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**Report on proceedings of HSE's Health Models
Review workshop - Manchester, 20th September
2005**

HSL/2006/15

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Special thanks are extended to Dr David Snashall for acting as chair. Thanks are also due to Mrs Shirley Whitehead for acting as workshop scribe.

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EXECUTIVE SUMMARY

Background

The Health and Safety Executive (HSE) is recognised for playing a major role in achieving a world-class safety record. However, HSE has not been as successful in achieving the same record for occupational health¹ issues. The workplace and the nature of occupational health is changing and informed health and safety practitioners and academics have questioned whether HSE's risk assessment approach to occupational health issues remains an effective framework to address the common health problems now seen in the workplace. Occupational health problems are now manifesting themselves as stress, anxiety, depression and musculo-skeletal disorders (MSDs). These are examples of conditions that do not demonstrate a clear dose-response relationship between exposure to hazard and harm.

The Health and Safety Commission's (HSC) strategy for workplace health and safety in Great Britain to 2010 and beyond recognises the need to do more and work differently to address the new and emerging work-related health issues and this project is, in this spirit, seeking to build on existing successes and address the issues in partnership. Preliminary discussions, inside HSE and with a small group of external stakeholders, suggested that there are a number of different ways of thinking about health issues, and so developing approaches to tackling the problems. Health models may offer effective ways of thinking about and tackling modern complex health problems.

There is a view that as well as focussing on prevention, supporting people to manage their health problems may be a more useful way of framing the issue. This is not to say that the risk prevention model cannot be applied to common health problems and rehabilitation, but rather that there may be alternative or better ways of tackling them. HSE, partners and stakeholders will need to utilise a range of models and philosophies for different aspects of its work. Consequently, a pluralist approach is likely to represent the preferred option, in which health models are tailored to the nuances of varying occupational health needs. HSE therefore needs to engage others as equal partners in the search for better solutions to address occupational health problems common to all. As part of HSE's Health Models Review, a workshop was organised by the project steering team to canvass the stakeholders for their views on how HSE should take these ideas forward.

Aims and Objectives

Review Aims

The review aims to provide HSE and its partners with a flexible decision-making framework for handling more effectively the spectrum of health issues arising in the 21st Century workplace. This will be accomplished by:

- Reviewing the different models which provide a means of framing health issues to establish their applicability to improving occupational health;
- Examining the scope for, and implications of, using the various models in joined-up approaches to improving occupational health;
- Providing guidelines for users of the various models to assist co-operation in joined-up approaches.

¹¹ For occupational health interpretation used by the Health Models Review see section 1.4 (page 2)

Workshop Aims

The review is centered on two stakeholder workshops. The aim of the first workshop, held on 20th September 2005, was to scope the potential value of different health models in accommodating 21st Century occupational health and well being needs. The workshop sought to:

- Systematically consider the future role and nature of risk assessment based approaches in improving health at work especially for contemporary occupational health needs.
- Gauge future projections of occupational health trends and their implications for the current risk prevention approach.
- Gain further insight into the ways in which other models of health can potentially facilitate occupational health in the long term.
- Achieve consensus on future work that needs to be undertaken to test the viability of other health models in improving the management of occupational health.

Based on the findings and recommendations of the workshop, detailed in this report, a period of research and development will be carried out on behalf of HSE and partners to investigate research gaps, take forward some of the research ideas and lay the foundations for informing new approaches to health 'risks'. The progress of the research will be formally reviewed in Spring/Summer 2006 and the next steps discussed.

Main Findings

It was agreed that risk assessment is not appropriate for all health problems and can be counter-productive. Simple, traditional risk assessment is widely understood and accepted, it is a valuable and effective tool where the risks are discrete and the cause-effect relationship is known. The stakeholders advised HSE to evolve and enhance the occupational health framework to keep pace with changes in the nature of work and also changes in perceptions, attitudes and behaviour around health and work. Risk assessment still has a role but HSE should provide the workplace with guidance and tools to help tackle the newly emerging health issues - where the risk factors are more complex, the cause-effect relationship is more ambiguous, and interactions are multifaceted. There are tensions between maintaining the risk assessment terminology with respect to future tools for stress and MSDs and the counter-productive nature of risk assessment with respect to these conditions. We need to bear these tensions in mind.

A main finding of the workshop was that health models can be useful and illustrate the complexity of health problems, such as stress or MSDs. They help to highlight the importance of factors such as beliefs, attitudes and behaviours in occupational health. The workshop recognised that it is a challenge for lay people to interpret and apply psychological and biopsychosocial models. To take things forward, HSE and partners need to incorporate health models into their thinking and ensure that both organisational and individual risk factors are considered. More evidence is needed regarding the application of health models to workplace health.

Another main finding was that the remit of this project goes beyond HSE's traditional scope: there is a need for more collaborative, multi-disciplinary working than exists currently, especially between Departments of Health (DH), Department for Work and Pensions (DWP) and HSE/HSL. HSE should continue moving forward by working with other organisations such

as employers' organisations, academia and Trade Unions. The knowledge base is multi-disciplinary and it would also be advantageous to have inputs from other specialisms.

A key message propagated at the workshop was that health problems are part of everyday life and occupational health should be viewed in the wider context of health, work and wellbeing. In this respect we need to take an individualised perspective in helping the working age population to deal with common health problems both in the occupational and non-occupational context. The positive and negative framing of messages is important. It is important to emphasise the benefits not just the hazards when trying to change people's behaviour.

Improved evaluation was another key theme of the day. Any intervention HSE initiates must be evaluated to show how it is progressing against its goals. Return to work could be used, as it is a readily measurable health outcome. At the outset we need to establish what the expectations are, what the baseline is, what would a new/revised strategy aim to achieve and how to account for the counterfactual.

It was noted by several delegates that there are some problems currently facing Occupational Health: occupational health strategy and goals are not well defined, employers who pay for occupational health services don't really understand what they are buying; occupational health in workplaces tends to be reactive in nature; the role of human resources departments is variable and unclear. HSE needs more occupational health resources. HSE has a trusted public image but some delegates thought worker involvement and HSE's public image and media exposure could be improved.

Recommendations

Key recommendations related to risk assessment were to keep some consistency from the point of view of legality and terminology and not to undermine the traditional risk assessment process which is appropriate in many situations. Risk assessment needs to evolve and to be enhanced to deal with the emerging workplace health problems.

There was strong consensus that there needs to be closer working between HSE and other strategic and policy-making organisations. Strategic links and two-way communications need to be opened up to ensure that future strategies are developed in synergy with approaches stemming from other governmental bodies.

Principles derived from health models should underpin the development and design of strategies, approaches and tools for tackling complex occupational health needs. The biopsychosocial approach may lend itself well to addressing complex, modern health problems, which span people's work and home-lives. An organisational, or cluster approach, was also considered important so that not all the emphasis is placed on the individual. To take things forward effectively, it was suggested that the essence of the models could be 'distilled' out to guide the underlying philosophy of future research questions, strategies and interventions. HSE and partners need to develop an integrative framework that spans the complete process of managing occupational health and incorporates key points from various models. Tools and interventions incorporating philosophies developed using health models will need to be translated into user-friendly language so that they can be understood and applied by lay-people. The research needs in this area should be explored. A multi-disciplinary approach will be needed for further health models research work.

Evaluation needs to take place, both to establish a baseline for further research and to judge the progress and effectiveness of new initiatives. Specifically the effectiveness of the risk assessment approach as it stands needs to be evaluated to provide an evidence base. Appropriate health indicators, such as disease incidence and prevalence rates, biomarkers and quality of life

measures, will need to be chosen to allow monitoring for occupational health continuity and intervention effectiveness.

Health messages should be framed carefully and appropriately and the benefits of work should be promoted. We need to take into account that work can involve both hazards and benefits for (physical and mental) health and the suitability of the person for the job ('person-job fit') is an important factor. We need to take a balanced approach to the relative risks and benefits. The basic message underpinning the biopsychosocial approach is that understanding and management of common health problems must take account of the individual, their health problem, and the context in which they live and work. In order for this message to be successful a need exists to identify what aspects of a job or workplace make it 'healthy'. A literature review will be required to explore what evidence exists on these issues and where there are gaps in knowledge.

1 INTRODUCTION

1.1 BACKGROUND

Britain has a world-class record for safety at work and HSE is widely respected for playing a major role in achieving this record. However, HSE has not been as successful in achieving the same record for health issues (HSC, 2004; HSC, 2000). There are likely to be many reasons for this difference, and the Health and Safety Commission's strategy has identified the need for partnership and the development of an occupational health (OH) and safety support system applied nationally, as key ingredients of a plan to secure improvement. One contribution to this difference is thought to be a reliance on a philosophy of regulation that is grounded in the prevention of the realisation of risks (HSC, 2001). While this has arguably proved successful for safety problems and, in a more limited way, for traditional health issues such as chemicals and noise, it has yet to be shown to be successful for non-traditional health issues such as musculo-skeletal disorders (MSD), work-related stress, depression and anxiety, that predominate in the working age population. Such conditions are examples of what have been described as 'common health problems'.

If sustainable improvements in health at work are to be achieved, HSE will need to ensure that regulators including local authorities, duty holders and independent advisors are able to address modern workplace health issues more effectively. The findings of this health models review will be useful in developing interventions to achieve future Public Service Agreement (PSA) targets (HSE, 2004) and in the implementation of the new Health Work and Wellbeing strategy and the national rollout of Workplace Health Connect (HSC, 2005), an OH support service aimed at small and medium sized enterprises (SMEs).

Preliminary discussions, inside HSE and with a small group of external stakeholders, suggested that there are a number of different ways of thinking about health issues, and so developing approaches to tackling the problems. Models derived from, for example, occupational medicine, health psychology, economics, horizon scanning, legal and public health domains may offer appropriate and successful ways of thinking about and tackling modern complex health problems. This will particularly be the case in dealing with rehabilitation, which cannot easily be embraced by the risk prevention model.

There is a view that as well as focussing on prevention, supporting people to manage their health problems may be a more useful way of framing the issue. It may also change how duty-holders view the issue and the way it should be tackled. This is not to say that the risk prevention model cannot be applied to common health problems and rehabilitation, but rather that there may be better ways of tackling them. It seems likely that using just one model (however successful it might have been in the past) for tackling these issues is likely to give us only partial answers. HSE, partners and stakeholders will need to utilise a range of models and philosophies for different aspects of its work. Consequently, a pluralist approach is likely to represent the preferred option, in which the most useful aspects of different models are tailored to the nuances of varying OH needs. HSE therefore needs to engage others as equal partners in the search for better solutions to address OH problems common to all.

As a first step in this review process, HSE invited 35 stakeholders to take part in a workshop on 20th September 2005. HSE and stakeholders took an eclectic, inclusive approach in discussing the future application of the risk assessment (RA) process and considered health models that can apply to the long-term management of OH. To ensure the output was grounded in the realities of the workplace the process was also informed by 'horizon scanning' forecasts of how the workforce has changed and is likely to change in the future.

1.2 REVIEW AIMS

The review aims to provide HSE and its partners with a flexible decision-making framework for handling more effectively the spectrum of health issues arising in the 21st Century workplace. This will be accomplished by:

- Reviewing the different models which provide a means of framing health issues to establish their applicability to improving OH;
- Examining the scope for, and implications of, using the various models in joined-up approaches to improving OH;
- Providing guidelines for users of the various models to assist co-operation in joined-up approaches.

1.3 WORKSHOP AIMS

The review was planned to be a consultative process running over approximately two years, centered on two stakeholder workshops. The aim of the first workshop on the 20th September was to scope the potential value of different health models in accommodating 21st Century OH and well being needs. The workshop sought to:

- Systematically consider the future role and nature of RA based approaches in improving health at work especially for contemporary OH needs.
- Gauge future projections of OH trends and their implications for the current risk prevention approach.
- Gain further insight into the ways in which other models of health can potentially facilitate OH in the long term.
- Achieve consensus on future work that needs to be undertaken to test the viability of other health models in improving the management of OH.

Based on the findings and recommendations of the workshop, detailed in this report, a period of research and development will be carried out on behalf of HSE and partners to investigate research gaps, take forward some of the research ideas and lay the foundations for informing new approaches to health issues. The progress of the research will be formally reviewed in Summer 2006 and the next steps discussed.

1.4 OCCUPATIONAL HEALTH CONSTRUCT

For the purpose of the review the following interpretation of OH was used. This definition was chosen because it provides a 'holistic' portrayal of health at work that is in line with the

aspirations of the health models review. The definition expands on the World Health Organisation's (WHO) definition, as follows:

Definition: “ A state of physical, mental and social well being at work, and not merely the absence of disease and disability, that is influenced by factors within and outside the work place.”

Related concepts: Implicit within this definition is the recognition that OH contributes to employees' overall quality of life experience² (QOL).

Achieved by: ensuring the work place is characterised by the principles underpinning the Scottish Executive/Health Direct (part of NHS Scotland) definition of “Healthy Working Lives”³.

This definition is embodied in Adisesh's 2003 Occupational Health Paradigm (see figure 1).

The Occupational Health Paradigm (Adisesh, 2003): “The interaction between health and work has been a long held paradigm for OH that tends to emphasise the adverse effects of work on health. This model includes ‘wellness’ - an often-overlooked factor in the OH equation. Work can contribute to good health”.

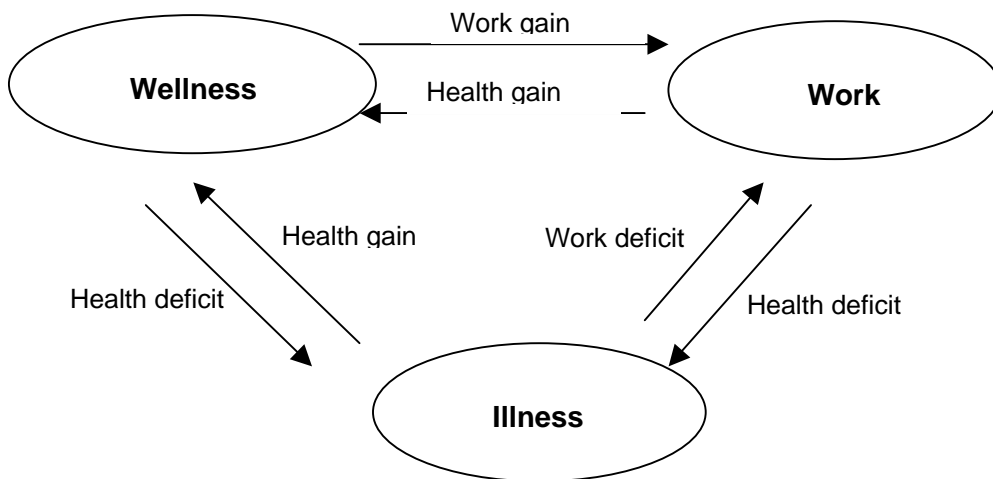


Figure 1. The Occupational Health Paradigm (Adisesh, 2003)

² The World Health Organisation (WHO) defines QOL as “an individual's perception of their position of life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (WHO, 1996). Consequently, an optimal quality of life concerns minimising the gap between current life experiences and perceptions of how life should be.

³ “A healthy working life is one that continuously provides working-age people with the opportunity, ability, support and encouragement to work in ways and in an environment which allows them to sustain and improve their health and well-being. It means that individuals are empowered and enabled to do as much as possible, for as long as possible, or as long as they want, in both their working and non-working lives.” (Healthy Working Lives: a plan for action, Scottish Executive, 2004).

1.5 SUMMARY OF HEALTH MODELS

For an overview of health models, please refer to the health models information pack (serial number HSL/2005/S7). This was prepared for the workshop and has been published on the HSE website at http://www.hse.gov.uk/research/hsl_pdf/2005/hsl0557.pdf

The models described in the Information Pack explain how psychological and social contextual factors interact to affect specific aspects of health, such as health behaviours, disability, illness representations or coping with chronic illness. Accordingly, they range from models that can inform behavioural change interventions, such as Azjen's 'Theory of Planned Behaviour' (1988) to models that demonstrate employee health to be integral to organisational health (de Joy *et al.*, 2004). In the information pack the model descriptions are sub-divided under behaviour prediction; coping and stress; disability; and intervention planning categories.

2 THE WORKSHOP

2.1 DELEGATE LIST

Name	Organisation
Dr Anil Adisesh	Medical Unit, HSL, Buxton.
Dr Andrew Auty	Re: Liability (Oxford) Ltd
Ms Carol Bannister	Royal College of Nursing.
Mr Gary Booton	Director of Health, Safety and Environment, EEF.
Miss Jo Bowen	Medical Unit, HSL, Buxton.
Dr Richard Broughton	Risk Policy Unit, HSE, London.
Mr Stewart Campbell	FOD Scottish Director, HSE, Edinburgh
Prof David Coggon	MRC Epidemiology Resource Centre, University of Southampton
Dr Jo Elms	Medical Unit, HSL, Buxton.
Prof Eamonn Ferguson	Professor of Health Psychology, University of Nottingham.
Dr Jim Ford	Occupational Health Physician, Well Work
Dr Liz Gibby	Injuries Reduction Programme, HSE, London.
Mr Rob Gwyther	South West Water
Ms Gret Higgins	Work Psychology, HSL, Buxton
Prof Philip James	Middlessex University Business School
Dr Jon Karnon	School of Health and Related Research, University of Sheffield.
Mr Peter Kelly	Health Psychology Unit, HSE, Bootle.
Ms Melissa Coutino	Legal Advisory Unit, HSE, London.
Dr Rebecca Lawton	Institute of Psychological Sciences, University of Leeds.
Ms Jennifer Lunt	Health Psychologist, Work Psychology, HSL, Buxton
Prof Michael O'Donnell	UnumProvident
Mr Simon Pickvance	Sheffield Occupational Health Advisory Service
Dr Roger Rawbone	HSE
Ms Emma Reed	Department of Health
Dr Ahsan Saleem	HID, HSE.
Dr Julian Smith	Corporate Medical Unit, HSE, Manchester.
Dr David Snashall	Faculty of Occupational Medicine, King's College, London.
Mrs Liz Standen	Health Unit, HSE, Edinburgh.
Mr Kerry Trow	FOD Northern Specialist Group – Occupational Health, HSE, Manchester.
Prof Gordon Waddell	Royal Society of Medicine
Prof Simon Wessely	King's School of Medicine.
Dr Zara Whysall	Horizon Scanning, HSL, Buxton
Dr Keith Wiley	Sickness Absence and Return to Work, HSE, London.
Dr Peter Wright	Corporate Medical Group, DWP

2.2 WORKSHOP PRESENTATION SUMMARIES

David Snashall introduced the day by saying the workshop marked the start of a new approach for HSE. At the end of the day, it was hoped that consensus would be achieved on future work required. This applies to both retention and return to work issues.

Keith Wiley outlined the origins of HSE's RA approach to OH and the factors that influenced this. He highlighted the drawbacks that had been identified of using this approach especially for common health problems and the drivers for change.

Simon Pickvance said that Risk assessment is considered to be a quantitative, 'hard science', technique, but individual responses to most health hazards mean that a quantitative approach works poorly in practice. One approach to this problem would be to incorporate health effects into RA but there are major problems here with workers' reluctance to disclose health effects (Pickvance, 1999). More fundamentally we could accept that risk is a flawed concept and that ergonomic approaches - making work fit the (individual) worker – are more useful. The central role of RA in UK OHS management arises from an interpretation of the EU Framework Directive that is open to question. The first step in the Directive is to avoid risks (requiring an appraisal of the workplace), with RA for residual risks (89/391 Art. 6.2a).

David Coggon said that the standard RA approach had been successful at controlling some health hazards, but had failed to work for others such as low back pain (LBP). Incapacity for work nationally due to LBP had increased 8-fold between the 1950s and 1990s. Cultural attitudes and beliefs are likely to have been a factor in this. If this is correct, a policy based only on reducing exposure to physical stresses on the spine is unlikely to solve the problem. Indeed, regulations to reduce such exposures could have paradoxical adverse effects by reinforcing public perceptions of the hazard. He stated the need to emphasise the positive benefits of work for health.

Mike O'Donnell called for a new way of looking at health. He pointed out that many of the risk factors for back pain and work stress were similar, and could be said to be part of everyday life. Denying people the opportunity to stretch themselves by avoiding any stress could be harmful - overcoming obstacles gives us a sense of achievement, and should be seen as a natural and positive part of life. He expressed concern that undue concentration on work as a health hazard may implant harmful beliefs and lead to unhelpful behaviours. He called for a common sense approach such as used by Healthy Working Lives (Scotland), and expressed concern about over-reliance on health modelling 'per se' as the resources could possibly be better used dealing with the problems in other ways, such as effective public education campaigns for which there is already a strong evidence-base.

Zara Whysall looked at future trends, and explained that the existing workforce is likely to be under increased pressure, partly due to the large number of anticipated retirements of post-war baby boomers. This further supports the need for effective return to work programmes, in order to increase the number of people at work. As decline of the UK manufacturing sector seems set to continue, with continuing growth in our business and service sectors, risk perception is likely to become particularly important. Although office-based work may be perceived as less 'risky', workers in these sectors are also susceptible to health and safety problems, particularly stress and MSDs. Flexible working patterns are likely to increase, eg teleworking, which may present different challenges in terms of regulation. A number of future trends also point towards the continuing importance of psychosocial risk factors, which may require a more individualised approach to risk management.

Gordon Waddell emphasised the need to take account of all of the bio-psycho-social elements of occupational (ill) health. A large proportion of people with long-term incapacity have 'common health problems' (mild-moderate MSDs & mental health problems) – which are largely subjective complaints with little evidence of tissue damage. The medical model fails to address these conditions adequately and treatment along purely medical lines often fails. Individual and contextual factors are also important. The biopsychosocial model addresses the 3 important elements, which are: the individual, their health condition and the context in which they live and work. Long-term incapacity should be rare and not seen as inevitable. These are 'whole' people with common health problems who need the opportunity, support and encouragement to deal with them. Rehabilitation should identify and address the obstacles to a return to work. The Scottish Executive's definition of a healthy working life⁴ was cited as a good example of an approach, which goes beyond RA. There is a need to rethink and consider the relationship between work and health. Work is not just a hazard to health: Work is also good for you. Perhaps the most dramatic illustration is that the risks associated with long-term worklessness usually greatly exceed the risks of work.

Eamonn Ferguson presented an overview of lay models of risk. These examine people's beliefs and knowledge about the causes of their illness and how it is treated. He described structural cognitive maps (SCM) which plot factors which cause/protect against ill health conditions. An individual's SCM can be plotted to learn the key factors exacerbating their ill health. He highlighted the problem of experts having different opinions and the need to understand the myths behind people's health beliefs, in order to change them.

Rebecca Lawton talked about the common elements of social cognition models. They almost all include aspects of weighing up the costs and benefits of new behaviours; perceived or actual control and the role of intention or motivation. The role of emotion has been neglected in many models and few describe how to use the model to change behaviour. Behaviour change theories have been used in public health interventions, however the interventions have not been properly evaluated. Evaluations of interventions should be conducted to identify both behaviour change and the effect of the intervention on targeted cognitions.

Emma Reed described policies and strategies from Public Health, drew parallels with OH, and related them to the biopsychosocial model. 'Choosing Health' is one example, which focuses on 20 health components, and aims to make advice more accessible. It advocates the theory that advice from 'next door' is more likely to change people's behaviour than advice from 'on high'. OH services will have a health promotion role in the future. The 'Condition Management Programme' (part of the 'Pathways to Work' initiative) includes cognitive-behavioural education approaches. Part of Emma's role in DH is to interface between DH, DWP and HSE to bring about more coordinated working.

⁴ For definition refer to footnote, p3

2.3 SYNDICATE DISCUSSIONS

For the afternoon session, the delegates were divided into 3 separate syndicate groups (see Appendix 1, section 6.1) to undertake the syndicate exercises.

The exercises involved answering the following 3 questions.

- 1. Is HSE's risk assessment approach appropriate, and what are its strengths and weaknesses?*
- 2. What is the future context for occupational health, and how does it modify the strengths and weaknesses of risk assessment?*
- 3. How do different health models offer us a way forward, and what more information and evidence do we need to develop an eclectic⁵ approach within the next 6 months?*

A rapporteur and facilitator were allocated to each group, each group discussed all 3 questions and fed their ideas back to the workshop in answer to one nominated question. There was an opportunity for plenary discussion after each rapporteur's presentation.

A summary of syndicate group discussions is detailed in Appendix 1 (section 6.2-6.5).

2.4 FEEDBACK FROM SYNDICATE GROUPS

2.4.1 Group 1 Feedback - response to Question 1. Rapporteur: Simon Wessely

RA is appropriate for concepts if the hazard/problem is correctly understood. However it is flawed and may be counter-productive for conditions such as MSD and stress. For example, at the moment it seems that electromagnetic sensitivity is mainly reported in Sweden and so if a classical OH model is followed then the solution is either never to work in Sweden or remove all Swedish workers from the workplace. Such a reduction to the point of absurdity demonstrates the limitations of the old fashioned approach to these new problems. If we move to some of the more difficult issues, and fail to properly analyse the real causes of the problem, then again not only may classic OH interventions fail to work, they may actually exacerbate the problem, RSI being a case in point, back pain another.

The mental health epidemic shows a related issue. We know that risk factors for work stress include personal factors such as family history/personal history and previous disorder. We also know that there is a high risk of relapse of common mental health problems. So employers might be tempted not to employ people with a history of such problems. Yet we also know that work is in general good for mental health, and lack of work detrimental. So on an individual level returning to work might be associated with an increased risk, which of course a classic RA model would wish to reduce, but it might also on both an individual and population level be associated with benefit. Using a crude individual RA in mental health might simply mean that people will deliberately conceal a history of mental health problems.

⁵ The term eclectic refers to an intention to distil elements of various models and to apply them to the specific characteristics of a given occupational health need.

Traditional RAs deal with the effects of work on health where it is possible to remove/reduce the risk or at least absorb the risk. The RA is not effective when looking at the effect of health on work, and nor does it work well when the outcome is a subjective and/or symptomatic one only. In the new terms we have decided it is ambiguous. The ambiguous nature of newer risks/subjectivity and individual's beliefs/views of their risk - calls for a reflective nature to RA. This is particularly so when the link between exposure and symptoms is subjective, and where there is a strong role for a person's health beliefs. It does not really matter whether or not a person believes that asbestos is harmful to health in assessing the risk to the individual from asbestos. It does matter for conditions such as work stress, and matters greatly when the outcomes include such illnesses of modernity such as RSI or multiple chemical sensitivity (MCS).

Risk assessment is appropriate, but if it is based on ignorance of the social/behavioural domain it may be at best ineffective and at worst counterproductive. Where the factors are ill-defined, an inappropriate RA is as bad as having no RA.

Employers make decisions about interventions – how do we bridge the gap? We do not know the drivers – but an approach can be defined not only on an individual basis but to include employers and HSE in evolving this approach should give guidance to employers. Risk/outcome should consider not risk of occurrence but of it becoming disabling and how that can be managed. Before we drop RA (law is a motivator) it should be replaced with an (RA?) approach in an open minded way. There are issues about how this interacts within health context, we need to keep consistency in terminology and evolve.

To sum up: for RA there are legal and consistency issues. The concept is good but its validity & application less so. Traditional RA is not suitable for modern health problems.

Questions/Comments:

Rob Gwyther asked how the employer decides which is best.

Peter Kelly said there is an argument for the individual approach, but there is also an argument for a cluster of people collectively experiencing problems.

David Snashall said that RA has its place, but it may be inappropriate or ill-defined. It also depends on what people believe.

Rob Gwyther asked how to bridge the gap between appropriate models/actions

Ahsan Saleem said: "we need to be careful not to confuse the principles of the RA approach from the specific way that the approach has been applied to the traditional OH risks. MSD and stress are more complex issues but the RA approach does require consideration of all the risk drivers, be they organisational, social, environmental or personal. There is a need for better analysis of the factors contributing to MSD/Stress risks, which should then form the basis of future prevention and control strategies."

David Coggon said that cultural influences are also relevant. For example, if there is a societal expectation that stress in the workplace can be a problem, then it will be so. Psychological influences aren't only at the individual level but also at the cultural level. HSE already advises employers on which approach to follow and will give guidance on specific health conditions to employers as this process evolves.

Gordon Waddell asked: ‘Can risk assessment disable us?’ Risk and outcomes are important. It’s not just the risk of getting the condition but also the factors for it becoming disabling that are of interest.

Rob Gwyther: ‘We employ risk assessment, but in different ways, for different people, and for all things.’

Simon Wessely: ‘Traditional risk assessment is being re-evaluated’

David Snashall: Use wider terminology now in place of risk assessment

Stewart Campbell: ‘The issue today is not about replacing risk assessment but about the traditional workplace-related approach. – how can the workplace deal with these new issues? We can regard anything as risk assessment if we approach it in a different way – the main issue is how we go about approaching these new health issues.

Rob Gwyther: ‘PLEASE, do not keep changing the terminology. This could cause even more confusion – get, and keep, some consistency in the terminology and don’t keep changing.’ We don’t want a message going out that risk assessment isn’t being practised any more.

David Coggon: the conventional approach to risk assessment, whereby risk is modelled as a simple function of exposure, is not appropriate for all categories of work-related illness.

Rob Gwyther: ‘Many employers have moved beyond that. RA is being used for mental health by some’.

Jim Ford: ‘The ‘health on work’ agenda (i.e. effect of health on work) applied to individuals is different to the traditional way of applying RA. The same principals are applied but in an individual context.

2.4.2 Group 2 Feedback – response to Question 2. Rapporteur: Rob Gwyther

1. Keep evolving the OH framework which has been built up. We don’t need revolutionary change – do not move into another direction – enhancement, modern ideas and consistency are now needed. Lurching in new directions would not be good for industry.
2. Adopt a multifaceted approach including RA. Health promotion may be the right way to get people to undertake RA.
3. HSE is the catalyst and evaluator. Do we want the above? - yes, but we want to see it done even better. HSE can help industry to involve workers even more, getting out amongst the workers, asking them as individuals what they think the answer is. Worker involvement is not as genuine as it could be and HSE should improve on this and stimulate it.

“Stay in the Boardroom” HSE’s Code of Practice for Directors’ Responsibilities” is an excellent guideline. HSE should put this into the workplace - HSE has work to do here.

The supply chain was discussed earlier – it is illegal and immoral to order from anyone who does not take into account their employees – it is a business continuity issue. HSE should help with investing in the community.

OH resources and delivery – OH expertise is needed and only HSE can ensure that this happens.

Evaluation – We need to present these good ideas and evaluate the success and continuity of OH. Evaluate at every level continuously – evaluate at the UK level. This is how we know if new strategies have worked. The traditional approach of assuming changes leads to improvements is no longer acceptable. Now need to evaluate to check progress and prove the effectiveness of initiatives

In summary: Keep evolving, use a multifaceted approach. HSE to continue working at the level they already are.

Questions/Comments:

Gary Booton: ‘What is OH? What services do OH-service providers provide? Most employers who employ OH physicians don’t appreciate what they are paying for. Businesses need to appreciate what services they need. There is a perception in business that OH physicians will focus on individual cases not problems stemming from how the business is run.’

Michael O’Donnell - ‘Does anyone talk about maximising and assessing the value of occupational health?’

Rob Gwyther – ‘It is essential that we go out and buy occupational health.’

Michael O’Donnell – ‘Occupational physicians need to work more closely with managers in a consultative role rather than just acting as clinicians or a resource for human resources (HR). We must also recognise that HR departments’ and managers’ attitudes can have a major impact on the effectiveness of OH provision’

Jim Ford – ‘It is very difficult to measure what occupational health does. Information technology (IT) is not up to speed with this because it does not pay to put in expensive IT systems – this could be one of the problems. Therefore, occupational health is rather vague because it is too difficult to measure.’

Peter Kelly – ‘Businesses tend to behave in a reactive way towards OH. There is a culture of getting ‘occupational health’ (i.e. physicians) in, rather than using occupational health to start this off. The physician should be there to prevent people going off sick, not to get them back to work. RA is lower in their priorities than reactive case management’

Stewart Campbell ‘How can HSE achieve importance in overall work unless we can influence the whole order of stress and health psychology? There needs to be closer alignment between HSE and PH. HSE cannot continue with this unless we integrate. There are inherent risks in this but it will have to happen’

David Snashall – ‘I think the interesting point is evolution. PH and OH can learn from each other’

Miss Emma Reed: ‘The biggest risk is not taking the opportunity that exists now for PH and OH to work together. The climate is ripe for collaboration’

At this point Jim Ford brought up passive smoking as an example of where public health and occupational health issues overlap.

David Snashall replied that we will, at some point, be going into line with Scottish Law.

2.4.3 Group 3 Feedback – response to Question 3. Rapporteur: Gary Booton

There is a very strong basis for going forward. We need to understand all regulations and guidelines such as those for manual handling and display screen equipment (DSE), and we share Rob Gwyther's concerns that rules cannot be changed half way through. This is a civil framework and these are legal requirements and someone has to implement them. Firstly, we need to use the evidence base and show clear methodology - has there been a health change in people? We need evidence. Do current requirements reflect this change? HSE needs to gain an understanding of that.

Secondly, there is a change in terms of public perception. The message needs to be right, not mixed. There is not a direct relationship between supplying information and changing behaviour. Information upon which people act is spurious.

We should move forward by working with Public Health. HSE and OH cannot operate alone. HSE cannot solve all problems. In society work is perceived as the problem, whereas it can be part of the solution (as in Scotland). There are areas in the country where real problems lie and we should concentrate on and put money into these 'high need' areas.

The NHS linkage needs to be explored/improved. NHS needs to recognise occupational aspects of illness/injury in Primary Care. There are implications for NHS treatment givers, who should consider the occupation of the people they treat. There is clearly a relationship between how different individuals are treated, e.g. footballers, sedentary workers, and so on. It could be useful to focus resources where a positive effect is most likely. The HR community also have a role to play. OH is more than provision from health professionals. HR is also a factor. What can be done to increase employers' knowledge about this? For absence management, OH is more than just doctors and nurses, for example, HR now have a growing input into this.

Also, think about SMEs and the demographics of UK population. We need to engage with SMEs. They do not have enough opportunity to put their views forward. Small organisations are not necessarily bad employers. They can often be good employers and lessons may be learned from these.

Knowledge/skills/attitudes - what health outcomes are achievable? We need to identify areas of activity and demonstrate progress towards goals. Then learn from that experience. What is the baseline we are working from? There has been a massive growth in incapacity benefits in recent times. What are the increases? What level of incapacity would be right for society? – N.B. a correction note was received from Peter Wright (see below).

To conclude, Health models are useful vehicles. Be systematic and use models to identify what works.

Questions/Comments:

Peter Wright stated that there has not been a massive growth in incapacity benefits in recent years. DWP's target was to get 1m people back to work of 2.7m on benefits.

Jim Ford stated that OH has evolved over the past 15 years and this has an impact on pensions policy via ill health retirement. Access to pension schemes ties in with OH and can be unequal to people with disabilities.

Ms Carol Bannister mentioned worker involvement. Avoid 'expert' systems. Understand where people come from – not top down initiatives but information from 'next door' (as mentioned by Emma Reed). Connect up workers and employers to share messages.

Stewart Campbell said we should distance ourselves from work-relatedness. Many cases of occupational ill-health are not actually work-related. It's more about conditions and people. The self-reported Illness Survey says 'caused by work' not 'work-related'. This lowers the statistics.

2.5 CHAIRMAN'S SUMMARY OF FEEDBACK

David Snashall said he was very heartened and delighted with the response to today's workshop. There was a relevant mixture of individuals bringing their own ideas and input and high levels of agreement.

'We have had a mixture of medical people, representatives from the Civil Service, Psychology, Business and Legal Profession and they have actually all managed to come together to make today an extremely useful and fascinating one.' He added that summing up is very difficult!

The issues raised go beyond the scope of OH and numerous possible ways forward have been revealed. There are various forms of adverse health outcome related to work and HSE impinges on only a small part of the process. The statistics of work-related diseases are very crude. There are always psychosocial issues to consider.

Does RA still have a place in the world? Yes, it does, for consistency, legal and social reasons and every one here agrees it must remain. But in terms of the wider bill of health, there have to be new, perhaps complementary approaches. RA is not a bad tool, but it has vague/blurred parameters. It is because of the blunt and uncomprehensible nature of RA and traditional RA methods that cause the failures. There has to be a new approach. HSE has to decide where the traditional approach does work and in the areas where it does not work, we must address the issues and deal with them. Intervention must be very carefully done and evaluated (we have a poor record for evaluation) taking evolution into account.

Key messages:

- consistency to be kept
- much more work needs to be done in areas where it is not working.

Consistency: there are business imperatives - and other reasons that may be more altruistic! OH professionals and business share the same aim even if their reasons vary. There is a need for OH and public health to be integrated. We have spoken about this before but nothing happened. Traditionally they were kept separate so that the cost of OH could be borne by industry. OH has always been divorced from the NHS, with good reason, but now the time has come to put the two together.

Proper evaluation is essential. There has been too much concentration on measuring changing attitudes rather than measuring health status. Return to work is measurable and a good health

metric. We could use return to work as a health outcome measure and various initiatives are ongoing at the moment.

The presentations we saw today gave an extremely full picture. The next steps are up to HSE.

2.6 NEXT STEPS – KEITH WILEY

HSE/HSL will write a draft report of the day's proceedings and circulate this to all attending this workshop to ensure it is an accurate account. In addition, we will be commissioning a contractor to examine the evidence base and to further consider the utility of the models discussed here today to provide a framework for addressing common workplace health problems. We will also communicate this project and the proceedings from today more widely in HSE. We would then aim to hold a final workshop in the spring of 2006.

3 MAIN FINDINGS

The workshop successfully achieved its first three aims (see section 1.3) and gathered a positive and constructive range of information and opinions from the participants upon which to progress with its fourth aim of achieving consensus on future research work.

The following main findings have been collated from the syndicate group discussions and other verbal contributions to the workshop and have been grouped into logical themes.

3.1 RISK ASSESSMENT

Where RA doesn't work

Inappropriate RA is as bad as having no RA. In some situations (for example, in relation to MSDs), a message that raises awareness of the risks associated with work activities may be counter-productive. Using RA in mental health could cause more people to cover up the nature of their problems. RA should be an ongoing, cyclical process rather than a 'one-off' assessment as is often the case.

Where RA works

Simple, traditional RA is a valuable tool where the risks are discrete and the cause-effect relationship is known. It shows up risks and reduces worker exposure to hazards. It works when dealing with the 'average/normal' individual, when it is easy to eliminate/reduce risk of the worker being exposed to a hazard. In its favour it is widely understood and accepted by employers and employees and utilises a goal-setting and disciplined approach. Additionally it should be preserved as it is an essential part of the legal system and is enforceable.

Evolution not revolution

The workshop delegates expressed a strong desire to maintain the RA approach and terminology to ensure that the RA process as it stands is not undermined. They advised HSE to keep evolving the OH framework which has been built up. There was a suggestion that the emphasis should not be on replacing RA but about the traditional workplace approach – HSE should provide the workplace with guidance and tools to help them tackle these new issues. There was consensus among the delegates for an evolutionary not revolutionary change and enhancement and consistency were the recommended ways forward. Unnecessary over-complication would hamper progress towards improvement.

The traditional approach to RA is not appropriate for all health problems. An alternative/supplementary approach is needed for health problems where the risk factors are more complex, the cause-effect relationship more ambiguous, and interactions multifaceted. As one delegate put it, 'HSE needs to decide where traditional RA doesn't work and intervene'.

Over the last couple of decades in the UK there have been changes in the nature of work and also changes in perceptions, attitudes and behaviour around health and work. The future will see more change but additionally we will see more variation in the composition of the workforce. The delegates agreed that RA must evolve to keep pace with these changes. RA still has a role but there is a need to incorporate individual health beliefs, emotions, behaviour and organisational psychology and culture.

3.2 THE WAY FORWARD

Collaboration

The remit of this project goes beyond OH: there is a need for more joined-up government working than exists currently. Especially between DH, DWP (Jobcentre Plus in particular) and HSE/HSL (see Box 10, p26). The biggest risk is that we don't take the opportunity to integrate OH and public health now, while the right climate exists. We should move forward by working with other organisations such as employers' organisations, academia and Trade Unions. A health promotion approach may be the right way to get people to tackle disorders such as MSDs and stress.

Health Messages

A key message propagated at the workshop was that health problems are part of everyday life and OH should be viewed in the wider context of health, work and wellbeing. In this respect we need to take an individualised perspective in helping the working age population to deal with common health problems both in the occupational and non-occupational context. There seems to be a requirement for a cultural change - for people to believe that work can be good for you. Some of the questions that remained were: what can be done to encourage and support organisations to support less than perfect health in their employees? Is legislation adequate? What are employers' concerns?

The health information upon which people act is spurious. Messages that successfully change people's behaviour appear to come from 'next door' not from 'on high'. We must ensure the messages we put out are the right ones (i.e. not 'catastrophising') and are consistent. The positive and negative framing of messages is important; we tend to pitch messages using 'loss frames' but research indicates that gain frames can be more effective for changing detrimental behaviours. It is important to emphasise the benefits not just the hazards. HSE has a trusted public image but some delegates thought worker involvement and HSE's public image and media exposure could be improved. There seems to be a large training need to take a different RA approach for complex health problems forward. The knowledge base spans more than one discipline and therefore multi-disciplinary collaborations will need to be established to bring expert professionals together. The workshop established that the biopsychological viewpoint could help us find a way forward; although it is not the only way of finding solutions. It would also be advantageous to have inputs from other specialisms.

Health Models

It was agreed by the workshop that health models are useful in that they account for the complexity of health problems such as stress or MSDs (for example, the same environment does not always result in the same outcome for different individuals), by highlighting the important roles played by attitudes and behaviours in reducing such problems. The workshop recognised that the challenge of interpreting the psychological and biopsychosocial models may put some people off and those without a technical/scientific background may not be receptive to the use of models 'per se'. There were calls from some delegates to integrate existing health models into one 'gold standard'. But this runs the risk of models losing their inherent value if they were 'homogenised'. Instead, it was suggested that the essence of the models could be 'distilled' out to guide the underlying philosophy of future research questions, strategies and interventions. It was recommended that, in order to take things forward effectively, HSE and partners need to develop an integrative framework that spans the complete process of managing health issues, perhaps integrating the most valuable aspects from each of the models.

It was frequently raised that strategies and approaches aimed at changing attitudes and behaviour should be pitched at both the organisational (cultural) level and at the individual level. Recent studies have shown that the 'stages of change' model can effectively be applied to employers and employees to tackle MSDs. Cognitive mapping (as demonstrated in Eamonn Ferguson's presentation) may be a useful way of tapping into individual beliefs, but the cost implications of this were not discussed. Research is needed to investigate the evidence-base on occupational 'health needs assessment'. Could an intervention be formulated? If not, we should identify the research gaps in the area of motivating people to return to work.

On the one hand we have identified that RA can be counter-productive but on the other hand, for consistency's sake, we want to maintain the terminology with respect to future tools for stress and MSDs. We need to explore how to deal with these tensions?

A biopsychosocial approach

There is scope to design tools, techniques and interventions that assess the biopsychosocial barriers that may exist for individuals and organisations. Any implementation strategy will need to encourage employers and duty holders to take on new approaches, such as those that consider psychosocial factors. If we expect employers and duty holders to tackle these factors, there needs to be a clear definition of what they are, and if possible, what are acceptable levels. The delegates asked how the stress management standards would fit into this work and whether there are additional factors that need to be taken into consideration?

Whilst it is important to acknowledge the individual element to problems such as stress, care must be taken to avoid stigmatising individuals with such health problems. Organisational risk factors should be addressed ahead of individual ones (i.e. level of control, involvement in decision-making, role clarity, and so on).

Evaluation

Improved evaluation was another key theme of the day. HSE has recently concentrated too much on measuring changes in attitudes and not enough on measuring improvements in health status. It was suggested that we could use return to work as a readily measurable health outcome.

The delegates called for the evaluation of intervention programmes, taking into account people's assumptions of disease and looking at process (e.g. illness representations) and outcomes (e.g. sicknesses). We need to identify the mechanisms, (e.g beliefs), use process measures to identify the causal mechanisms (e.g. changes in illness representations) and actual health outcomes and avoid surrogate measures such as absenteeism.

We need to establish what the expectations are, what is the baseline and what a new/revised strategy would aim to achieve? Some occupational disease rates are falling; can a further drop in occupational disease rates realistically be achieved?

Occupational health – societal and industry role

It was noted by several delegates that OH is more than provision from health professionals. HR also often make a contribution to OH issues and this role needs to be recognised in future strategies and interventions. Businesses in the UK today tend to behave in a reactive way towards OH. Some contributors saw the problem as being related to prevention rather than RA: there is a culture of getting 'occupational health' (i.e. physicians) in to trouble-shoot individual cases, rather than using OH to develop a workplace conducive to good health.

It was felt that OH faces some fundamental problems: its strategy and goals are not well defined, employers who pay for OH services don't really understand what they are buying and HSE needs more OH resources and delivery. Other ways of providing for OH needs in the future could include involving insurance companies or holding the employer responsible for return to work (as in some other countries).

4 RECOMMENDATIONS

Some key recommendations emerged during the workshop and appeared to receive consensus from the delegates. The information and opinions gathered on the day, as described herein, will be utilised by the review Steering Team to chart a way forward and formulate research questions which reflect the recommendations which follow:

Risk Assessment (RA) – ‘Don’t throw the baby out with the bathwater’ (*Liz Standen*)

Keep some consistency for RA (from the point of legality and terminology) and don’t undermine the traditional RA process, which is appropriate in many situations. RA also needs to be enhanced to deal with the emerging workplace health problems. It was suggested that:

- HSE continue to provide tools for specific tasks but they will also build extra tools.
- HSE should develop an integrative framework that spans the complete process of managing OH, perhaps integrating the most valuable aspects from each of the health models.

Collaboration – ‘The biggest risk is not taking the opportunity that exists now for PH and OH to work together. The climate is ripe for collaboration’ (*Emma Reed*)

There was strong consensus that there needs to be alignment between the health and wellbeing strategies of different government departments (see box 10 for developments since the workshop).

Box 10.

On 19th October 2005, the Government announced its new strategy: “Health, work and wellbeing – Caring for our Future” produced jointly by DWP, DH and HSE, in which it sets out its plan to:

- Improve the health of the working age population
- Promote work as being important and beneficial for all
- Improve employee retention
- Enable rehabilitation.

It seeks to bring together all the government departments concerned with the health of working age people. More information can be found at:

http://www.dwp.gov.uk/publications/dwp/2005/health_and_wellbeing.pdf

Health Models – ‘The future should focus on commonalities rather than individual models. It is important that models are used “with thinking”’ (*Roger Rawbone*)

Health models should be integrated into strategy development and design of tools and approaches. Those underpinned by the biopsychosocial ideology were well received at the workshop and may lend themselves well to addressing complex, modern health problems, which span people’s work and home-lives. An organisational, or cluster approach, was also considered important so that not all the emphasis is placed on the individual.

We need to distil the underlying philosophies of the different models into a coherent framework, which encompasses the whole process from prevention to rehabilitation. The research needs for this should be explored. One suggestion was to identify the research gaps in the area of

motivating people to return to work. The health models philosophies need to be translated and made user-friendly so that they can be understood and applied by lay-people.

A multi-disciplinary approach will be needed for further health models research work that draws on psychological, sociological, health promotion and OH disciplines, among others.

Evaluation – ‘We need to present these good ideas and evaluate the success and continuity of occupational health. This is how we know if new strategies have worked. The traditional approach of assuming changes lead to improvements is no longer acceptable. We now need to evaluate to check progress and prove the effectiveness of initiatives’ (Rob Gwyther)

Evaluation needs to take place, both to establish a baseline and to judge the progress and effectiveness of new initiatives. Specifically, the effectiveness of the RA approach as it stands needs to be evaluated to provide an evidence base. This throws up challenges of deciding upon appropriate health indicators, such as disease incidence and prevalence rates, biomarkers and quality of life measures. David Snashall suggested that return to work is a readily measurable health outcome. In presenting any new ideas HSE and partners need to include evaluation steps that will allow continuity of OH to be monitored and success of interventions to be measured. We should continuously evaluate at a range of levels that gauge the mechanisms of change as well as outcomes. HSE should see themselves as the catalyst to new approaches and the evaluator.

Strategy development – ‘The issue today is not about replacing risk assessment but about the traditional workplace approach. – how can the workplace deal with these new issues?’ (Stewart Campbell)

HSE should take a systematic approach to new strategy development and use models to implement it. An iterative, multifaceted and systematic approach will be required to develop new strategies. In the meantime, HSE should continue working at the level they already are.

Framing Health Messages – ‘From the evidence presented, we can conclude that LIFE is hazardous!’ (Mike O’Donnell)

Health messages should be framed carefully and appropriately and the positive benefits of work should be promoted. We need to take into account that work can involve both hazards and benefits for (physical and mental) health and the suitability of the person for the job (‘person-job fit’) is an important factor. We need to take a balanced approach to the relative risks and benefits. The basic message underpinning the biopsychosocial approach is that understanding and management of common health problems must take account of the individual, their health problem, and the context in which they live and work. In order for this message to be successful a need exists to identify what aspects of a job or workplace make it ‘healthy’. A literature review could be conducted to explore what evidence exists and where the knowledge gaps are.

HSE’s role - HSE can help industry to involve workers even more by getting out among the workers and asking them as individuals what they think the answer is. (Rob Gwyther)

It is difficult to engage with workers and some delegates suggested that worker involvement by HSE could be improved and made more genuine. There is a lack of evidence as to why SMEs are not enthusiastic to engage with HSE. However, HSE and HSL have several initiatives underway, such as the new ‘Healthy Work Matters’ website (Sheffield Occupational Health Development Group, 2005) Workplace Health Connect (HSE, 2005), and the Centre for Workplace Health based at HSL, which are aimed at raising awareness of the effects of work

on health and implementing HSE's Occupational Health Strategy, particularly for SMEs. The HSC sees workforce involvement in health and safety as a key strategic issue and central to improving health and safety standards in the UK. It issued a declaration to emphasise the importance of worker involvement in 2004 (HSC, 2004).

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6 APPENDIX 1

6.1 SYNDICATE DISCUSSION GROUPS

Feedback:	Question 1	Question 2	Question 3
Facilitator:	R. Rawbone	L. Gibby	C. Bannister
Rapporteur:	S. Wessely	R Gwyther	G. Booton
	J. Bowen	A. Auty	A. Adishesh
	R. Broughton	P. James	S. Campbell
	J. Ford	P. Kelly	D. Coggon
	G. Higgins	R. Lawton	J. Elms
	M. Coutino	A. Saleem	E. Ferguson
	S. Pickvance	E. Reed	J. Lunt
	L. Standen	J. Smith	M. O'Donnell
	Z. Whysall	K. Trow	D. Snashall
	J Karnon	G. Waddell	K. Wiley
		P. Wright	

6.2 SUMMARY OF SYNDICATE GROUP RESPONSES TO QUESTION 1

“Is HSE’s risk assessment approach appropriate, and what are its strengths and weaknesses?”

Group 1

The risk prevention approach is useful when looking at the effects of work on health (e.g. for HSE and LAs) and is an effective tool for looking at the risk that exposure to workplace hazards presents to the ‘average’ individual. The group cited the following weaknesses of the RA process:

- It cannot operate when a clear relationship cannot be drawn between hazard and health effect
- It is difficult to quantify the variables (e.g. worker susceptibility to hazard)
- RA doesn’t always work to protect people from hazard if, for example, there are problems with implementation
- RAs are not done on a continuing basis (see box 1)

- RAs are not always carried out adequately or implemented properly
- There can be problems with disclosure (workers might not want health problems to be known)

Some members of the group agreed that the fit of the worker to the job is the key to avoiding many of the negative effects of health on work (see box 1). However, this is very difficult to implement in practice without risking discrimination. The RA process is being undermined, perhaps unfairly, as it serves a purpose for inspectors and from a legal perspective. It was argued that a formal RA isn't necessary for safe and healthy working in many businesses; applying 'good practice' to work tasks is sufficient. RA should be an ongoing, iterative process. Promoting health can embrace risk, but it's difficult to gain acceptance for this view. Health promotion can be counter-intuitive if the message isn't framed in the right way. The recent HSE 'Backs' campaign is an example of a catastrophising message being conveyed about back injuries, i.e. make one mistake and you've got it for life (see box 1).

Box 1: Statements made in syndicate 1

"The 'fit' of the worker is key. Risk Assessment is looking at the worker – is he appropriate for the job?" - John Karnon

"Risk assessment can be a 'one off' event, the piece of paper is filled in and filed away for ten years" - Zara Whysall

"The message is framed in the wrong way" - Richard Broughton (about the recent HSE radio adverts)

Group 2

Syndicate group 2 drew up a table of RA strengths and weaknesses (see Table 1)

Table 1: RA strengths and weaknesses.

STRENGTHS	WEAKNESSES
Understood (perhaps not as well by some as by others!)	It is often not done.
Systematic & structured.	It is a narrow approach (but 'do-able').
Seen as successful.	Requires expertise to apply it.
Raises profile of Health & Safety (H&S).	Can translate to a paper exercise without actual change in work activity.
Acts as a trigger for people to control risk, ie produces action.	It is not participative. Often it is done by managers and excludes the worker.
Can show it has reduced exposure in some instances e.g. wood dust (but not isocyanates).	It is negative. Encourages identification of bad things (however the consequences of not doing so could be worse).
HSE has reduced fatality rate in accidents at work by one third.	It can be difficult to apply because it is a generic approach.

<p>Readily applied by lawyers.</p> <p>Encompasses goal-setting, gives flexibility to employers.</p> <p>Reduces the burden of a prescriptive H&S system.</p> <p>Fits well with other business activity e.g. environmental risk.</p> <p>Has got H&S onto the commercial agenda.</p> <p>Enforceable and regulatory – provides a framework for civil recourse.</p>	<p>Readily applied by lawyers!</p> <p>Need an identifiable risk.</p> <p>Too complex, e.g. COSHH.</p> <p>Hasn't helped to deal with mental health</p>
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The strengths the group identified are summarised above. They thought RA could be successful in reducing risk, or at least there is a perception that it is. However the group was uncertain whether RA had been evaluated and whether there was evidence for the approach being effective with respect to ill health outcomes. They agreed that there is evidence that RA carried out properly in traditional industry effectively controls risks and reduces exposure to hazards. There are now fewer of the traditionally hazardous industries and RA needs to change accordingly. RA gets H&S onto the agenda of business/managerial factions. The weaknesses are also summarised in Table 1. The group identified that RA can be counter-productive in approach – it identifies “bad” things and suggests a causal link to work. It doesn't allow for any other aspects, such as the health promoting aspects, of work to be considered.

Box 2 - Statements made in syndicate 2

“It [risk assessment] is well understood and easily applied”. -Rob Gwyther

“Lawyers love it!” – Gordon Waddell

Group 3

The group thought that RA still has value and is appropriate for simple health problems but fails as an application when considering health problems with complex aetiologies, such as stress or MSDs, where there is no clear-cut dose-response effect (see box 3). How would you quantify exposure leading to stress, back pain and mental health? It could be ‘perceived pressure’ but this would include other stressors not just the work induced ones. Employers at the moment have to follow the traditional RA approach for stress; this cannot address all issues but does adopt reasonable standards.

RA has a legal impact on what employers do but for some health problems it is difficult to quantify the exposure, which makes enforcement difficult. This is true for stress but not for ergonomics. RA shouldn't be abandoned and we shouldn't make things more complex than they need to be when looking for a way to take it forward.

It is counter-productive to present work-pressures as a hazard from which workers need to be protected. RA implies work is bad for health, but there is less risk to mental health from being at work than not being at work. Avoid making negative perceptions with messages such as, “Don’t do this because it’s bad for you”. Instead convey more positive messages, such as “Do this because it’s good for you” (see box 3).

Box 3: Statements made in syndicate 3

“The HSE approach is wrongly characterised as being related to risk assessment; it is related instead to prevention. HSE needs to recognise that we need to engage in a different way from risk assessment, particularly as we cannot directly influence the cause of many health problems.” – Stewart Campbell

“It may be counter-productive to present workplace stress as a hazard from which workers must be protected. The emphasis should be on maximising the positive psychological benefits of work” – David Coggon

“Need to avoid talking about ill health, instead good health. Need to talk about risk perception.” – Mike O’Donnell

6.3 SUMMARY OF SYNDICATE GROUP RESPONSES TO QUESTION 2

“What is the future context for occupational health, and how does it modify the strengths and weaknesses of risk assessment?”

Group 1

The syndicate group discussed various changes to working patterns that will have an impact on future OH. They foresaw a shift of working activities that will force more emphasis onto health issues and the individual worker.

It is predicted that numbers of migrant workers; home-workers and contract workers are already increasing and will increase further (see box 4). It is likely that this transient workforce will not raise issues of OH with their employers and may disregard or conceal their work related ill-health in order to safeguard their employment.

There was debate about whether SMEs foster better OH and opinions were divided (see box 4). It was agreed that these employers need to be reached and this will require a different approach. The group were informed that HSE already has schemes that reach out to SMEs and improves awareness of OH issues in different sectors.

The issue of pensions was also raised. Working long hours increases the risk of heart disease, but some people might want to carry on working to increase their pensions. It was thought that aged workers may often conceal OH issues. Jim Ford highlighted the need for RA (for individuals) for entry to pension schemes. Most pension schemes do not have an ill health aspect and there are benefits to an employer of workers continuing to work (see box 4).

Box 4: Statements made in syndicate 1

“Risk assessment falls apart on manual jobs – these jobs are increasingly being given to migrant workers, who feel that at least they have a job, which they didn’t have at home, and

would not want to jeopardise that. These workers are more likely to ‘put up’ with things” – Simon Pickvance

“SMEs are already moving to more individual risk assessment; they have better disability figures” – Melissa Koutino

“For ‘final salary’ schemes robust gatekeepers make it work, e.g. in ship-building. The National Health Service (NHS) and teaching professions have a poorer track record. There needs to be a framework for gate keeping ill-health retirement to prevent people retiring and then returning to work.” – Jim Ford

Group 2

There was a view among the group that any new policies need to be broad, coordinated and represent joined-up policy making (between HSE and other bodies). It was thought that more psychologists were needed in industry (instead of residing in universities). HSE has a role as: catalyst; adviser; and sustainers of action.

This group had concerns about access to OH for temporary workers, illegal workers and the ageing population and warned there is a danger of social inequality.

A ‘one size fits all’ approach will not work (see box 5). There is currently a ‘top-down’ approach to RA and there is a need now to involve workers and discuss how workplace characteristics contribute to stress. Many health conditions are multifactorial and dealing with these should be presented as ‘normal management’. To promote this successfully would require engagement and commitment from top managers. Genuine workforce engagement is also necessary, but changing worker behaviour is difficult. The ‘stages of change’ approach to MSD appears to be working successfully. There is often a plea from workers that ‘managers don’t care’. An insincere attempt to engage workers could be counterproductive.

Another issue the group raised was the reducing resource of OH specialists. Some clarification is needed about who does what. Insurance companies could get involved in OH. However, insurance companies are tied to a RA approach. This is not necessarily a problem since insurers sell services and products, which benefit their customers.

Box 5 - Statements made in syndicate 2

“One size does not fit all” - Rob Gwyther

“We need more work psychologists out of universities and into industry” -Gordon Waddell

Group 3

Group 3 viewed the future changes affecting OH as: manufacturing base reducing; ageing population; downsizing; demographic changes; more skilled workers needed. They identified a need for more collaboration (see box 6) and joint strategic activities between HSE and other government public health bodies. HSE needs to integrate with health promotion. HSE’s current approach focuses on ill-health prevention, whereas the DWP emphasises health management more. Public health (PH) is a major issue in Scotland and there is effective collaboration between OH and PH (see box 6). Employers too need to recognise the link between public health and OH.

Other viewpoints raised within the group were that employees with health problems, with the possible exception of those in Scotland, are currently managed by decisions to either get rid of or keep them. Also, there is the possibility of a link between deprivation and OH. The implication is that OH problems may be best resolved by targeting deprivation. David Coggon noted that health messages should be carefully framed (see box 6)

Box 6 - Statements made in syndicate 3

“This (Improving Occupational Health) cannot be achieved by HSE on its own. The real drivers are elsewhere.” – David Snashall

“In Scotland there is the willingness for everyone to participate in joined up thinking on health. However it is easier to coordinate exercises in Scotland as it’s smaller” – Stewart Campbell

“There should be a caveat: if we raise people's expectations unrealistically, we may generate dissatisfaction, and thereby impair wellbeing.” – David Coggon

6.4 SUMMARY OF SYNDICATE GROUP RESPONSES TO QUESTION 3

“How do different models offer us a way forward, and what more information and evidence do we need to develop an eclectic approach within the next 6 months?”

Group 1

The group discussed the validity of models and how they could be used to improve OH. Health psychology models seemed to provide a way forward where exposure-outcome models aren't sufficient. The models in the information pack that were discussed at the workshop are likely to provide an effective way forward but it is not immediately evident how to utilise them best in OH (see box 7). The models help with OH, in that they help health professionals decide what to do. They allow for complex problems and have a temporal dimension but they are not the entire solution.

There was disagreement about lay-people's perception of illness. One view was that people with ill health often don't recognise or can't express the psychological and social aspects of their illness, patients will often describe how their physical health has suffered rather than their mental health. But in contrast other participants thought that most people have a sophisticated understanding of their own illness models. To help people to relate to health messages, it helps if you talk to people in their own language. Perhaps a way forward would be to communicate the underlying principles of the health models, rather than focus on the content of the models themselves (see box 7) Beliefs and behaviours would need to be incorporated.

The group realised that it is difficult to assess risks and communicate risk without leading to perceptions that certain workplace activities may be damaging to health (see box 7).

Box 7 - Statements made in syndicate 1

“We could use the psychology/alternative models when traditional risk assessment doesn't fit. It's important to use models appropriately and carefully and to avoid nineteenth century ways of thinking” – Simon Wessely.

“The concept of risk as used in occupational health contexts is too inflexible and too negative a concept to clarify what employees should or should not do. 'Fit' is more useful; the fit between

work demands and work opportunities on the one hand and employees' needs and aspirations on the other." – Simon Pickvance.

"How far can we learn from the models – can we distil the essence out of the models? The future should focus on commonalities rather than individual models. It is important that models are used with 'thinking' to allow flexibility." – Roger Rawbone

Group 2

There were concerns in the group that employers may be intervening beyond their scope. Where do we draw the line? For example, could they insist on only employing non-smokers?

A number of research gaps were identified as follows:

- Can behaviour change improve health?
- What are the barriers to behaviour change?
- What is the optimum way to manage absence?
- How effective is the RA approach?
- RA: how does it influence people's attention focus (attention awareness)?
- What are the positive effects of work? Gordon Waddell is currently doing a literature review of this, but HSE could identify the appropriate people to contact.

Other relevant issues include:

- Difficulty of gauging the work-related part of health
- Interaction of home and work
- Delivery of health promotion messages in other contexts.

Box 8 - Statements made in syndicate 2

"How do we bridge the gap between appropriate models and actions?" – Rob Gwyther

"The psychological aspects (of dealing with modern health problems) aren't only at the individual level – but also at the cultural level. HSE already advises employers on which approach to take and will give guidance to employers on specific conditions as this process evolves" – Gordon Waddell

Group 3

As discussed in detail for question 2 the group identified a need for HSE to link into the wider public health agenda. The group then focussed their attention on research needs and possible interventions to improve OH.

There was a call for HSE to carry out research to identify whether the current approach is working and evaluate what is being done regarding manual handling, DSE assessments and back pain (see box 9). We need to learn more about OH needs assessment and motivating people to return to work. This could inform interventions. There were some notes of caution that there has been little/no research on the application of health models to OH; that the way HSE pitches messages turns people off; that you can evaluate and add nothing; and that models must be adopted to change behaviour. With any new intervention the group agreed that we would need to target SMEs and managers as well as employees. We need to dismiss unfounded

assumptions that all SMEs have a sub-standard approach to OH compared with large organisations.

The group called for evaluation of intervention programmes, taking into account people's assumptions of disease, looking at process (e.g. illness representations) and outcomes (e.g. sickness). We need to use process measures to identify the causal mechanisms (e.g. changes in illness representations and beliefs) and actual health outcomes and avoid surrogate measures such as absenteeism.

We need to establish what the expectations are, what is the baseline, what would a new/revised strategy aim to achieve? Some occupational disease rates are falling. Can a further drop in occupational disease rates realistically be achieved?

We should learn from other successful public health interventions effecting behavioural change such as the Finnish studies, which used positive messages in the workplace to change eating behaviour. The impact of implementation intention interventions upon OH has probably not been evaluated, which could be a research gap. This led to a discussion about the importance of message framing and the 'prevention framework' (see box 9).

Box 9 - Statements made in syndicate 3

"The traditional model is not appropriate: HSE needs to identify whether the current approach is working - evaluate what's being done. For example, are the manual handling and display screen regulations causing a reduction in back and arm pain?" – David Coggon

"In communicating risk for behaviour change we currently use a lot of loss frames, everyone uses negative messages which have been shown not to work. We need to pitch messages using a gains framework which emphasises the positive aspects, 'food tastes better when you don't smoke'" – Eamonn Ferguson