

A new model for the provision of health and work services to smaller businesses in the UK

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Abstract

Engaging small and medium sized enterprises with the provision of occupational health support is difficult. Early research showed that such services are seen as costly, not a business priority, and produce difficult to use advice; the focus of smaller businesses is on compliance with safety law. The traditional model for OH relies on specialist reports of the medical issues that set out actions for the employer. In the UK it is intended to provide more advice to workers through primary healthcare focusing on the barriers to a return to work. This paper describes a pilot scheme to provide advice to employers by a telephone helpline to enable them to understand the barriers and how to overcome them; it will have an emphasis on mental health issues. The study will operate in 9 areas using a local partnership approach.

Key words

Return to work; occupational health; small businesses; barriers

Introduction

Research undertaken for NHS Plus and the Department of Health (The Focus Group, 2004) shows that there are many barriers to SME engagement with occupational health (OH). Occupational health still sits at the margins of SME activity and is seen as a health provision (which in the UK is

strongly identified with state delivery) and not a business matter. Small and medium sized businesses are largely reactive towards health and safety, with a very strong emphasis on safety and compliance with the legal duties. Sickness absence is not recorded in most small companies and comes to prominence only when a member of staff is off work for a long time. There is a strong reluctance to pay for traditional OH interventions which are seen as expensive, not suited to the specific circumstances of small businesses and a low priority.

As organisations, SMEs lack many of the structures – formal management structure, dedicated human resources department and written policies – upon which much traditional OH department activity is based and through which its services are delivered. A new model for the provision of OH support to SMEs is needed.

Background.

The large majority of healthcare in the United Kingdom (UK) is provided by the National Health Service (NHS). The organisation was created in 1948 and the provision of OH care was specifically excluded from the NHS remit. The political justification for the exclusion was that the new health service would provide ‘cradle to grave’ care for the benefit of all individuals in the population. Access to the service should be based on clinical need and be free at the point of delivery. It was argued that the ‘outputs’ of an OH service were exclusively for the benefit of the employer and hence the employer should pay directly for such arrangements. At that time the majority of the workforce was employed in the nationalised industries or large companies which were strongly unionised and had a good history of providing health services for their workers. Coal mining, steel making, gas and electricity utilities, and the railway industry had powerful OH services with a proud history and substantial resources. The provision of health services at the workplace was regarded as an essential part of running such organisations.

Changes in employment practices across Europe are well documented. In the UK, we have seen a break up of the nationalised industries and a reduction in the membership of trades unions. In 1960, probably the low point in the number of small businesses in the UK, Storey (Storey, 1994) reported that only 19% of manufacturing employment was in small enterprises; this compared with 31% in 1935. Since then, the number of small and medium sized enterprises has grown rapidly. In 2007 in the UK, it was estimated that there were 4.7 million businesses, with 99.3% having fewer than 50 employees (UK Government, 2007). These companies supply nearly 50% of all employment in the private sector in the UK.

There is no legal requirement for an employer in the UK to provide occupational health services to their employees. A paper published by the Health and Safety Executive in 2002 (Institute of Occupational Medicine, 2002) looked at what proportion of employers provided OH support to their employees. The study used 2 definitions of OH support. A broad definition simply looked for evidence of hazard identification, risk management, and provision of information; a tighter definition also required evidence that the employer modified work activities, provided relevant training, measured work hazards and monitored health. On the broad definition 15% of UK companies provided support and on the tighter definition only 3% of enterprises provided services. Given that these figures relate to all UK companies and the survey found that large companies were much more likely to provide support than small businesses, the picture was truly gloomy. Even more worrying was that these results were produced after extensive campaigns by HSE such as the 'Good Health is Good Business' programme, launched in 1995 which sought to highlight the benefits to employers of managing health at work.

Small Businesses

In the year 2000, *Securing Health Together* (UK Government, 2000), the government's 10 year strategy for occupational health was published with its vision to 'to tackle the high levels of work

related ill-health and to reduce the personal suffering, family hardship and costs to individuals, employers and society'. Primarily led by the Health and Safety Executive, other government departments also contributed, including the NHS.

'I am interested in exploring whether there is scope for the NHS more generally to provide similar occupational health services to employers, 'NHS Plus' if you like. A service of this sort might be particularly valuable for small and medium-sized firms which lack the size to organise in-house services but where ill-health amongst key employees can have devastating consequences.'

A Healthier Nation and a Healthier Economy: The NHS Contribution

Rt Hon Alan Milburn, Secretary of State for Health

6th Annual Health Lecture at the London School of Economics, 8th March 2000

NHS Plus

In 2001, NHS Plus was launched at the instigation of the then Secretary of State for Health (see box), recognising the particular position of small and medium sized enterprises (SME). This brought together about 100 OH departments in the NHS, which were situated in various hospitals across England. Many of these units had already provided services to employers within their local communities. Initial growth was strong and OH departments provided either a full OH service or specific services such as health surveillance or return to work advice to small businesses. The work was based on the traditional OH role and ways of working

A number of local initiatives were taken to increase the uptake of OH services by SME. These included local advertising on radio and in newspapers, a local telephone helpline and dedicated websites. These initiatives generated some new traffic but only on a small scale; further, most of the enquiries were not about health matters but tended to concentrate on safety issues. Other larger pilot schemes to increase use of OH support by SME, for example 'Workplace Health Connect' (WHC) sponsored by the HSE, found similar results. The evaluation of WHC (Institute for Employment Studies, 2008) found that 'Employers ... do not immediately identify with, or call to discuss, health issues, as they appear to be driven primarily by concerns about safety'. It was clear

that more than 25 years of the Health and Safety at Work Act 1974, the major UK enabling legislation in this field, the focus had remained on safety. Small employers (often known as 'unmanaged enterprises') in particular did not see the health of their workforce as a matter with which they could, or should, be actively concerned. Little work has been done to investigate why small businesses do not engage with 'health' rather than safety. Surveys suggest that two thirds of employers think the health of employees is important for productivity and success but very few see it as a business priority (Norwich Union Healthcare, 2008). Speculation has focused on lack of structure, cost, the long term nature of many interventions, lack of detailed legislative requirement and in the UK at least, a feeling that the state (through the NHS) takes care of such matters. Whatever the reason, engagement with SME is low.

Health and Work

In addition, the knowledge of the broader relationship between good work and good health, not only for individuals but also for their families, led to a government White Paper (a position paper setting out the government's thinking and proposals for action on particular topic) on public health being published in 2004 (Department of Health, 2004). The paper set out, in Chapter 7 the relationship between work and health. It noted the societal costs of not addressing health in the workplace. This approach, together with a recognition that no substantial progress was being made with improving work related health indices such as sickness absence rates, employment / health related social security payments such as incapacity benefit and self reported work induced ill health surveys led to the appointment of a National Director for Work and Health.

Professor Carol Black, a distinguished rheumatologist and former President of the Royal College of Physicians of London brought a new mind to the problem of poor performance in the field of work and health. She identified in her report (Black, 2008) a number of problems with the way occupational health had been seen and practiced over many decades, viz

- Detachment from mainstream healthcare; the separation from the NHS since 1948
- Limited remit; only provided to those of working age who have employment and and has an employer who is prepared to pay

- Uneven provision; very few employees of SME have access to a service
- Inconsistent quality
- Diminishing workforce
- Shrinking academic base
- Image and perception

It was clear that compared with the scale of the problem (less than 3% of 4.6 million small businesses had access to OH support) a radical new approach would be required to improve the health of the working age population. The provision of OH services by specialist units alone could never hope to solve the problem. There would not be enough specialist OH practitioners and the costs would be prohibitive.

Occupational Health Services

The provision of OH services had been based on a legislative paradigm, in the same way that safety had been regulated. A duty had been put on employers to ‘safeguard ... the health ... at work of all his employees’¹ but no precise duties had been specified in relation to health; indeed there was discussion about what the phrase ‘health ... at work’ really meant. Whereas the safety field had been supported by detailed legislation relating to specific hazards, this was not the case with health. A new approach was needed.

Not every person requiring an occupational health intervention requires the attention of a fully trained and qualified occupational health professional. Nor indeed does the person need to attend an occupational health clinic. This is the normal process with other branches of medicine. Not all sick children require the intervention of a trained paediatrician in a specialist unit. What is required is the confidence that if a specialist intervention is required, access to such a service is readily available.

In the NHS, the proportion of total care delivered by general practitioners is estimated at between 70% and 83% (Hennell, 1999) . It is the first point of call (apart from serious accidents and emergencies) for those who are ill. For those who are absent from work through illness or injury, they need a GP certificate (often known as a 'sick note') to present to their employers after the first week of absence. It provides an ideal opportunity to provide work focused interventions and reset some of the psycho-social pathways that so often provide barriers to a successful return to work. Back up by a specialist OH service, in the UK, our part of healthcare would be a seamless extension to normal care provision.

A good example of this model may be seen in the UK military health services. Here, OH provision is totally integrated in the primary care provided for military personnel. This is supported by, for example, local, regional and national rehabilitation services and an interlocking support service from specialist occupational physicians. Of course this model cannot be translated directly into civilian life but it shows that the model of OH support in primary care backed up by specialist services for more complex cases can work.

A New Approach

The government, in accepting Dame Carol Black's report (UK Government, 2008), put in place a number of work streams to improve access to OH support. Central to the new approach is to position occupational health advice back into the mainstream of the NHS and for working age people to receive advice about their work and health in the primary health services. To this end, improvements in the training of GPs have taken place, employment advisers are being located in GP clinics and improvements in access to psychological therapy (common mental health problems are the major cause of failure to return to work). Further, the government intends to replace the 'negative' sick note with a more 'positive' fit note as the mechanism by which GPs express whether or not an individual is able to attend work. It is hoped that through these measures and others set out

in the government's response, individual employees will receive more realistic advice which addresses the barriers to returning to work.

But what then of the small business? The owner of a small business will have employees returning to work who have had positive advice from primary care. Those with back pain or common mental health problems such as depression or anxiety will be returning to work with some continuing symptoms and advice about a need for modified duties. Research suggests (Seymour, 2005) that for mental health problems at least, the most important positive factor for achieving a successful return to work is manager / supervisor attitude and behaviour. How can we help small business owners to capitalise on this new approach. A new model for the provision of OH support to SMEs is required where advice and encouragement is given directly to the employer. Further, this advice should focus on helping small businesses manage their own staff and 'de-medicalising' the reasons why people are absent from work. This will require a substantial change in behaviour. The use of sick notes has engendered a view that employers can do nothing about attendance – 'his doctor says he can't work so I just have to accept it'. Employee feel that they have been told not to go to work and lose any incentive to get back to work.

The Model

The Department for Work and Pensions has decided to pilot the new model in 9 areas in Great Britain. The new model for the provision of OH support to SMEs will be in three parts. Firstly the local SME market will be surveyed and its distribution by size and sector noted. On the basis of this analysis, a local partnership will be created. A key part of the marketing strategy has been to devise a local partnership arrangement with those who may influence SMEs. These includes government agencies such as Business Link and Chambers of Commerce, trade associations such as the Federation of Small Businesses and the Engineering Employers Federation together with other bodies who advise SMEs such as the banks. Involvement of local government is also key and

ensures that the project is aligned to key local priorities. Finally local health service organisations such as Primary Care Trusts and Strategic Health Authorities are engaged. The guidance that these bodies can provide, and their endorsement by is a key means of increasing uptake of the new service.

A marketing campaign is regarded as essential given the low level of penetration of OH into smaller businesses at the present. Simple messages about the benefits of early return to work, the relatively simple and cheap work modifications that may help, the importance of maintaining contact with absent employees and the dangers (to the individual, their families and the business of a slide into long term worklessness and benefits) of prolonged absence from work.

Finally, a telephone helpline will be created in each pilot area. The purpose of the helpline is to provide employers from small and micro businesses with early and easy access to high quality professional occupational health advice tailored to their needs, in response to individual employee occupational health issues and with a particular focus upon mental health. It will be focused on companies with up to 50 employees but where capacity exists, companies with up to 250 employees will also be offered advice.

Employers often find it difficult to talk to staff about health and worry, particularly in the case of mental health problems, that they will make things worse (MindOut for mental health, 2004).

Simple advice, and the opportunity to discuss fears in a private environment with a qualified health professional is helpful; the provision of a simple toolkit electronically will facilitate discussions with employees.

NHS Plus, together with NHS Direct – a national telephone helpline for patients in England, will run a dedicated SME telephone helpline. The first point of contact for the small and micro business manager will be a unique national telephone number operated by NHS Direct. After initial triage, callers will be transferred live to the appropriate local provider unit, which will undertake a

telephone assessment and provide immediate advice; this will be followed up with an electronic report and guidance. Where the specific case appears to be complex, the OH professional can arrange onward referral, where appropriate, to a specialist support service.

Specific software has been created to allow simple record keeping and to learn what are the common difficulties encountered by SME. It will also allow evaluation of the service using suitably anonymised data.

The new service will launch on 1st December 2009 and run for 16 months. The pilot sites have been chosen and the SME profiling analysis has been completed. Local partnerships are being created and staff are undergoing training. The software will be alpha tested in September.

Conclusion

The overwhelming proportion of those who go off sick return to work without specialist OH intervention. For the small percentage who do not, the reasons are usually based on barriers to successful reintegration into the workplace; the failure to return is not based on clinical medical issues, except in a tiny number of cases. The key feature of the new service is to help SME owners deal directly with staff returning to work and help them to identify the barriers to a successful return to work.

ⁱ S2(1) Health and Safety at Work, etc, Act 1994

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