity. The TUC estimate that British businesses lose **4.9 million days per year of employee absenteeism through work related back pain.** The cost of back pain to the exchequer is estimated to be in the region **of £5 billion per annum.** Evidence suggests that appropriate occupational health advice and early access to intervention can reduce this human and associated cost of back pain.

For older employees, pre-retirement advice will need to be adapted. 4th and 5th decade of working courses could provide health coaching and careers advice, as well as guidance on planning finances.

There are many myths about employing older workers. Evidence indicates that individual attitudes and skill sets, rather than age, per se, are the important determinants of performance. Matt's boss will need training to understand the specific needs of the older worker and to be aware of how simple work adjustments could help Matt continue to be healthy and effective at work. He also needs access to specialist advice and support. Matt's manager needs to learn to avoid age stereotypes, and consequent age discrimination, by being given positive information about the characteristics of the older worker and to ensure that employment decisions are evidence-based, with the help of occupational health advice.

Matt needs rapid access to therapies to help him manage his chronic back pain and his current stress and to be able to access appropriate occupational health advice that will analyse the functional impact of his symptoms with a view to suggesting adjustments, negotiate change with Matt and his boss and offer case management support until the changes have been established.

John, 25, call centre operative in the complaints section. He suffers from obsessive-compulsive disorder (OCD). He feels under a lot of pressure to meet targets and he works long days. His GP has told him that he is suffering from anxiety and he has been referred for cognitive behavioural therapy. However, the waiting time for NHS treatment is over 8 weeks and he is worried that he may have to take sick leave in order to cope.

More than one million people now cite mental or behavioural problems in support of claims for sickness benefits – a rise of more than 200,000 in a decade. It is estimated that each year **one in six workers in England and Wales is affected at any one time by anxiety, depression and unmanageable stress.** Research by the Chartered Institute of Personnel and Development finds that it is not just absence that hits business. Most people with poor mental health continue to work yet may struggle with concentration, making good decisions and providing effective customer service. It is estimated that this 'presenteeism' costs UK businesses £15.1 billion per year in reduced productivity, while mental health related sickness absence costs £8.4 billion.

OCD is estimated to affect about 1.2% of the population. The presence of symptoms may interfere with work because of the impact of obsessive thoughts or the need to carry out ritualistic behaviours. The social impact of OCD may lead to the development of other mental health problems, such as depression.

John's type of work may mean he is experiencing job strain, the combination of high job demands and low control at work, which has been associated with a more than 20% increase in coronary heart disease. The World Health Organisation estimates that by **2020 depression will have become the second leading cause of disability in the world** – the workplace is a key and cost effective environment to address this. John's employer should be aware of the guidance on mental health at work, such as "No Health Without Mental Health" and the "Time to Change" campaign funded by the Department of Health. John needs to be able to understand his underlying condition and how it might affect him at work. OCD may be treated using cognitive behavioural therapy (CBT) and it is important that the workplace component forms part of this. Many occupational health practitioners are skilled in CBT techniques or will have access to a trained therapist or occupational psychologist. His employer needs to know what adjustments could be made to assist John. Easy access to specialist occupational health information and advice is required. If working in the call centre proves to be impossible, John needs advice and help to find and move to a more suitable job.

Dipti, 45, secretary is now finding work difficult because her eye sight has deteriorated. She is overweight and has type 2 diabetes, high blood pressure and a raised serum cholesterol, for which she now takes a multitude of tablets. She feels that she is starting to fall apart.

There are **2.9 million people who have been diagnosed with diabetes in the UK** and a further **800,000 suspected undiagnosed.** By **2025, it is estimated that five million people will have diabetes** in the UK. Type 2 diabetes is up to **six times more common in people of South Asian** descent and up to three times more common among people of African and African-Caribbean origin. By 2031 ethnic populations will make up 15% of England and 37% in London. The workplace is an ideal environment to assist employees with long term chronic conditions and all employees benefit from strategies for controlling diabetes because these strategies can also reduce the risk for, or help to manage, other chronic diseases, including heart disease, stroke, high blood pressure, and obesity. Provision of targeted education addressing diabetes and work, coupled with easy access to clinical expertise in the workplace should be part of an integrated care pathway for this condition.

In England **65% of men and 58% of women are either obese or overweight.** Obesity reduces your life expectancy by around nine years on average and is responsible for 9,000 early deaths each year in England. Around one in five cases of heart disease are attributed to obesity. Obese workers take more sick days, have longer sick leaves and incur greater productivity losses than do non-obese workers.

A study (by John Hopkins Bloomburg School of Public Health) found that only 44% of general practitioners reported success in helping people lose weight – workplace programmes can tackle obesity on a daily basis by encouraging a healthy diet and active lifestyle among employees through an organisational culture of health and wellbeing and specific health promotion campaigns. Because most employees spend more than a third of their waking hours at the worksite, the workplace has a unique opportunity to provide health and wellbeing information and in facilitating healthy behaviours. For example, her company could have an active travel policy to encourage walking or cycling to and from work. There could be lunchtime walks. There might be women only sessions sponsored by the company at a local gym. There might also be groups of workers that play competitive sports or that organise sporting events. There should be healthy eating options in the staff canteen, with calorie labelling of foods.

Dipti needs to understand her underlying health condition and how she can take control to improve her health and wellbeing. She needs access to information that includes health at work. She needs to become more active and to eat healthily. Her ethnic background means that she is at an increased risk of developing a metabolic syndrome and she might have benefited from health and wellbeing advice from an early age and when she first started work.

Dipti's eye sight problems might be related to her diabetes or may be age related. She will have regular eye checkups because of her diabetes, and she is also eligible for regular eye tests because she works all day at a computer. The ergonomics of her place of work should be assessed. The management of her diabetes, high blood pressure and raised cholesterol should be holistic and integrated and the care pathways should include her occupational health and promoting her work ability.

Milos, 48, CEO of a biotech company in Cambridge. His company employs 50 staff. He is frustrated by the high turnover of staff, which is disruptive and costly to his business. He wants to improve productivity and demonstrate that his company is an attractive place to work. He would like to improve staff morale. He has considered doing something about health and wellbeing but is unsure what.

Every year 140 million working days are lost to sickness absence and employers pay sick pay and associated costs of £9 billion a year.

PriceWaterhouseCoopers have shown that wellness programmes have a positive impact on intermediate and bottom-line benefits. In their report *Building the case for wellness*, 45 out of 55 case studies showed a benefit via a reduction in sickness absence and 18 an improvement in staff turnover.

Milos needs to implement a tailored health and wellbeing strategy based on (a) a health needs analysis of his workers, and (b) an assessment of the health risks to which his employees could be exposed. He needs to look at introducing tangible benefits linked to health and wellbeing such as flexible working; healthy eating/free canteen; "Me" time; fitness programmes at on-site gym or discounted membership of local gyms; address any health and safety concerns by providing user friendly health and safety information and procedures, and he needs to demonstrate commitment to staff via suitable and sufficient workplace risk assessments and transparent health risk management. The Foresight Mental Capital and Wellbeing project identified five ways to mental wellbeing, akin to "five fruit and vegetables a day". A health and wellbeing programme that encourages the following individual actions is supported by an extensive review of published literature: Connect, Be active, Take notice, Keep learning, Give. These five actions are incorporated into the Workwell model developed by Business in the Community.

Margaret, 53, healthcare carer developed breast cancer. Treatment included surgery and chemotherapy. She took time off work during her treatment and, following an absence of 6 weeks is now thinking about returning to work. However, she feels scared to go back. She feels tired all the time and, were it not for her 13-year old daughter, she wonders what is the point of anything. She knows she must get back to work because, as a single parent, she must provide for her daughter. She has been receiving support from a Macmillan nurse, which she has found helpful.

323,000 people are diagnosed with cancer each year and 109,000 are of working age – at the same time survival rates are improving. At least 8,000 deaths and a further 14,000 cancer registrations are estimated to be related to or caused by work conditions; these are all potentially preventable with the provision of good occupational health and occupational hygiene services on how to prevent, or control adequately, exposures to the cancer-causing agents concerned. Research shows that cancer patients have better outcomes at work if they receive support early on to consider how cancer and its treatment might affect their working lives. **More than 4 in 10 people who are working when diagnosed have to make changes to their working lives after being diagnosed.** Research shows single mothers are more likely to be disadvantaged in several areas. They tend to have lower educational levels and a higher likelihood of reporting ill health or disability. They may be low income earners and there tends to be a higher incidence of poverty in the group.

Margaret needs advice and support from Macmillan and her employing organisation. This will enable an informed choice about when and how she will return to work. Occupational health practitioners can supplement the work of Macmillan by ensuring that evidence-based decisions about fitness for work are taken, linking knowledge of the illness with functional ability and the needs of the job. The Disability Rights Commission (DRC) reported that 82% of callers with cancer complained of unfair treatment at work following diagnosis and that their employers were failing to make reasonable adjustments. This is despite guidance from the Chartered Institute for Personnel and Development (CIPD) *Cancer and Work - Guidelines for employers, HR and line managers.* A survey by CIPD found that 73% employers do not have a formal policy for managing employees with cancer and many organisations do not emphasise the importance of provision of information or support. Breast cancer is considered to be a disability under the Equality Act 2010. However, more than 20% employers surveyed were unaware of cancer being considered to be a disability.

The new government funded health and work assessment and advisory service will also be able to offer help and advice so that Margaret has a supported return to work.

Dawn, 52, self-employed and a carer for her invalid mother. Dawn has built up a successful business working from home as a part-time bookkeeper for several small businesses in her locality. She has just been diagnosed with Parkinson's disease. She does not know how she will cope in the future.

One person in every 500 has Parkinson's and most are diagnosed over the age of 50. Changing patterns of employment mean that an increasing proportion of the working population are employed in small enterprises where there is no ready access to occupational health support and almost **4.2 million people of these are currently self-employed** like Dawn. Around 6 million people provide unpaid care in the UK in April 2001 and 45 per cent of carers are aged between 45 and 64. By 2037, it's anticipated that the number of carers will increase to 9 million. In 2001, 1.2 million men and 1.6 million women aged 50 and over in England and Wales were providing unpaid care to family members, neighbours or relatives. This represents 16 per cent and 17 per cent of older men and women respectively. Dawn needs occupational health input to supplement occupational therapy and access to support networks. For example, she needs advice on arranging her job to take account of the functional impact of the Parkinson's disease with provision of working aids, information technology solutions and scheduling her working hours to match her optimal performance hours. We need to look at innovative models of access and delivery including via social media and the internet using smart phones and telehealth.

Steve, 25, unemployed is a veteran of Afghanistan. He was injured during active service and he now has a prosthetic limb. He was discharged by the army with a pension. He managed to find two short-term jobs in the security industry but he is now unemployed. He suffers from depression. He has approached the Citizen's Advice Bureau for help.

The veterans community is a wide and disparate population estimated to be over 10 million people in the UK. The MOD seven stages of medical care needs to be modified for injured or unwell military veterans to achieve employment in civilian life.

There are over 6.9 million disabled people of working age, which represents 19% of the working population. Occupational health can help disabled workers by advising on changes aimed at removing barriers to employment, linked to a fundamental understanding of the relationship between health and work, and of the functional requirements of various job activities. There are currently 1.3 million disabled people in the UK who are available for and want to work.

The skills of occupational health professions are also applicable to helping those, like Steve, who are out of work get back into work. Steve needs access to psychological therapies. He should be able to get help via Job Centre Plus working in conjunction with the Royal British Legion's Civvy Street and other services to develop a programme of support. Occupational health support input could include functional and psychological assessment of abilities and provision of support with workplace adaptation; this would feed into careers advice.

David 50, is a Local Authority Director who sits on a health and wellbeing board. There are concerns about rising levels of obesity amongst fire fighters and impact on operational fitness. He wants to commission a health and wellbeing support programme that uses fire fighters as health and wellbeing champions for the local community.

The standard of physical fitness for fire fighters is high. There is a requirement to climb a 13.5 metre ladder, drag a heavy dummy around a course whilst wearing full protective equipment, perform a ladder lift simulator test, perform an enclosed space test and demonstrate the ability to assemble and carry equipment. To maintain this level of fitness requires a level of training that might be considered to mitigate against the development of obesity. However, Loughborough University study found 53 per cent of firemen were overweight and 13 per cent were obese. In England 24% of men and 26% of women are obese. In the United States, fire fighters have the third highest prevalence of obesity of 41 male dominated occupations. A recent research paper in the American Journal of Industrial Medicine has highlighted five themes that might be relevant to the occurrence of obesity: (1) fire station eating culture; (2) night calls and sleep interruption; (3) supervisor leadership and physical fitness; (4) sedentary work; and (5) age and generational influences.

David speaks to his occupational health team who develop a programme that links requirements for operational fitness of fire fighters, the five themes identified in the research and the specific health needs analysis for the community. The occupational health team work in partnership with the public health team based in the Local Authority. They use health beliefs and change management models to create a shared sense of purpose around obesity and wellbeing. A range of interventions are commissioned that will improve overall fitness as well as weight loss. The emphasis is on making the interventions fun and promoting a community approach to facilitate sustainable activities. A key element is role modelling by the fire fighters. This motivates the fire fighters as health and wellbeing champions as well as encouraging the local community. The team identifies metrics to monitor success and to feedback to the participants. The initiative is covered by the local press and there is a high level of involvement. The Health and Wellbeing Board is impressed with how a workplace-based project can be extended to involve the local community in a way that is mutually beneficial.

Gillian, 40, Human Resources Director working for a local authority has a big problem with high levels of frequent short-term absences in the workforce. Absence rates have been running at around 10%, with the most common reasons for absence being mental ill health and musculo-skeletal conditions. She is determined to halve the current agency bill of £150,000 per annum.

With the help of occupational health, Gillian implements a case management approach to sickness absence management and a new temporary worker approval system. She issues new guidance and training of managers in sickness absence management. The company adopt evidence-based health and wellbeing initiatives and the result is that absence rates fall to below the average for large public sectors organisations in the locality. Gillian halves the agency bill within 12 months.

The Office for National Statistics reports **that 131 million days were lost due to sickness absence in the UK, in 2011.** The trend, since 2003, is for sickness absence levels to fall. On average, about 4.5 days are lost for each worker and the most common reasons for absence are minor illnesses, such as coughs and flu-like illnesses. The cause of absence associated with the greatest number of days lost is musculoskeletal illness. The percentage of hours lost in the public sector is higher than in the private sector: 2.6% compared to 1.6% respectively. Workforces with a higher percentage of women workers and which are larger (over 500 workers) and have older workers tend to have higher absence rates. The North East of England and Wales were the regions of the UK with the highest sickness absence rates. Thus there are many social and cultural reasons that lie behind sickness absence rates that should be considered when planning a programme to reduce absences rates.

A case management approach has been shown to be effective in reducing sickness absence rates, using various models. In Scotland, OHSxtra used case managers working along side occupational health professionals. Workers were able to access physiotherapy, occupational therapy, cognitive behavioural therapy and counselling. **Evaluation of the scheme estimated savings of £1.66 for every £1 spent,** with 99% workers who had been struggling at work remaining at work. The *Return2health* sickness absence initiative, led by the occupational health service at the University Hospital Southampton NHS Foundation Trust, comprised a multidisciplinary rehabilitation programme aimed at staff absent from work for more than 4 weeks. **The proportion of greater than 8 week absences fell giving a difference in improvement in the rate of return to work by 8 weeks of 9%, compared to a control Trust.** This equates to a considerable opportunity cost saving and actual savings where agency staff are used to cover absences.

7   STRATEGIC ANALYSIS OF THE ENVIRONMENT

The purpose was to describe and identify strategic factors that could have an impact on the overall direction of occupational health provision. This needs to be taken into account together with the case studies when designing future service and workforce.

7.1 PESTEL analysis

In the telephone interviews and in the stakeholder workshop, the standard business analysis tool PESTEL (Political, Economic, Social, Technology, Environmental, Legal) was used (Appendix 5b). The results are summarised in appendix 5. They include a mixture of fact and informed opinion about changes anticipated in the workplace, the nature of work and the working environment.

7.2 Driving forces for change

On the basis of our analysis, we believe there will be three main driving forces for change in the next 20 years; finance, demographics and chronic and long–term conditions.

7.2.1 Finance

There will be huge financial pressures on government agencies, including the NHS, as we adapt to care for an ageing population. Appendix 4 shows the massive funding gap the NHS is facing. The solutions to these pressures are not restricted to cost control and radical changes in the delivery of healthcare will be required. This presents opportunities for occupational health to position itself within mainstream healthcare. Work and the workplace can be used to promote health and wellbeing through healthy lifestyles, health risk management and supporting people with long-term conditions as part of integrated care pathways. Improvement to working conditions also mitigates the effects of work-related illness, helping to keep people active in work for longer. The protracted economic downturn is likely to continue for some years. Independent of this, the balance of economic power is predicted to move eastwards and western economies are striving for greater competitiveness. Spending on welfare benefits will reduce and there will be pressure to reduce the costs of sickness absence. Whilst spending on healthcare has been relatively protected, demographic changes will force healthcare delivery to change in order to contain costs and make up funding gaps.

7.2.2 Demographics

The second primary driving force will come from demographic changes. The Kings Fund estimates the following trends:

- Over the next 20 years (2012-2032) the population in England is predicted to grow by 8 million to just over 61 million, 4.5 million from natural growth (births – deaths), 3.5 million from net migration.

- By 2031, ethnic populations will make up 15 per cent of the population in England and 37 per cent of the population in London.

- By 2032 11.3 million people are expected to be living on their own, more than 40 per cent of all households.

- By 2032, life expectancy will increase to 83 years for men and 87 years for women. Healthy life expectancy is growing at a similar rate, suggesting that the extra years of life will not necessarily be years of ill health.

- Over the next 20 years the population aged 65-84 will rise by 39% and those over 85 by 106%.

- The Office for National Statistics estimated that over the past decade, an increasing number of older people (those aged 65 and over) are in work. In October to December 2010

  - 2.7% (270,000) worked full-time, up from 1.2% (106,000) in January to March 2001.

  - 6.1% (600,000) worked part-time, up from 3.4% (306,000) in January to March 2001 (3).

Age group	Numbers by mid-2012	Numbers by mid-2032	Percentage change	2011 census
0-14	9,332,300	10,399,600	11	9,386,200
15-64	34,697,300	37,182,000	7	34,991,400
65-84	7,812,500	10,896,600	39	7,536,300
85+	1,264,400	2,609,700	106	1,193,300
Overall population	53,106,500	61,087,900	15	53,107,200

7.2.3 Chronic and Long-term conditions

The third main driving force will be chronic and long term conditions and the health issues arising from obesity.

In England 24% of men and 26% of women in England are obese, while 65% of men and 58% of women are either overweight or obese. However, the rate of increase in obesity prevalence has been slowing over recent years. A study by John Hopkins Bloomberg School of Public Health found that only 44 percent of primary care physicians reported success in helping obese patients lose weight and that primary care physicians identified nutritionists and dieticians as the most qualified providers to care for obese patients.

Fewer people are dying from cancer in the UK despite an increase in the numbers being diagnosed, according to figures from the Office for National Statistics. Nearly 323,000 people are now diagnosed with cancer each year. Data for 2001-03 showed there were 403 new cases of cancer for every 100,000 men and 343 per 100,000 women in the UK. Those figures increased to 431 per 100,000 men and 375 per 100,000 women in the 2008-10 analysis. At the same time the death rates fell from 229 to 204 per 100,000 men and 161 to 149 per 100,000 women.

Alzheimer's Society have estimated that there are 800,000 people living with a form of dementia, and that the figure will be one million by 2021.

7.3 Technology

Technological changes will also have a great impact on the workplace. The Institute for the Future, in California, predicts that smart machines will begin to dominate our lives as they replace humans for certain tasks and augment our capabilities for others. Developments in areas such as biotechnology and nanotechnology will also create new processes, materials and potential risks. An era where everything is programmable is just around the corner. The ability to collect large amounts of data about every aspect of life will pose challenges about its analysis and interpretation. Social media using multimedia technologies will continue to transform the way we interact and communicate. An example is the web site "Patients like me". People send information about their conditions and how they have been treated. This enables benchmarking of treatments as well as sharing information about how conditions affect them and what support is available and effective. People will become part of multiple, complex and fluid networks where information of varying quality and provenance will be able to move rapidly. It will be necessary to discern the accuracy and reliability of such information. Telemedicine and tele-health will come to the fore, again with opportunities for occupational health. The new technology will enable true global marketplaces to become the norm reinforcing the need for 24/7 operations. UK occupational health will need to assume an international perspective if it is to remain relevant. New skills founded on ways of thinking, communicating and inter-relating with technology will be essential.

7.4 Education and Training

Changes in the education and training of healthcare practitioners are likely. The creation of Health Education England (HEE) and its sub-committees called Local Education and Training Boards (LETBs) will stimulate change in the current models of training in England. Funding for post-graduate training will come from HEE. LETBs will be concerned with training for all healthcare practitioners, not just medical practitioners and there will be increasing pressure to gear training towards multi-disciplinary team orientated healthcare delivery. There is an ongoing review of the training of doctors (The Shape of Training) which will make recommendations that are likely to change the focus of training to equip doctors to care for an ageing population, largely outside hospitals and as part of such teams. There is a proposal to establish a national school of occupational medicine, in England, with the intention of raising the profile of the specialty and of the quality of training. This could be the vehicle for integrating the training of a variety of occupational health disciplines, setting national standards and quality managing the delivery of training.

In allied professions there are examples of established programmes. For example, the training and development of occupational hygienists uses peer-reviewed modules that are linked to an internationally transferable qualification system at Technician level. These can be supplemented by postgraduate training to lead to professional level qualifications, but this training and qualifications system needs to be expanded rapidly in order to cope with the anticipated worldwide demand. In particular, there is a critical need for more postgraduate courses and students creating an opportunity to integrate this into multi-disciplinary occupational health training.

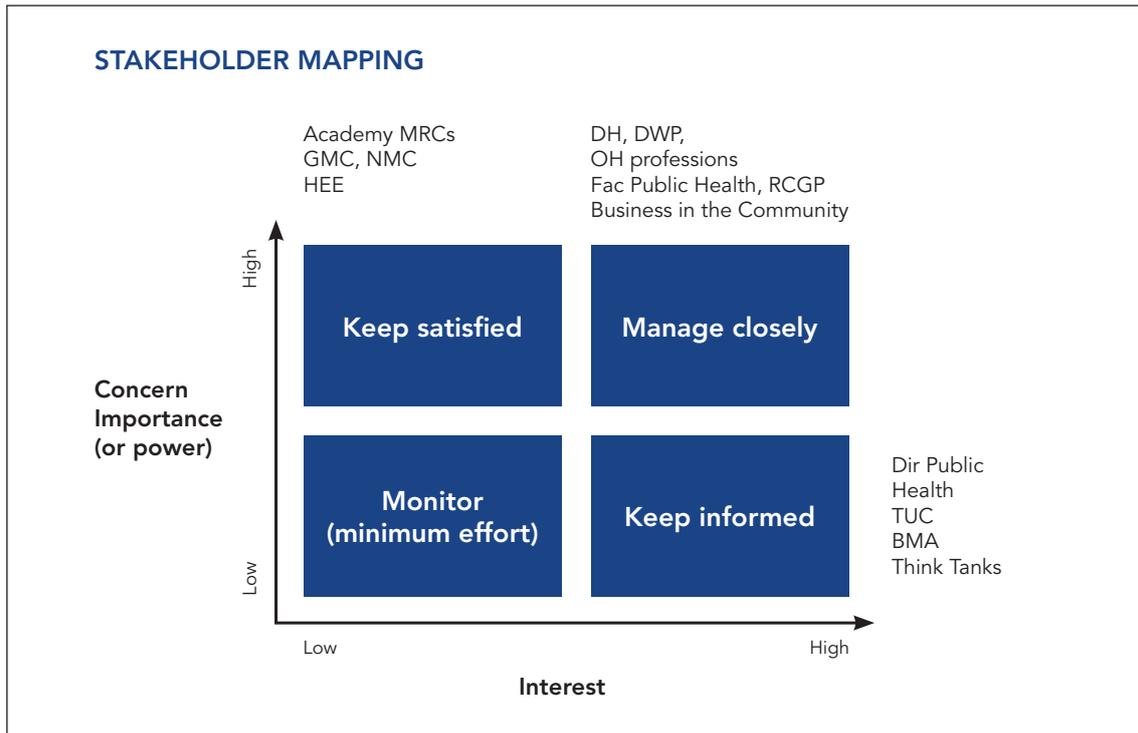## 8 IMPLICATIONS OF THIS STRATEGIC ANALYSIS FOR THE DEMAND AND SUPPLY OF OCCUPATIONAL HEALTH SERVICES

- Carrying on as normal will not be an option, with pressure for change coming from the top, through employers seeking greater efficiency and productivity savings, and through demographic trends.

- Occupational health has an opportunity in both helping with prevention and management of chronic conditions, but may have to decide the level at which it incorporates preventative wellbeing strategies into its arsenal.

- With care being increasingly moved into the community, some occupational health services will need to follow. Occupational health will need to be effective in engaging with local health and wellbeing boards and clinical commissioning groups.

- Occupational health services will similarly need to engage independent providers, employee representatives and employers as users of the services, particularly those with in-house occupational health services.

- As the health system is moving resources towards care rather than medicine, occupational health will need to review the knowledge and skills required of the multidisciplinary workforce including behavioural psychologists, therapists, physiotherapists, etc.

- Occupational health will need to consider the implications of 7 day working for GPs and hospitals and potential demand from employers for 24/7 support.

- The dominant model is becoming the integrated care pathway. Occupational health needs to position itself so that it is cemented in that model for all relevant cases.

- Occupational Health will need to position itself as a major player to tackle obesity.

- Cancer may likely be a manageable condition in the next 25 years with a number of key advances in genomics in recent years making treatments more effective. If there will be more people in the workplace managing cancer, occupational health will need to be ready to support people in the workplace.

- More people are working from home, and this trend will continue. Teleconferencing will become ubiquitous and with smart phones, tablets and other communication devices becoming more advanced, coupled with the cost, efficiency and productivity pressures facing the NHS – occupational health will need to make best use of this emerging technology. Jeremy Hunt recently announced 7 telehealth pathfinders, and an article in the Guardian highlighted that "NHS Direct's experience of telehealth started in 2008 when it was commissioned by NHS South East Essex to assess the benefits of telehealth by managing 80 patients with chronic obstructive pulmonary disease (COPD). An evaluation of the pilot, which ran until March this year, showed that 94% of patients said the equipment was easy to use; 83% felt it had helped them; and 84% wanted to continue with the service. In addition, the average number of 999 calls made each month

by the patients using the telehealth service was down by 72% and the number of visits made by those patients to their GP had reduced by 56%. Large scale, fully managed telehealth pilots managed by NHS Direct for 300 COPD patients in Leeds and Hull, backed with innovation funding from NHS East of England, yielded similarly positive results".

- In the next 25 years, nano-patches for vaccinations – which have been already trialled with success – may be more effective and implemented in the health system. This may drastically change the role and resources of occupational health in terms of administration of flu vaccines etc.

- In addition, precision medicine will revolutionise our ability to predict, prevent, monitor and treat a range of conditions. There will be investment in education and training in genomics.

- Along with the improvement in technology comes an increased use of patient data to improve services. The Government is currently consulting on patients having to opt-out to have their records used for approved research. Informatics and health informatics is growing rapidly and websites such as PatientsLikeMe are pioneering patient-driven data. Occupational health must develop strategies to collect and use data to meet the demands of stakeholders and improve service delivery.

- There will also be a need to build capability for multi-disciplinary services that can adapt to technological and demographic changes and function to mitigate and prevent illness caused or made worse by work.

- With the range of disciplines and allied professions, there is the prospect of bringing these under a new single organisation occupational health to build on the strength of current professions and provide a truly multi-disciplinary portal for occupational health.

9 STAKEHOLDER MAPPING AND MANAGEMENT

Stakeholder management involves classifying stakeholders against certain criteria, usually power and influence. The results of this process determine future actions. Thus, stakeholders that need to be actively managed are identified, as opposed to those who should be informed or kept satisfied.

STAKEHOLDER MAPPING

Academy MRCs
GMC, NMC
HEE

DH, DWP,
OH professions
Fac Public Health, RCGP
Business in the Community

Concern
Importance
(or power)

High

| Keep satisfied | Manage closely |

| Monitor (minimum effort) | Keep informed |

Low

Low   Interest   High

Dir Public
Health
TUC
BMA
Think Tanks

A long list of stakeholders in this change management process has been identified and the initial mapping process has been started (see appendix 6). In stages 1 and 2 of the project the focus is on engaging and getting buy-in from the stakeholder groups who deliver aspects of occupational health services; identifying potential funders for the future stages of the project and communicating with key government bodies.

Stages 3 - 6 will involve wider stakeholder management and engagement with other business bodies; commissioners and educational establishments.

10 COMMUNICATIONS

The communication strategy and plan is provided in appendix 7.

Communication is about influencing opinion. It is about shifting behaviours and perceptions. The key tenet of the communications strategy is to harness the collective communication muscle of all of our stakeholder organisations in effectively conveying our vision and the goals of this project. If we can do this, then real transformational change can occur. Successful major change projects demand multi channel and repeated communication of core messages and progress updates that build and maintain active stakeholder engagement.

The aims of the communication strategy are to

1. Agree a shared purpose amongst the membership organisations of the Council for Work and Health.

2. Map other stakeholder organisations and manage communication and engagement.

3. Create a shared culture and 'key message' information set so all of the members of the Council for Work and Health and other key stakeholders are advocates and 'pulling' in the same direction.

4. Build alliances and use a range of communication tactics to further the aims of the project.

5. Communicate effectively to potential funders of stage 3 - 6.

6. Begin dialogue with Government and other bodies who will be responsible in the long term for implementing change such as those responsible for doctor and healthcare professional education.

11 CONCLUSIONS

Building on a clear philosophy, vision and set of principles to underscore the practice of occupational health over the next 5 - 20 years, progress has been made in initiating a change management process that will define an occupational health proposition for the UK. It has been evident during this project, and in the workshops held in 2012, that there is not a large majority view about what occupational health is and which populations should be served. There does, however, appear to be a consensus that change is necessary and future occupational health practice will be multi-disciplinary. There is an appetite for change.

There appears to be agreement that occupational health should be concerned with the working age population. This includes people in employment and those who are able to work between the ages of 16 and 65. There is concern at the persistently high level of occupational illness that is related to working conditions and a need for a range of multi-disciplinary occupational health professions to advise on their prevention and control.

There is a recognition that the state pension age will increase with time, thus extending the age range of the working population. It is also accepted that the ageing population and the concomitant rise in importance of managing long-term conditions will impact on occupational health practice. Pragmatically, it is suggested that subgroups of the working age population be targeted. This would include people over the age of 50, people with chronic, long-term conditions particularly those that impact on fitness for work, people working in SMEs and people at risk of worklessness. The latter would include anyone exposed to a workplace hazard that could lead to a health limiting accident or illness.

Inclusion of people that are out of work, but capable of work, is controversial. There appears to be two schools of thought. The first is that occupational health should be involved in helping people get back into the workplace as unemployment is associated with increased morbidity and mortality, compared to people in employment. Helping people back into employment addresses health inequalities. Occupational health practitioners are well placed to use their knowledge and skills to advise about return to supported work. The other school of thought is that occupational health practitioners are employed to advise people in employment. It is not realistic to extend a responsibility for advising about fitness for work to people that are unemployed. In resolving this issue, it will be important to distinguish between occupational health as a function of what practitioners do and occupational health as a concept that promotes health and wellbeing via employment as part of the public health agenda.

Strategic analysis of the future has highlighted a large number of potential influences on occupational health practice and service delivery. In particular, economic, demographic and condition specific factors will have powerful influences. There is a real opportunity for occupational health to make the business case for health and wellbeing interventions based around the workplace and employment.

However, to do so will require active marketing of occupational health, coupled with evidence-based proposals for cost effective interventions. Should occupational health continue to be called occupational health? What range of disciplines is included? What is the occupational health proposition? How can the proposition be made relevant for the changing world of work, where technological changes, new ways of working and globalisation will impact on practice and service delivery. How will occupational health ensure that it can respond to new markets and new challenges? The government response to the sickness absence review by Dame Carol Black and David Frost has proposed a new state-funded assessment and advisory service staffed by occupational health practitioners. How can the capacity of the occupational health workforce be increased? How can the production of new practitioners be stepped up without compromising quality of training?

A compelling case for the development and repositioning of occupational health can be made. It centres on the strategic themes of prevention of work-related illness, health and wellbeing, integrated care, particularly of long-term conditions, and sickness absence management. They meet the needs of government and business by contributing to prosperity and the public health agenda and they are consistent with the philosophy of occupational health that good work is good for health, good for business and good for national prosperity. The case studies give examples of occupational health interventions that are consistent with these themes; they depict target populations and markets with the strategic analysis to provide an evidence base for a model of occupational health practice and service delivery.

12 NEXT STEPS AND OPTIONS APPRAISAL

An important outcome of this project is a set of actions concerned with shaping the future. The future of occupational health is in its own hands. However, it can only secure that future by coming together with an agreed vision and shared purpose and working effectively with other stakeholders. Having agreed the occupational health proposition, the next stages will be to determine the models of service delivery, the competencies required to deliver the interventions and then the roles and future workforce. The occupational health proposition must be compelling in order to attract further funding to take forward the project.

12.1 Taking forward stages 3 - 5 of the workforce planning approach

Stages 3 - 5 of the change management framework are concerned with the supply side of occupational health. They build on stages 1 and 2 which were externally facing. Thus, stages 3 - 5 are grounded in reality. Stage 6 represents a safety check to carry out a reality check and to perform a gap analysis. Stages 3 - 5 must be carried out in sequence. Stages 3 and 4 could be worked through together, perhaps at a one day workshop. Stage 5 will require careful planning as this is the stage where the roles of the respective professionals are determined. Each stage will require consultation with the grass roots professionals; stage 5 may require extensive consultation. Leadership through the change management process will be essential both at Council level and at the uni-disciplinary organisational level. It is estimated that the timescale to achieve stages 3 - 5 will be between 12 - 24 months. However, if occupational health is to seize the opportunities presented by imminent changes in the strategic environment, it will be desirable for significant progress to be made within the next 12 months.

Specialist workforce advice was crucial in executing stages 1 - 2 of the Population Centric Approach. We recommend that specialist support is engaged for stages 3 - 6 at an approximate cost of £10K.

12.2 Implementation of a communications strategy

The communications plan, which is part of the current project, will be a key part of the next phase of the project, incorporating the stakeholder management plan and setting out the necessary actions required to proselytise occupational health. It is an overarching plan that will assist both the demand side and the supply side strategy.

Agreeing an occupational health proposition that the respective occupational health disciplines can sign up to is crucial. This will underscore communication with key stakeholders, such as government departments, Health Education England, health and wellbeing boards and other commissioning organisations. It will also assist the renaissance of academic occupational health.

The Working Group advises that the Council should identify dedicated professional resource to invest in implementing the communication strategy.

12.3 A marketing campaign for occupational health

There are two main areas on which to focus, both of which may be considered to be part of a coordinated marketing campaign for occupational health. The first is externally facing and is concerned with developing markets and responding to and influencing the demand side of occupational health provision. This will include responding positively to initiatives, such as the government response to the sickness absence review and other government policy initiatives, and the changing world of work. This addresses principle 4, namely

"the need for an occupational health resource is such that there is a demand for it by a public who understand it, value it, and know how to access it."

The second is internally facing, within occupational health, and is concerned with the supply side of a sufficient capacity of suitably trained and competent practitioners to deliver the demanded interventions.

OPTIONS APPRAISAL

An options appraisal for the delivery of stages 3 - 6 of the framework;

1. **Acknowledge report; leave further development to respective occupational health organisations.**

   Council could acknowledge the report and endorse its findings, but leave it to the constituent organisations to do further work on stage 3-5. This is a low cost option but misses a leadership opportunity for the Council.

2. **Acknowledge report and assume responsibility for taking forward stages 3 & 4 of the workforce planning project only.**

   This option gives a leadership role to the Council for implementing the recommendations to develop models of service delivery and specify the competences required to deliver the models. However, the responsibility for determining the relative roles of respective practitioners within the models would rest with the constituent member organisations. The Council would coordinate responses. This option recognises that this stage is likely to be controversial and that individual membership organisations may wish to retain control of this stage, at least initially. However, it will be critically important to avoid silo thinking.

3. **Acknowledge report and assume responsibility for implementing the recommendations.**

   The Council will commit to taking forward the remaining stages of the workforce planning process. This is consistent with its leadership role and is recommended by the Working Group. There will be a need to identify sources of funding and to invest time and resources in organising future workshops and consultations, as well as implementing the communications plan. The Council will have to clarify its remit and role in leading transformational change with its constituent members.

RECOMMENDATIONS FOR COUNCIL

1. Acknowledge and endorse the findings of the report.

2. Take forward the next steps of the workforce planning project by:
   a. Constituting a working group to lead the implementation for stages 3 - 5 of the framework
   b. Implementing the communications strategy
   c. Developing a marketing strategy for occupational health

3. Explore sources of funding[3]. Possibilities include:
   a. Government departments
   b. Grant awarding bodies, e.g. IOSH
   c. Private sponsorship
   d. Shared contribution from members of the Council for Work and Health
   e. Health charities, such as the Colt Foundation

[3]NHS Plus has banked some residual consultancy time for Carol Brooks to support the project. In addition, NHS Plus is prepared to invest further in the project through consultancy support from Syngentis.

This vision, philosophy and set of principles have grounded the future-focused work and whole project. They were developed at a stakeholder workshop held on October 15th 2012.

Philosophy

Good work is good for health, good for business and good for national prosperity

Vision

Universal access to multidisciplinary occupational health resources delivers good health and good business for the working age population

Principles

1. Occupational health arrangements include people and other resources - they address non-medical and medical barriers to remain in or return to work and advise on ensuring that workplaces are safe and healthy environments

2. Effective leadership is essential to ensure the appropriate positioning, marketing and delivery of occupational health.

3. The multidisciplinary occupational health workforce is trained in unified core competencies including leadership - they are accredited to a standard that reassures the public*

4. The need for an occupational health resource is such that there is a demand for it by a public who understand it, value it, and know how to access it.

5. Occupational health resources are affordable and sustainable

6. An occupational health professional input on functional capability is an integral part of health decision-making in people of working age.

*The public includes……. people of working age, their employers and advisers (medical and non-medical) who we work in partnership with to achieve this philosophy.

[Source – Developed and agreed at a Stakeholder workshop held on October 15th 2012 and refined by the Working Group]

Stage 06

Gap analysis, reality check
Planning for implementation

Stage 05

Defining roles and future workforce

Stage 04

Defining knowledge, skills and competence levels

Stage 03

Design service delivery models

Stage 02

Population definition / Strategic environment

Stage 01

Establishing the change management approach

STRATEGIC FRAMEWORK FOR WORKFORCE
PLANNING—The Population-Centric™approach

APPENDIX 3 · WORKING GROUP MEMBERS

John Harrison	Chair DH
Richard Heron	SOM
Keith Johnston	NHS Plus
Anna Harrington	AOHNP
Leonie Dawson	CSP
Julia Skelton	COT
Tom Stewart	IEHF
Roger Alesbury	BOHS

Finances will be one of the three main driving forces for change in the next 25 years. The NHS has been asked to find £20 billion in "efficiency savings" by 2015. Although occupational health is not provided through the NHS the funding issues for the NHS will impact on the whole of society, including employers.

Even if the 'Nicholson challenge is met, the Nuffield Trust has estimated that there could be a further £54billion needed for the NHS. (see below)

CLOSING THE GAP IN 2014/15

Funding (£bn)

- Funding pressures on the NHS in England
- Funding pressures after pay restraint
- Funding pressures after pay restraint and managing hospital activity for chronic conditions
- Funding pressures after pay restraint, managing hospital activity for chronic conditions and productivity savings
- Funding allocation based on 2010 spending review

FUNDING GAP IN 2021/22 UNDER THREE SCENARIOS FROM THE IFS

Funding (£bn)

- Funding pressures on the NHS in England
- Increase in allocation in line with NHS long run average
- Increase in allocation in line with GDP
- Real terms freeze in allocation

FUNDING GAP IN 2021/22 UNDER THREE SCENARIOS FROM THE IFS

Funding (£bn)

- Funding pressures on the NHS in England
- Funding pressure after releasing all semi-fixed costs from QIPP
- Funding pressures after releasing all semi-fixed costs from QIPP and management of activity for chronic conditions
- Increase in allocation in line with GDP

a) Feedback from stakeholder workshop re population definition and potential markets

A summary of the views expressed is presented.

- The unemployed who COULD work e.g. those people with mental health illness
- Could the customer be the Government?
- Could we link to the employment service?
- Focus on barriers to employment
- Long-term conditions linked to lifestyle factors and link to employers
- Long-term conditions linked to e.g. disability
- Throughout working life which could be 16/18 – 65/75 i.e. working age, but is the appropriate term?
- The changing work environment will provide different opportunities and we need a different business model for accessing occupational health services
- Market linked to integrated care pathways and the interface between educational and social development
- Markets outside of the UK long term
- Unhealthy workplaces
- "Unfitness", whether medical or motivational
- Where we can support people to become the "working well"
- Specific types of occupation

b) PESTEL analysis

Political

- Public sector reforms impacting on the NHS, and the potential role of Clinical Commissioning Groups and Health and Well-Being Boards
- Public sector reform impacting on access to benefits and the drive for people to be in work/employed
- A push towards rehabilitation
- Increased retirement age
- Recession and not knowing how/when recovery will occur
- Difficulty in gaining interest of the politicians
- Election cycle
- Impact of political approach, such as reinforcing a link between responsibility and individual health status and the "cost" of health status to the employer as well as individual
- Awareness/Knowledge of occupational health among politicians and civil servants
- Timely access to interventions at time of need
- Incentivising workfulness rather than worklessness
- The workplace is a place where general health can be implemented for good
- Legislation and the EU

Economic

- Increasing "casual" nature of work, with many changes in job and career
- Increasing global workplaces
- Little cash to invest in training the workforce
- Insurers will want to know who has future risk
- Sickness and absence
- Vocational rather than university education
- Business case promoted to employees and the public purse, extending what's in it for (?them)
- Poor management, lack of training in management
- Long term conditions
- Changing workforce – employment status – legal protection, non-contract
- Prove/market CBA/ROI of occupational health
- Impact on "bottom dollar"
- Increasing self-employed
- Possible increase in manual workers and manufacturing
- Decreasing benefits bill

Sociological

- Increasing diversity of the population
- Cultural differences
- Recruitment issues in specific groups in the future e.g. doctors
- The need to look at different models of delivery linked to different models of workforce
- The ageing population and the impact on the ageing workforce
- Increases in complexity of need in the workforce (related to age)
- Rising levels of poverty
- Increasing stress levels in the population
- A more risk averse society
- Increasingly litigious
- Health issues are increasingly emotive
- Increasing interest in public health and the social benefit of being in work
- New and emergent diseases related to occupations and work in general
- Occupational health not a "sexy" specialty
- Not on the undergraduate curriculum
- The need to focus on employment as a number of activities and not just employment
- Re-energising the local community for local interaction – to relieve concerns of remote working
- Change the pattern of work – possibly working across jobs within a working week
- The "blame culture", "fault culture"

- Loyalty to organisation
- Skills of the employee

Technological
- Development of drugs (to manage conditions)
- New technology can mean new risk
- Increasing access to technology to assist people working at home as well as to support people in the workplace
- Technology enables people to work for longer periods and therefore are less likely to take breaks
- Increasing focus on high tech and research type work and the impact on the type of workforce
- New types of work bring new hazards
- Working with new materials brings new hazards
- Increasing access to healthcare support through technology, such as telehealth techniques for diagnosis and consultation
- The potential to integrate everyday technology into support, such as the use of smartphones
- Home/remote working
- Blackberries/IPhones – always available
- Hot desking
- Adaptability to technology changes – rapid rate

Environmental
- Pressure on the environment, such as improvements in air quality and emissions
- Decreased health status in adolescents (future workers), psychological and obesity
- Accessibility; to working environment, buildings, toilets
- Economic location
- Migration
- Physical workplace is reducing, more virtual interactions, teleconferences etc
- Philosophical approach to work needs changing e.g. multiple employments

Legislative
- Need to keep a watch on where European legislation related to the workplace is going
- The Black/Frost report
- Equality Act
- Employment law
- Increased retirement age

Organisation	Power	Interest	Action	Key contact name(s)
COUNCIL WORK & HEALTH MEMBERS (representing the professions and organisations that deliver health and work services):				
Chair	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Diana Kloss
Association of Chartered Physiotherapists in OH and Ergonomic (ACPOHE)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Nicola Hunter Stuart Paterson (deputy)
Association of Occupational Health Nurse Practitioners (AOHNP UK)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Christina Butterworth Sara O'Hara (deputy)
Association of Occupational Health Technicians	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Pauline Proud Karen Talbot (deputy)
British Occupational Hygiene Society	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Roger Alesbury Steve Bailey (deputy)
British Psychological Society (BPS)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Emma Donaldson-Feilder Sharon de Mascia (deputy) Nigel Atter (info only)
British Society of Rehabilitation Medicine (BSRM)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Judith Allanson
Chartered Society of Physiotherapy (CSP)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Natalie Beswetherick
Commercial Occupational Health Providers Association (COHPA)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Karen Talbot
College of Occupational Therapy (COT) - Specialist Section for Work and Vocational Rehabilitation	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Julia Skelton Peggy Frost Mandy Kelly

Organisation	Power	Interest	Action	Key contact name(s)
Defence Medical Services	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Gp Capt Alastair Reid
Faculty of Occupational Medicine (FOM)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Olivia Carlton Nicky Coates
Institute of Ergonomics and Human Factors	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Dave O'Neill Tom Stewart
Institution of Occupational Safety and Health (IOSH)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Nattasha Freeman
International Institute of Risk and Safety (IIRSM)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Brian Nimick
NHS Health at Work Network	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Anne de Bono
Royal College of General Practitioners	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Nigel Sparrow John Chisolm
Royal College of Nursing (RCN) – Public Health Forum	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Helen Kirk
Society of Occupational Medicine (SOM)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Richard Heron Hilary Todd
Syngentis – the Health and Work community interest company progressing work of NHS Plus	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Keith Johnston
UK Rehabilitation Council (UKRC)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Susan Berdo
Vocational Rehabilitation Association (VRA)	H	H	Key stakeholder for stage 1 - 6 Regular engagement and involvement	Chris Parker Joy Reymond

Organisation	Power	Interest	Action	Key contact name(s)
Government Departments:				
Department of Health	H	H	Need to engage, keep regularly informed via face to face meetings and copies of key documents.	Dame Carol Black Geoff Dessent Graeme Henderson Anna Soubry (Minister)
DWP	H	H	Need to engage, keep regularly informed via face to face meetings and copies of key documents	Bill Gunnyeon
Scottish Government	H	H	Need to make contact, build relationship and engage	
Welsh Assembly Government	H	H	Need to make contact, build relationship and engage	
Northern Ireland - Department of Health, Social Services and Public Safety	H	H	Need to make contact, build relationship and engage	
Department for Business Innovation	H	L	Need to make contact, build relationship and engage	
Health and Safety Executive (HSE)	L	H	Keep informed and engage stages 3 - 6	Jane Willis John Osman
European Commission	?	?	Who and why?	
Relevant business/other organisations				
Ass. Brit Insurers	H	L	Keep informed and engage stages 3 - 6	
Chartered Management Institute	H	L	Keep informed and engage stages 3 - 6	

Organisation	Power	Interest	Action	Key contact name(s)
Institute of Directors	L	L		
Chartered Institute of Personnel and Development	H	L	Keep informed and engage stages 3 - 6	
ACAS (Advisory, Conciliation and Arbitration Service)	L	L	Keep informed when appropriate (stage 3 - 6)	
Trade Union Congress + other individual unions?	H	L	Stage 3 - 6 Keep informed/satisfied	Hugh Robertson
Business in the Community	L	L	Keep informed when appropriate (stage 3 - 6)	
Confederation of British Industries	H	L	Keep informed and engage stages 3 - 6	
Federation of Small Business	H	L	Keep informed and engage stages 3 - 6	
British Chambers of Commerce	L	L	Keep informed when appropriate (stage 3 - 6)	
Chartered Inst. for Procurement Professionals	L	L	Keep informed when appropriate (stage 3 - 6)	
Association of Personal Injury Lawyers	L	L	Keep informed when appropriate (stage 3 - 6)	
Law Society	L	L	Keep informed when appropriate (stage 3 - 6)	

Organisation	Power	Interest	Action	Key contact name(s)
Education/training establishments				
Universities who train occupational health specialists Need to be specific – which ones/name of department/ contact?	H	H	Key stakeholder for stage 3 - 6 Regular engagement and involvement	
Academy Medical Royal Colleges	H	L	Need to make contact, build relationship and engage stages 3 - 6	
Local Education Training Boards (LETB)	H	L	Need to make contact, build relationship and engage stages 3 - 6	
Other health organisations/people				
Health Education England	H	H	Need to make contact, build relationship and engage stages 3 - 6	
Public Health England	H	H	Need to make contact, build relationship and engage stages 3 - 6	
Health and Care Professions Council	L	L	Keep informed when appropriate (stage 3 - 6)	
GMC	H	L	Keep informed and engage stages 3 - 6	
NHS Employers	H	H	Need to make contact, build relationship and engage stages 3 - 6	Dean Royles
NHS Commissioning Board	H	H	Need to make contact, build relationship and engage stages 3 - 6	
Royal Society for Public Health	H	H	Need to make contact, build relationship and engage stages 3 - 6	

Organisation	Power	Interest	Action	Key contact name(s)
Faculty of Public Health	H	H	Need to make contact, build relationship and engage stages 3 - 6	Lyndsey Davies
Directors of Public Health	H	H	Need to make contact, build relationship and engage stages 3 - 6	
British Association for Supported Employment	L	L	Keep informed when appropriate (stage 3 - 6)	
Other occupational health organisations				
British Medical Association (Occ health committee)	H	H	Keep informed and engaged stages 3 - 6	Paul Nicholson
Assoc of NHS Occ Health Physicians ANHOPS	L	H	Regular email updates stages 3 - 6	
Local Government Assoc.	L	L	Keep informed when appropriate (stage 3 - 6)	
Association of Local Authority Medical Advisors (ALAMA)	L	H	Regular email updates stages 3 - 6	Tok Hussain
Higher Education Occupational Health Physicians (HEOPS)	L	H	Regular email updates stages 3 - 6	
RCP HWDU	L	H	Regular email updates stages 3 - 6	
British Toxicology Society	L	H	Regular email updates stages 3 - 6	
Royal Society for Protection of Accidents	L	H	Regular email updates stages 3 - 6	

Organisation	Power	Interest	Action	Key contact name(s)
American College of Occupational and Environmental Medicine (ACOEM)	L	H	Bespoke occasional updates by SOM President	
Engineering Employers Federation (EEF)	L	H	Regular email updates stages 3 - 6	
Chartered Institute of Environmental Health	L	H	Regular email updates stages 3 - 6	
Think Tanks				
Work Foundation	L	L	Keep informed when appropriate (stage 3 - 6)	
Centre for Wellbeing economics	L	L	Keep informed when appropriate (stage 3 - 6)	
Voluntary organisations				
Macmillan Nurses	L	L	Keep informed when appropriate (stage 3 - 6)	
MIND	L	L	Keep informed when appropriate (stage 3 - 6)	
National Voices	L	L	Keep informed when appropriate (stage 3 - 6)	
Patients Association	L	L	Keep informed when appropriate (stage 3 - 6)	
NCVO	L	L	Keep informed when appropriate (stage 3 - 6)	

A man visits a site where a group of men are at work stone-cutting and building. 'What are you doing?' he asks the first worker. 'I am shaping this stone so that it will fit perfectly against the next one,' the man replies. 'And what are you doing?' the visitor asks a second worker. 'I am laying this stone on top of another one to make a wall,' he replies. 'And what are you doing?' the visitor asks a third worker. The worker puts down his tools, looks up with a gleam in his eye, and replies: 'What am I doing? I am building a cathedral.'

Occupational health is changing. The report ''Planning the future: Delivering a vision of occupational health and its workforce for the UK for the next 5 – 20 years", outlines the strategic environment and challenges that we need to address to ensure that we have a workforce that is fit for purpose and will meet the health needs of the UK's working population over the next 20 years. We also need to facilitate a multi professional focus within workforce planning. This is a unique opportunity for us to deliver a 'step change' for occupational health and demonstrate the pivotal role that we can contribute.

All of the stakeholders have a key role to play in delivering that ambition, by helping to shape and articulate it, for audiences both internally and externally. It is very easy for all of us to view the future from our own perspective and see it in terms of the 'stone' that needs to be 'placed' rather than look at the bigger picture. Our aim is that all of the stakeholder organisations should share a clear vision of the 'cathedral' that we are seeking to 'build', and participate in making it happen.

Communication is about influencing opinion. It is about shifting behaviours and perceptions. The key tenet of the communications strategy is to harness the collective communication muscle of all of our stakeholder organisations in effectively conveying our vision and the goals of this project. If we can do this, then real transformational change can occur. Successful major change projects demand multi channel and repeated communication of core messages and progress updates that build and maintain active stakeholder engagement.

This communication plan draws on and builds on the work outlined in the paper and is intended to illustrate how we can effectively communicate these plans. It covers communication for stage 1 and 2 of the project.

The Working Group believes that the Council should engage professional communications support to the project. We estimate that a budget allocation of £8K should be identified for approximately 25 days.

We recommend;

- Council for Work and Health sources funding and approves the appointment of a Communications Adviser to drive the implementation of the Communications strategy
- The Communication Advisor liaises with communication leads from membership organisations to ensure a pro-active and co-ordinated approach

Communication Aims

The key aims of the communication strategy are to

1. *Agree a shared purpose amongst the membership organisations of the Council for Work and Health*

2. *Map other stakeholder organisations and manage communication and engagement*

3. *Create a shared culture and 'key message' information set so all of the members of the Council for Work and other key stakeholders are advocates and 'pulling' in the same direction.*

4. *Build alliances and use a range of communication tactics to further the aims of the project*

5. *Communicate effectively to potential funders of stage 3 – 6*

6. *Begin dialogue with Government and other bodies who will be responsible in the long term for implementing change such as those responsible for doctor and healthcare professional education*

Communication approach

The plan will be reviewed periodically but the approach and recommended initial key activities are listed below:

1. *Agree a shared purpose amongst the membership organisations of the Council for Work and Health*

The vision, principles and the broad aims of the project need to be cascaded through the different stakeholder organisations. The aim is for all of the membership organisations of the Council to formally sign up to the paper and actively get involved in communicating it to their members.
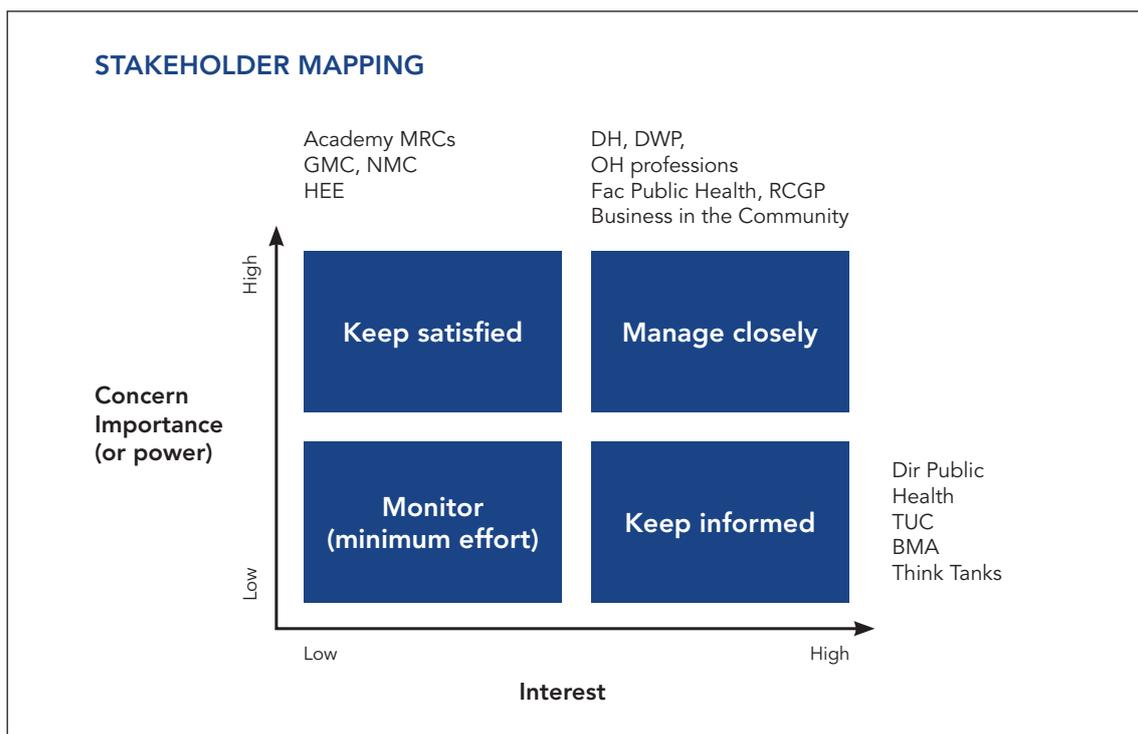
Once the members of the Council have agreed the paper and next steps the following is recommended

a. The project needs a short meaningful name that all stakeholders use when referring to it. This should be easy to remember and not be able to be given an acronym or shortened.

b. A network of communication leads from the Council's membership organisations is established – this can either be the person who sits on Council , or another designated person or a member of the communication team from the relevant stakeholder organisation

c. A section on Council website is established

d. A letter + executive summary (with link to full paper) is provided for each membership organisation 'rep' to take to their respective board. A draft of this is attached.

e. Each organisation formally endorses the paper and next steps and agrees to the use of their logo on the paper and the proposal document aimed at obtaining future funding

f.   FAQ to be developed, circulated, and put on the website

g.   Regular communications via electronic/other newsletters and any other internal communication outlets owned by stakeholder organisations

h.   Letter from Diana Kloss thanking people and advising next steps

i.   Update at next Council meeting

2. Map other stakeholder organisations and manage communication and engagement

A long list of stakeholders in this change management process has been identified. (See appendix 6) Stakeholder management involves classifying stakeholders against certain criteria, usually power and influence. The results of this process determine future actions. Thus, stakeholders that need to be actively managed are identified, as opposed to those who should be informed or kept satisfied. (See below)

STAKEHOLDER MAPPING

	Academy MRCs GMC, NMC HEE	DH, DWP, OH professions Fac Public Health, RCGP Business in the Community	
High	**Keep satisfied**	**Manage closely**	
Concern Importance (or power)	**Monitor (minimum effort)**	**Keep informed**	Dir Public Health TUC BMA Think Tanks
Low	Low — Interest — High		

We will need to consider this carefully and consider for each audience the level, detail and tone of communication. As well as considering our stakeholders in terms of power/influence and their interest in the project – we also need to consider where they currently stand in relation to the ideas we are proposing and where we need to move them to.

Recommendations

a. Further work is undertaken mapping the stakeholders by the communications advisor and core project group

b. Bespoke communication is scheduled with 'manage closely' group

c. Gap analysis identified and letter sent informing others who need to be informed

d. A specific list of potential funders is identified and prioritized according to likelihood of funding

3. *Create a shared culture and 'key message' information set so all of the members of the Council for Work and other key stakeholders are advocates and 'pulling' in the same direction. Develop 'the occupational health proposition' and underlying key messages. Universal adoption of these messages.*

We need to create a common language that we can use to talk about the benefits of occupational health and the future need. We need a clear and consistent set of messages about what occupational health is, our work, why it is important, the benefit we bring. In marketing terms, what is our Unique Selling Point or USP? At present we have numerous different ways of describing ourselves, and we have not succeeded in coming up with a clear and satisfactory encapsulation of our purpose.

Although there is limited communication capability on this specific project, the aim is to get some key messages and facts to be incorporated in as many of the communications from our respective stakeholder organisations as possible. They may vary slightly from audience to audience but they are the shorthand for what we are trying to achieve and they help to underpin the image of a unified profession that knows its purpose.

This will involve developing an occupational health proposition and set of key messages. If these can be accepted universally by stakeholder organisations it will make our proposition to the external world incredibly strong. Individual organisations will, of course have their own key messages that sit under this and convey their unique contributions.

Recommendations

a. Circulate draft key messages for agreement by Council members. These include
   - the OH proposition - what it is
   - Key facts and statistics demonstrating the benefits we make to individuals, businesses and the economy
   - The project goals

b. Where possible these are adopted by membership organisations

c. Council reps and the communication advisor to disseminate as widely as possible

d. These form the basis of all communications around 'making the case'

e. They are included on the website and where possible on the websites of member organisations

4. Build alliances and use a range of communication tactics to further the aims of the project

We have limited communication resource for stage 1 and 2. The real power of this project will be unleashed if everyone involved uses the agreed core messages to effectively engage stakeholders and get the message out as to why we need occupational health in the future and the importance of planning for a fit for purpose workforce to deliver health and work services.

Recommendations

a. Bespoke media work – looking at trying to place a couple of key features in key publications

b. A small range of communication 'tools' are developed that can be adapted for Council members to use. These to include a short synopsis piece that can be adapted for membership newsletters and powerpoint presentation

c. All members of Council consider how they can help with communication and feed into the communications plan

d. The communications advisor to coordinate, monitor and manage feedback from Council organisations and adapt communications accordingly

5. Communicate effectively to potential funders of stage 3 – 6

Recommendations

a. A proposal 'brochure' outlining the need for the project, the benefits to potential funders, the specific costs and the deliverables is developed – this will be used either as a mechanism to get meetings arranged or as the basis for discussions. It will include the case studies that are the personal representations of the 'essence of occupational health' We will use these as symbols to show the real need of occupational health services in the future. They are the device or mechanism that we are using to show the actual benefits we can bring if we effectively plan for the future workforce delivering health and work service in the UK.

b. The most appropriate person to approach each potential funder is identified and a timescale agreed.

c. Timetable and action to be reviewed after each approach.

6. Begin dialogue with Government and other bodies who will be responsible in the long term for implementing change such as those responsible for doctor and healthcare professional education

The stakeholder analysis will have defined those bodies/specific contacts who are responsible for commissioning occupational health services; those bodies who are responsible for training and others who will potentially be responsible for implementing the final recommendations of the project. These people need to be liaised with and kept informed at this early stage of the project.

Recommendations

    a. Small working group to manage this area of work

    b. A series of bespoke communications are planned to influencers

    c. Meetings with key individuals

Although this strategy relies on support from each of the stakeholder organisations the support of the communication advisor will need to be budgeted for as part of the on-going costs of the project.

A detailed communication timetable will be produced once the Council for Work and Health has approved the final report and communication resource.

The 'Planning for the future' project – What is it?

The 'Planning for the future' project aims to clearly articulate a vision of how occupational health should be delivered over the next 5-20 years and identifies the medium and long-term workforce planning that is needed to support that vision.

The project is being run by a multidisciplinary group of occupational health leaders and is sponsored and supported by the Council for Work and Health.

Good occupational health services need to be delivered by a multidisciplinary team including doctors, nurses, occupational therapists, physiotherapists, mental health support workers, technicians, vocational rehabilitation specialists, occupational hygienists, human factor specialists, occupational psychologists etc. – the project team reflects that multidisciplinary approach.

What is the vision?

Good work is good for health, good for business and good for national prosperity. Universal access to multidisciplinary occupational health resources delivers good health and good business for the working age population

Occupational Health – What is it? We need to be able to briefly and clearly communicate what we do and why it's important – the elevator speech

Occupational health specialists deliver a range of vital healthcare services that keep staff healthy and companies productive.

Occupational health is the multi-faceted specialism concerned with protecting and improving the health of workers and those who are currently unemployed but able to work.

Occupational health is provided by a unique team of multidisciplinary specialists that between them prevent work- related illnesses; identify and manage the risks and exposures that cause work related ill-health, provide early interventions for those who develop a health condition; reduce sickness absence; and use the workplace to promote health and wellbeing. We are distinctive because we offer a holistic approach that focuses on the person, the workplace and the business rather than a disease.

Why is occupational health important?

Good occupational health services help individuals stay healthy and save businesses money.

Occupational health can play a major part in revitalising the UK's economy by enabling people to continue to work, supporting people back into work and reducing sickness absence.

Work is good for people's health – occupational health supports people to stay in work and return to work more quickly after they have had health problems.

The ageing population in the UK means that people will need to carry on working, as they get older. We need a radical rethink as to how we support people to continue working. The workplace is the ideal environment to address health issues, support those with long-term conditions and provide a holistic approach.

Occupational Health – the business case

Cost-benefit analysis studies show that investing in occupational safety and health yields positive results.

Investing in occupational safety and health contributes to company performance through tangible outcomes

Research shows that occupational health services can be very cost effective, and make a positive impact on the probability and frequency of accidents, sickness absence and ill health in the workplace.

It has been demonstrated that a pro-active occupational health service can help to improve the overall morale of staff.

Occupational health – the facts

- Approximately 70% of the population does not currently have access to occupational health services.

- SMEs account for 99.9 per cent of all private sector businesses in the UK. Only 1 in 10 small employers provide employees with access to occupational health services compared with 8 in 10 large employers.

- The aging population means that more people will need work-related health support to continue to work, as they get older. Around one-third of the population will be over 60 by 2033.

- 65% of men and 58% of women are overweight or obese and 15 million people currently live in England with a long-term health condition – the workplace is the ideal environment to address these health issues

- 175 million working days in Britain are lost due to ill health annually – occupational health can reduce sickness absence and support people so that they return to work more quickly

- After only six weeks' sickness absence, almost one in five people will eventually leave paid employment.

- Every year about 400,000 people in the UK report work-related stress at a level they believe is making them ill. By 2020 depression will have become the second leading cause of disability in the world – the workplace is a key and cost effective environment to address this issue.

- 80% of the adult population will suffer with back pain at some time in their working lives – early interventions via a multidisciplinary occupational health service can support people to stay at work

- 12,000 people die from occupational diseases in the UK. This number is orders of magnitude higher than the number that die from accidents at work each year; the latter figure is less than 200. Of the 12,000 occupational disease deaths, around 4,000 are the result of previous exposure to asbestos, another 4,000 are from COPD as a result of workplace exposures, and the final 4,000 are from occupational cancers due to exposures at work to carcinogens other than asbestos.

Throughout this report occupational health refers to the full range of healthcare professionals and other resources involved in improving health and work. These include:

- Human factor specialists and ergonomists

- Occupational health doctors

- Occupational health nurses

- Occupational health technicians

- Occupational hygienists

- Occupational psychologists

- Occupational therapists

- Mental health support workers

- Physiotherapists

- Vocational rehabilitation specialists

- Workplace safety professionals