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The Value of Occupational Health to Workplace Wellbeing

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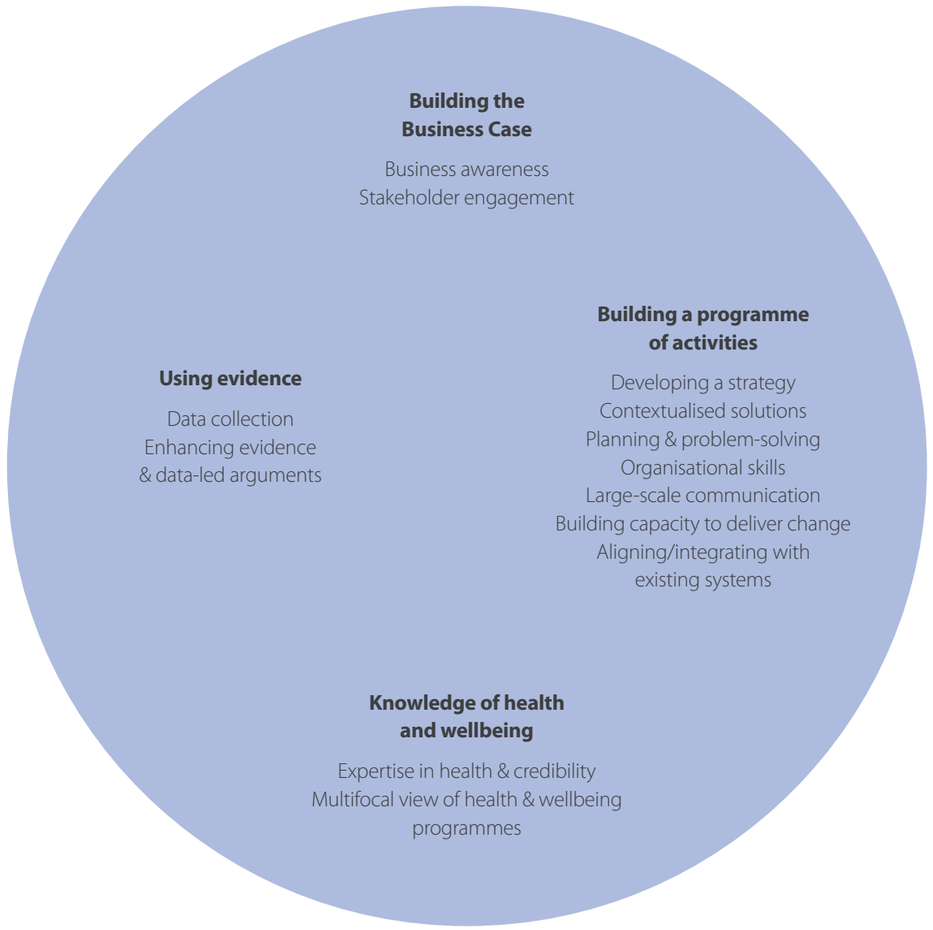
EXECUTIVE SUMMARY

The purpose of this report is to examine how occupational health practitioners and providers can add value to workplace wellbeing initiatives by focusing on the knowledge, skills and competences required to introduce workplace health and wellbeing programmes.

We argue that wellbeing is a composite construct, comprising many elements in addition to a core of subjective wellbeing. We note that the distinction between health and wellbeing is fuzzy. We propose that workplace health and wellbeing programmes require co-ordinated initiatives addressing: management capabilities, improving job quality, enhancing social relationships at work, workplace health promotion and providing support for workers coping with health conditions and/or life stresses.

To identify the areas of knowledge, skills and competences required, we draw on three sources of evidence: survey data collected by the Society of Occupational Medicine (SOM); the available but limited scientific literature; and interviews with 11 expert informants. We identify four major areas of knowledge, skills and competences with more specific elements: these are summarised in the figure below.

Figure 1. Key areas of knowledge, skills and competences



1. INTRODUCTION

The purpose of this report is to examine how occupational health practitioners and providers can add value to workplace wellbeing initiatives. More specifically, our aim is to provide a point of focus for reflection and on-going research on the knowledge, skills and competences needed by occupational health practitioners to contribute to successful workplace wellbeing initiatives.

A report of this kind is needed for a number of reasons, reflected in conversations we have had amongst ourselves and with a range of stakeholders from different organisations and professions.

The first concerns identifying whether there is a point of difference between 'wellbeing provision' and 'occupational health provision', and consequently what that difference might be. If there is a difference between wellbeing on the one hand and health on the other, it is doubtless a blurred one. Any confusion here is also reflected in uncertainty over which legislative regulations might apply – for example, both health and safety legislation and equality, diversity and inclusion legislation are relevant.

The second concerns which professional group is responsible for workplace wellbeing. Is it human resources professionals, for whom wellbeing might be linked to initiatives concerning employee engagement, retention or equality, diversity and inclusion? Or should the responsibility reside with occupational health professionals, who can lay claim to specialised knowledge around health?

The third concerns what to do about wellbeing and how to do it. Given the breadth of a concept like wellbeing, we have found that service commissioners/service providers can be somewhat confused about what to procure/offer in what is a crowded and somewhat unregulated market place (almost anyone can be a wellbeing practitioner, whereas the occupational health professions come with accredited practice and an established body of codified knowledge). Even if these uncertainties can be resolved, we find both human resources and occupational health practitioners still have concerns over making the business case for, implementing and sustaining workplace wellbeing initiatives.

By focusing on the knowledge, skills and competences needed by occupational health practitioners, we can address these concerns and provide some initial guidance on how occupational health practitioners can add value to workplace wellbeing initiatives. This knowledge entails knowledge of what should be included in a workplace wellbeing offering, but also knowledge of how to implement workplace wellbeing initiatives.

To address our overall aim, we draw on multiple sources of evidence, including syntheses of existing literature on what kind of wellbeing initiatives work, the literature that prescribes or describes how occupational health and other professional practitioners implement workplace wellbeing initiatives, findings from a survey of current practice and findings from interviews with expert informants.

In the next chapter, we look at various definitions of wellbeing and its relation to (occupational) health, and then consider five major classes of initiatives that can help enhance workplace health and wellbeing. The third chapter describes some evidence on the current state of wellbeing provision and the motivations for adopting workplace wellbeing initiatives. Comparing findings from chapters 2 and 3 does enable us to spot some gaps and opportunities for developing current provision.

In chapter 4, we examine the existing literature for ideas on how occupational health practitioners can contribute to implementing and sustaining workplace wellbeing initiatives. Noting limitations in that literature, chapter 5 provides a summary of findings from interviews with expert informants from both human resources management and occupational health practice. In our concluding chapter, we summarise our findings with respect to the knowledge, skills and competences required by occupational health practitioners, as well as highlighting key evidence gaps to take this work forward.

2. WHAT WORKS

In this chapter, we will consider various definitions of wellbeing, contrast wellbeing with (occupational) health, and also consider broad categories of wellbeing initiatives that can realise benefits for health and wellbeing.

Defining Wellbeing

In the United Kingdom, the Office for National Statistics (ONS) uses four key indicators of wellbeing that represent aspects of ***psychological*** wellbeing.[1] These indicators are life satisfaction, happiness, anxiety and a sense of meaning and purpose in life. Psychological wellbeing has two major components, subjective wellbeing and eudaemonic wellbeing. Subjective wellbeing is further sub-divided into summative assessments of life satisfaction and hedonic experience such as positive affect (e.g. joy, enthusiasm) and the relative absence of negative affect (e.g. lack of anxiety, feeling calm).[2] Eudaemonic wellbeing has its roots connected to notions of a 'life well lived'. The ONS indicators only tap into some aspects of eudaemonic wellbeing, namely meaning and purpose. Other aspects of eudaemonic wellbeing include feelings of autonomy, mastery, personal growth, positive relations with others and self-acceptance.[3]

Psychological wellbeing is also domain specific,[4] so it is possible to talk about work-related aspects of wellbeing such as job satisfaction and a range of mood/emotional states that may be experienced at work or perceived to be caused by work, such as anxiety, happiness, enthusiasm, anger and fatigue.[5] There are also other concepts closely related to work-related wellbeing, such as work engagement[6] that reflects high levels of energy and resilience, dedication to and absorption in work activities.

Psychological wellbeing clearly has overlaps with mental health, especially mood disorders. More broadly, there is a fuzzy distinction between health and wellbeing. In some frameworks, physical and mental health are seen as drivers of subjective wellbeing.[7] On the other hand, the World Health Organization includes wellbeing in its definition of health – "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[8] The various definitions of health and wellbeing do indicate significant overlap in the concepts. Moreover, evidence on layperson perceptions of wellbeing also indicates that health and wellbeing are closely related concepts.[9]

The International Organization for Standardization offers definitions of occupational ill-health, occupational health and wellbeing:[10]

> Occupational ill-health: "The adverse effect on the physical or mental condition of a person arising from exposure to a workplace health risk or work-affecting condition."
>
> Occupational health: "Prevention of occupational ill-health and improvement of worker health."
>
> Wellbeing: "Positive state of mental, physical and social health."

These three definitions suggest that, at least in relation to occupational health, the difference between health and wellbeing might be one of emphasis. Traditionally, the practice of occupational health may have been seen as largely concerned with occupational health assessments and the prevention of or rehabilitation from specific conditions. In contrast, practices connected to wellbeing may be seen as subsuming prevention, rehabilitation and promotion of positive general health or wellbeing. However, accepting a difference of emphasis does not provide a clear demarcation between (occupational) health on the one hand and wellbeing on the other.

One way around the problem of definition is to consider health and wellbeing as broadly related concepts, that indicate areas of research and practical activity rather than precise concepts that can necessarily be measured. Within these broad concepts, more specific concepts can be defined and measured more precisely. In other words, health and wellbeing reflect a range of related concepts that can be indicated by measures of psychological wellbeing, general perceived physical health and, where there are reasons for so doing (e.g. prevalence of risk factors), markers of specific conditions.

Within this fuzzier approach to the problem of definition, the value of occupational health practice could include:

a. Prevention of and rehabilitation from specific conditions;

b. Promotion of good mental, physical and social wellbeing.

As both prevention and rehabilitation involve working with multiple stakeholders (different health professionals, workers, worker representatives, line managers, different management functions), we may expect that promoting wellbeing would also involve occupational health professionals working with a broad range of stakeholders too. Moreover, given the close connect between health and wellbeing, the moral, legal and business cases also apply.[11]

What Works: Five Ways to Workplace Wellbeing

Based on series of systematic reviews for the What Works Centre for Wellbeing and systematic reviews produced by other research teams, we have identified five major areas that practitioners can target to protect and enhance wellbeing and health.[12] For general managers and human resource professionals, the five areas are combined into an intuitive and easily remembered typology of areas for action, and can be considered to be five ways to workplace wellbeing.[13] The benefits of actions in each of the five areas are largely for psychological health and wellbeing. However, there are also benefits for physical health for three reasons. First, there is evidence that subjective wellbeing confers physical health benefits.[14] Second, some physical health conditions can be influenced by some of the same working conditions that influence psychological health.[15] Third, some of the initiatives are targeted at physical health, with psychological health a secondary outcome.

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The five areas in which to act are:

1. Management capabilities;
2. Improving job quality;
3. Enhancing social relationships at work;
4. Providing support for workers coping with health conditions and/or life stresses;
5. Workplace health promotion.

Areas 1, 2 and 3 are target areas for primary, preventive control of risk factors. Therefore, in the UK, it is legally mandated that organisations act to minimise any harm through examining practices in these areas.[16] These three areas are also highlighted as critical factors for "good work" that promote and protect mental health[17] and emerge as priorities for workers in consultation exercises.[18]

1. Management Capabilities

A worker's relationship with his or her line manager is perhaps the most important relationship in the workplace. Research has indicated that good and supportive relationships between workers and their line managers are associated with better health and wellbeing outcomes,[18] including sustainable return to work following sickness absence due to common mental health problems.[20] Line managers also have a key influence on how work is performed, clarifying role expectations, delegating authority to make decisions and role modelling appropriate behaviours that set the tone for the social climate at work – thus potentially affecting job quality and social relations at work (see below). For all of these reasons, line managers are considered a foundation for attempts to protect and enhance health and wellbeing in the workplace, as well as a fulcrum for implementing reasonable adjustments to facilitate return to work.[21] The Health and Safety Executive and Chartered Institute of Personnel and Development have produced guidance on leadership competences for managing stress.[22]

As well as the weight of evidence from observational studies (e.g. surveys) and the intuitive appeal of targeting line managers as a point of intervention, another reason for this focus is the potential for cost effective solutions. Training managers has multiplier effects, as each line manager has responsibility for a number of workers.

However, in spite of these reasons and the widespread availability of management development programmes, the evidence base on the effectiveness of management development on health and wellbeing used controlled methods is limited. Two recent and relevant systematic reviews on leadership development identified six[23] and five[24] studies only (one study appeared in both reviews). Across the two reviews, there was no evidence for universal beneficial effects of management training. However, there may be contextual factors. For example, the authors of one of the reviews concluded that for management development to be an effective approach to improving worker wellbeing, it needed to be group based and interactive.[25]

2. Improving Job Quality

Job quality is a composite concept, consisting of a number of more tangible elements or characteristics of jobs and the wider working environment. For example, a recent report on the measurement of job quality[26] concluded job quality could be assessed by:

- Terms of employment, including job security and minimum guaranteed working hours.
- Pay and benefits, including satisfaction with pay as well as actual pay.
- Health and safety, relating to minimising risks for physical and psychological health and safety.
- The nature of work, subsuming the use of skills, training, control over elements of how work is done, opportunities for progression, feeling a sense of purpose at work.
- Voice and representation, representing communication, employee representation and employee involvement.
- Work-life balance, including flexible work arrangements, overtime, working hours and advance notification of working hours and locations.
- Social support and cohesion – which we consider separately here under line manager relationships and social relationships, as the means of taking action in these areas are quite distinct.

There are many other typologies, although all tend to converge around some or all of the factors listed above. For example, the UK Health and Safety Executive (HSE) concentrate on a more limited number of psychosocial risks, relating to workload, levels of control, clarity of role, consultation during change, relationships and support. The HSE's list of psychosocial risks excludes key factors such as job insecurity and variability in working hours.

The research evidence is that different aspects of job quality have independent effects on health and wellbeing outcomes[27] and influence health and wellbeing outcomes through different pathways.[28] It is therefore not surprising that in general, those initiatives that have most success are those that tackle multiple aspects of job quality simultaneously.[29]

However, there is emerging evidence for robust effects of one particular type of initiative directed at job quality: this is training focused on providing workers with the skills and knowledge to make small scale, incremental improvements to the quality of their own jobs.[30]

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3. Enhancing Social Relationships at Work

There is reliable evidence from a range of sources that good social relationships at work predict a range of markers of health and wellbeing.[31] There are several explanations for these relationships which are well supported in the scientific literature.[32] These include the provision of social support, promotion of a positive social climate and fostering a sense of shared identity in the workplace. These explanations overlap (e.g. shared identity facilitates support)[33] and also predict that good social relationships have a direct and enhancing effect on health and wellbeing, but also a protective effect that can offset other psychological or social risk factors. On the other hand, overtly negative relationships, even if low level, can be very detrimental to psychological health and wellbeing.[34]

Like initiatives focused on line manager capabilities, there is a wealth of observational evidence and evidence from laboratory based studies. However, there are very few studies that evaluate actions to improve social relationships in workplaces: a recent systematic review found only six studies using controlled designs, none of which was a randomised control trial.[35] Nonetheless, the evidence across the studies was consistent that planned attempts to improve social relationships at work can improve relationships and markers of wellbeing. However, a closer look at the studies indicates some qualifying features: the initiatives studied all had multiple elements (e.g. problem-solving workshops, training events, social events), had some input from someone from outside of the workgroups (e.g. external training facilitator) and workers tended to look forward to the different elements. Notwithstanding the qualifying elements, initiatives to improve workplace social environments are relatively straightforward to implement and would seem to incur very little in the way of cost.

4. Providing Support for Workers Coping with Health Conditions and/or Life Stresses

Initiatives captured under this heading include those focused on:

- Treatment and rehabilitation of workers with health conditions or injuries;
- Workplace accommodations;
- Flexible working practices to allow people with: a) caring responsibilities to attend to those responsibilities or b) health conditions greater opportunity to attend healthcare appointments;
- Flexible benefits;
- Enhancing personal resources to manage psychological health and wellbeing.

Occupational health practitioners and service providers should already have capabilities related to treatment, rehabilitation and workplace accommodations, as part of accreditation, training, continuing professional development and practice. However, as noted above, line managers may be critical to successful return to work by allowing workplace accommodations and providing other support. There is therefore a clear role for occupational health providers to engage in line manager training around return to work, making workplace accommodations in a fair and equitable manner and otherwise supporting workers with health conditions or caring responsibilities. Indeed, for family supportive flexible working practices, there is some evidence from controlled studies[36] that training managers to support family friendly flexible working arrangements can have beneficial effects on health and wellbeing for those with difficulties managing family arrangements.

In relation to improving workers' resources to manage their own wellbeing, there is evidence that training programmes can develop those skills[37] (e.g. mindfulness,[38] resilience[39]). Such training programmes appear to be beneficial for people without any specific problems or symptoms, but can be targeted effectively at people at particular risk, either because of stressful working conditions (e.g. police) or because of poor wellbeing. Such training can be successfully combined with other initiatives focused on improving other aspects of job quality.[40]

5. Workplace Health Promotion

Workplace health promotion programmes targeted at changing health behaviours (e.g. alcohol consumption, smoking, exercise, diet) would also be familiar to occupational health practitioners and service providers. The evidence however is somewhat mixed with respect to their effectiveness on health and wellbeing.[41]

One of the reasons why there may be small overall effects across programmes and organisations, and no effects for specific programmes, might relate to how the programme was implemented.[42] Because implementation issues apply to all classes of initiatives and the focus of this report is on occupational health practitioners' role in implementing initiatives, implementation will be addressed in more detail later in the report.

However, there is some recent evidence that suggests the benefits of workplace health promotion may be more subtle than direct effects on health and wellbeing. Two studies[43] indicate workplace health promotion programmes targeted at improving health behaviours may work to change organisational cultures.

In turn, this might create an environment in which communications concerning health and wellbeing are better received by workers and so facilitating the introduction of a range of other initiatives targeted at improving health and wellbeing.

Conclusion

Wellbeing is not one single thing, but is a composite of more specific concepts. The distinction between health and wellbeing is also fuzzy. In relation to occupational health, the distinction may reflect a traditional emphasis on disease control and treatment, rather than health promotion. However, the centrality of psychological wellbeing in definitions of wellbeing may direct practitioners to focusing on psychological aspects of health and wellbeing and general health, rather than specific (physical) health conditions. Because of the fuzzy distinction between health and wellbeing, occupational health practitioners and service providers could consider them to be parts of the same thing and amenable to the same classes of intervention.

There are multiple ways of classifying specific health and wellbeing initiatives: we have introduced a five-fold classification that is intuitive to general and human resource managers. The evidence indicates that interventions in each class can be effective. However, as highlighted by workplace health promotion in particular, how initiatives are implemented can influence their effectiveness. Given specialised knowledge, occupational health professionals may add value to workplace wellbeing through signposting employers to evidence-based actions and working with employers to implement those evidence-based actions.

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3. CURRENT STATE OF PROVISION – SOME SURVEY EVIDENCE

The purpose of this chapter is to summarise the results of a survey conducted by the Society of Occupational Medicine (SOM), and to use this summary to identify opportunities for occupational health practitioners to develop knowledge, skills and competences to add into the provision of workplace wellbeing services. The survey was conducted by the SOM in 2019, and 62 members of the SOM responded from a range of private and public organisations. The survey examined current wellbeing provisions, barriers to implementation and reasons for an interest in workplace wellbeing.

Table 1 shows the breakdown in respondents by whether the organisation they worked for was public or private.

Table 1: Whether respondent worked for a private or public organisation

Organisation Type	%
Private	65
Public	35
N (=100%)	62

Respondents' answers to a series of multiple-response questions on their organisation's workplace wellbeing offer are shown in tables 2, 6 and 8 below, while tables 3, 7 and 9 show crosstabulations with the organisation type.

The most popular reason, by some margin, for the implementation of workplace wellbeing as part of the organisation's occupational health offer (table 2) was an explicit aim to improve the health of employees. While this may indicate widespread and genuine compassion from employers at these organisations for their staff, it could also be a result of other perceived outcomes of improved employee health. Around half of respondents meanwhile gave the effects that improved wellbeing might have on sickness absence and productivity as key reasons, while the remaining reasons were considered less central to the decision.

Most of the reasons for implementing workplace wellbeing into the organisation's offer were not statistically different between whether the organisation was private or public.

A significant difference was however found in whether or not respondents chose 'Attract contracts' as a reason. Around half of respondents working for public organisations chose this option compared to less than a quarter of those in private companies. Reasons for this difference are not clear from the data, although it may relate to public sector tendering practices.

Table 2: Main reasons for respondent's organisation implementing workplace wellbeing as part of its offer

Reason	%
Preventative approach to improve the health of employees	84
Metrics (e.g. support sickness absence reduction)	50
Improve productivity	45
Attract contracts	29
Retain contracts	24
Boost client proposition	21
Other	18
N (=100%)	62

Table 3: Crosstabulation of the main reasons for respondent's organisation implementing workplace wellbeing as part of its offer by whether the organisation was private or public

Reason	Private org %	Public org %	N (=100%)	Statistical difference[44]
Attract contracts	21	45	61	Yes
No answer	79	55		
Retain contracts	23	27	61	No
No answer	77	73		
Preventative approach to improve the health of employees	80	91	62	No
No answer	20	9		
Boost client proposition	18	27	61	No
No answer	82	73		
Metrics (e.g. support sickness absence reduction)	46	59	61	No
No answer	54	41		
Improve productivity	38	59	61	No
No answer	62	41		
Other	18	18	61	No
No answer	82	82		

Table 4: Who was responsible in respondent's organisation for developing and deploying wellbeing programmes

Title or Department	%
Human Resources	66
Occupational Health	60
Wellbeing Manager (or similar)	40
Health and Safety	29
Other	18
N (=100%)	62

44. In this and subsequent tables showing responses for public and private organisations, we determined whether there was a statistically significant difference using Chi-square and Fisher's Exact tests as appropriate. A difference was deemed to be statistically reliable if there was less than a 5% chance of the difference occurring due to sampling error (i.e. $p < .05$)..

Table 5: Crosstabulation of who was responsible in respondent's organisation for developing and deploying wellbeing programmes by whether the organisation was private or public

Title or Department	Private org %	Public org %	N (=100%)	Statistical difference
Occupational Health	51	77	61	Yes
No answer	49	23		
Human Resources	65	68	62	No
No answer	35	32		
Wellbeing Manager (or similar)	41	41	61	No
No answer	59	59		
Health and Safety	31	27	61	No
No answer	69	73		
Other	21	14	61	No
No answer	79	86		

Human resources and occupational health departments were responsible in more than half of organisations for developing and deploying the wellbeing programmes (table 4). For occupational health, there is much lower involvement (just over 50%) in the private sector than the public sector (table 5), although this is not the case for human resources.

Health and safety departments meanwhile received responsibility for wellbeing programmes less frequently than other individuals with other explicitly dedicated people management or health roles, but this could reflect a low number of organisations operating in high hazard contexts in the sample (e.g. police, construction).

The majority of wellbeing programmes featured a component of mindfulness practice or other mental activities (table 6), and physical exercise was also commonplace. Other health related behaviours were targeted in 50% or more cases (sleep, nutrition). Job design reviews were rare.

Although cultural transformation and listening exercises saw more frequent use than job design reviews, they were still used in less than 40% of cases. Management training appeared in more than half of the programmes but tended to appear more frequently in public organisations (table 7).

Table 6: Core components to respondent's organisation's workplace wellbeing offer

Component	%
Mindfulness/mental wellbeing	84
Activity/exercise	50
Management training	45
Nutrition	29
Sleep	24
Cultural transformation	21
Listening exercises	18
Review of job designs	62
IT offer	15
Other	15
N (=100%)	62

Table 7: Crosstabulation of the core components to respondent's organisation's workplace wellbeing offer by whether the organisation was private or public

Component	Private org %	Public org %	N (=100%)	Statistical difference
Management training	56	82	61	Yes
No answer	44	18		
Review of job designs	15	23	62	No
No answer	85	77		
Listening exercises	33	36	61	No
No answer	67	63		
Cultural transformation	31	50	61	No
No answer	69	50		
IT offer	13	18	61	No
No answer	87	82		
Activity/exercise	73	68	62	No
No answer	28	32		
Mindfulness/mental wellbeing	88	86	62	No
No answer	13	14		
Nutrition	58	64	62	No
No answer	43	36		
Sleep	45	59	62	No
No answer	55	41		
Other	15	14	61	n/a
No answer	85	86		

The most commonly cited major barriers to organisations' implementation of their workplace wellbeing programmes were related to resource allocation and management interest. The most commonly cited moderate barriers related to establishing the benefits and business case (table 8). Taxable benefit status was the least common but was still considered by half of the respondents to be applicable to their organisations.

Table 8: Respondent's ratings of the main barriers to their organisation's implementation of a workplace wellbeing programme

Barrier	Not applicable (%)	Minor barrier (%)	Moderate barrier (%)	Major barrier (%)	N (=100%)
Lack of budget	10	24	31	40	58
Unclear of business case	25	23	33	18	60
Unclear of health benefits	23	33	30	13	60
Difficulty in assessing what works	14	29	42	15	59
Taxable benefit status	50	26	19	5	58
Lack of resources to deploy	10	29	25	36	59
Lack of management interest	15	34	21	30	61
Other	*	14	43	43	7

* blank due to high proportion of missing values – 67% of respondents

No significant differences were found in the frequency of perceived barriers between private and public organisations (table 9). No respondents in the public sector at all saw there as being any additional barriers to the ones listed in the survey; the named barriers would appear to be comprehensive for the public sector.

Table 9: Crosstabulation of the main barriers to their organisation's implementation of a workplace wellbeing programme by whether the organisation was private or public

Barrier	Private org %	Public org %	N (=100%)	Statistical difference
Lack of budget	83	86	62	No
No answer	18	14		
Unclear of business case	70	77	62	No
No answer	30	23		
Unclear of health benefits	73	77	62	No
No answer	28	23		
Difficulty in assessing what works	83	82	62	No
No answer	18	18		
Taxable benefit status	45	50	62	No
No answer	55	50		
Lack of resources to deploy	85	86	62	No
No answer	15	14		
Lack of management interest	88	77	62	No
No answer	13	23		
Other	18	0	61	n/a
No answer	82	100		

Respondents' perceptions of increasing interest in workplace wellbeing are shown in tables 10 to 12 below. The vast majority of respondents had seen an increase in interest in workplace wellbeing from companies that was at least moderate (table 10). The most frequent reasons for increasing interest were employee demand and a void in employer strategies, with at least half of respondents selecting each (table 11).

Table 10: Extent to which respondent had seen an increasing interest in workplace wellbeing from companies

Extent of Increase	%
Not at all	5
A small increase	18
A moderate increase	38
A large increase	25
A very large increase	13
N (=100%)	60

Table 11: Reasons for extent of respondent seeing an increasing interest in workplace wellbeing from companies

Reason	%
Demand from employees (e.g. response to 24/7 working climate)	58
Employers lack efficient mental health strategies	50
To fill the gap left by cuts in NHS services	35
Clear return on investment	23
Occupational health not seen as able to deliver this area	16
Other	18
N (=100%)	62

This was also the case for the reason of making up for NHS cuts for respondents working for public sector organisations, but not those working in the private sector (table 12). As with table 9, those in the public sector were also more likely than those in the private sector to see the list of reasons listed in the survey as sufficient. Related to having an unclear business case as a barrier (table 8), table 11 shows only 23% of participants perceived that return on investment was a reason for increasing interest in workplace wellbeing.

Table 12: Crosstabulation of the reasons for extent of respondent seeing an increasing interest in workplace wellbeing from companies by whether the organisation was private or public

Reason	Private org %	Public org %	N (=100%)	Statistical difference
Demand from employees (e.g. response to 24/7 working climate)	58	59	62	No
No answer	43	41		
Clear return on investment	28	14	61	No
No answer	72	86		
Employers lack efficient mental health strategies	44	64	61	No
No answer	56	36		
Occupational health not seen as able to deliver this area	15	18	61	No
No answer	85	82		
To fill the gap left by cuts in NHS services	26	55	61	Yes
No answer	74	45		
Other	26	5	61	n/a
No answer	74	95		

Conclusions

Although only a relatively small sample that is not representative, the results from the Society of Occupational Medicine (SOM) survey do highlight some areas where there is divergence/convergence between the scientific evidence base and practice, plus areas where occupational health practitioners have the potential to add value in other ways.

First, it is clear that there are potential opportunities for occupational health professionals to get more involved in the provision of workplace wellbeing services. Given the presence of other professionals (human resource professionals in particular), it is most likely to involve working alongside these other professionals. However, human resource and occupational health professionals often work alongside each other already (e.g. in return to work cases).

In relation to the scientific evidence base, of the five ways to workplace wellbeing identified in chapter 2, improvements in job design is one of the least frequently used category of action, with cultural transformation being used in 37% of cases and management development also being used relatively infrequently in the private sector. Therefore, it appears areas of potential added value relate to developing knowledge of and competences in implementing the more preventive strategies targeted at workplace social environments, working practices and management practices, rather than provision of specific personal wellbeing resources or workplace health promotion.

Other reasons for developing capability in services targeted at workplace social environments, working practices and management practices include:

a. Consonance with UK health and safety regulation, specifically the 1974 Health and Safety at Work Act, and the 1994 ruling that there is no difference in law between psychiatric injury and physical injury;[45]

b. The Department of Business, Energy and Industrial Strategy has accepted the metrics put forward by RSA/Carnegie Trust for assessing and reporting on job quality in particular, following the Taylor report;[46]

c. The Stevenson/Farmer report makes a number of recommendations, including around job quality and management practice, for promoting workplace mental health.[47] The Civil Service and National Health Service have agreed to adopt the Stevenson/Farmer-recommendations.[48]

Other areas where occupational health practitioners can add value include developing skills in acquiring financial and/or other resources for workplace wellbeing programmes. This may in turn be dependent on developing skills in persuading senior managers to take interest and promote workplace wellbeing and developing persuasive business cases. Although a persuasive business case may involve presenting a plan that includes evidence-based actions to improve wellbeing and clear return-on-investment/cost-benefit analyses, an effective business case could include consideration of less tangible assets (employer attractiveness, adding social value and corporate social responsibility, consistency with corporate values). Table 11 also indicates at least 50% of the reasons given for an increasing interest in workplace wellbeing relates to employers lacking efficient mental health strategies. A further source of added value could therefore include growing the ability to develop and implement strategies that integrate activities across all or some of the five ways to workplace wellbeing identified in the previous chapter.

45. Walker and Northumberland County Council (1994), England and Wales High Court, [1994] EWHC QB 2 http://www.bailii.org/cgi-bin/format.cgi?doc=/ew/cases/EWHC/QB/1994/2.html&query=walker+northumberland Accessed 25th November, 2019

46. Measuring Job Quality Working Group (2018). ***Measuring Good Work***. Dunfermline: Carnegie Trust.
Taylor, M. (2017). ***Good Work: The Taylor Review of Modern Working Practices***. London: Department of Business. Energy and Industrial Strategy.

47. Stevenson, D. & Farmer, P. (2017). ***Thriving at Work: A Review of Mental Health and Employers***. London: Department for Work and Pensions and Department of Health and Social Care.

48. Department of Work and Pensions/Department of Health (2017). ***Improving Lives The Future of Work, Health and Disability.*** London: HMSO.

4. IMPLEMENTING WORKPLACE WELLBEING INITIATIVES – THE STATE OF THE LITERATURE

In this chapter, we will examine the advice given to occupational health practitioners on how to implement workplace health and wellbeing initiatives. There are some frameworks that have been developed specifically for practice, and we will review examples of these in the first section. There are also a range of frameworks developed to help researchers evaluate how well specific initiatives have been implemented which can provide additional information on the factors practitioners need to consider. These research-oriented frameworks do overlap to some degree with the practice-oriented frameworks. Examples of these research frameworks are reviewed in the second section. In the third section, we look at some of the evidence from studies of the roles of practitioners in implementing workplace health and wellbeing initiatives.

Frameworks to Guide Practice

A number of sources have presented prescriptions for how best to implement workplace health and wellbeing interventions. Some of these are based on practitioner experience,[49] some on reviews of the literature[50] and some on a mixture of literature reviews and empirical evidence.[51]

Jordan and colleagues[52] produced a good practice model consisting of four components:

1. Top management commitment (and culture change);
2. On-going risk analysis;
3. Multifocal elements in a comprehensive and continually improving programme that has prevention as a key aim;
4. Widescale participative approach.

Jordan and colleagues indicate health and wellbeing programmes should have multiple components (see chapter 2 of this report) and can have components that are manager or worker initiated and led. Jordan and colleagues indicate the importance of multichannel communication, involvement of a range of stakeholders (senior managers, middle managers, workers, experts such as occupational health and human resources specialists) and changes in organisational culture as a potential mechanism of change. Elements of culture change can be triggered by senior management speeches and other symbolic acts (e.g. commitment of resources) and setting wellbeing targets (e.g. number of wellbeing initiatives implemented). Jordan and colleagues also point to the integration of wellbeing into existing systems, such as management development programmes, employee voice mechanisms and appraisal systems.

49. Campbell, Q. (2014). 12. Developing and implementing corporate wellness programs: lessons from the firing line. In Burke, R.J. & Richardsen, A.M (Eds.), ***Corporate Wellness Programs: Linking Employee and Organizational Health*** (pp 257-276). Cheltenham UK: Elgar.

50. Kendall, N., Burton, K., Lunt, J., Mellor, N., Daniels, K. (2016). ***Development of an Intervention Toolbox for Common Health Problems in the Workplace***. Bootle: HSE Books.

51. Tyers, C., Broughton, A., Denvir, A., Wilson, S., & O'Regan, S., (2009). ***Organisational Responses to the HSE Management Standards for Work-related stress. Progress of the Sector Implementation Plan.*** Bootle: HSE Books.

52. Jordan, J., Gurr, E., Tinline, G., Giga, S. I., Faragher, B., & Cooper, C. L. (2003). ***Beacons of excellence in stress prevention: Research Report 133.*** Bootle: HSE Books.

The UK Health and Safety Executive has also produced its own set of guidance on implementing the HSE's Management Standards for Work-Related Stress.[53]
The HSE recommends a four-stage, sequential process:

1. *Prepare the organisation:* Prepare a business case, secure senior management commitment, consult employees and/or employee representatives, set up a multi-stakeholder steering group (including senior management, occupational safety and health, human resources, employee representatives, union representatives, line managers), identify a project champion to represent the project at board/senior management level, identify a day-to-day manager (to run day to day activities, risk assessments etc.), develop a project plan, secure resources, develop a communication strategy, develop a stress policy.
2. *Decide who might be harmed and how:* Use existing data, surveys, communicate survey findings, gather data through toolbox talks or focus groups, analyse the data, evaluate the risks (consult employees to explore problems and discuss findings), link problems to solutions using focus groups, develop locally appropriate solutions, develop action plans with more focus groups, communicate results, monitor and review solutions (e.g. follow-up surveys).
3. *Deal with individual concerns:* this is about creating an environment where there is support for individuals from occupational safety and health, human resources and line managers.
4. *Review organisational policies and procedures, continuous monitoring and improvement and develop competencies in managers.*

Two succeeding frameworks took the HSE's approach and developed further practice frameworks based on research into the HSE Management Standards[54] and a variety of other frameworks have also been developed. These largely replicate the HSE's approach of a linear progression of stages and also the contents of Jordan and colleagues' framework. The models differ in they may place emphasis in different areas or make additions to the existing frameworks.

For example, Cox and colleagues and Tyers and colleagues[55] take into account organisational capability to make changes. Cox and colleagues also indicate the importance of assessing resistance to change. Tyers et al. suggest steering groups should be kept small but with board level representation and the importance of authoritative, external party support for securing senior management commitment.

Mellor and Webster[56] listed key enablers, such as regular reporting to the board on progress of the programme. Similarly, Herrera-Sanchez and colleagues[57] added alignment of the health and wellbeing programme with the organisation mission and values.

Ammendolia and colleagues[58] suggested programmes incorporate mandatory training for managers on priority health conditions, incorporating health objectives into annual performance plans and having multiple channels of communication. In her framework, Campbell[59] developed the idea of communication to incorporate branding of health and wellbeing initiatives, so that they are appealing, novel and fresh. Others stress the importance of setting specific achievable and measurable targets,[60] and using simple practical tools to facilitate ease of initial action.[61]

As noted, most models specify a series of steps in the progression of development and implementation of a health and wellbeing initiative. An exception is the Dynamic Integrated Evaluation Model (DIEM).[62] Although DIEM has a sequence of eight steps, at some steps in the process there are feedback loops resulting in adaptation of the initiative. One model explicitly included decision criteria,[63] recommending any action be subject to three tests before implementation:

1. Responsive to worker needs and flexible enough to be implemented;
2. Acceptable to all relevant stakeholders;
3. Worth investing in, in that the solution gives the best return on investment compared to other options as well as being consistent with other policies and practices.

53. Health and Safety Executive, (2017/2019). ***Tackling Work-Related Stress using the Management Standards Approach: A Step-by-Step Workbook***. http://www.hse.gov.uk/pubns/wbk01.pdf. Accessed 25th November, 2019.
54. Cox, T., Karanika, M., Mellor, N., Lomas, L., Houdmont, J., & Griffiths, A. (2007). ***Implementation of the Management Standards for Work-Related Stress: Process Evaluation***. Nottingham: University of Nottingham.
Tyers, C., Broughton, A., Denvir, A., Wilson, S., & O'Regan, S., (2009). ***Organisational Responses to the HSE Management Standards for Work-related stress. Progress of the Sector Implementation Plan***. Bootle: HSE Books.
55. Cox, T., Karanika, M., Mellor, N., Lomas, L., Houdmont, J., & Griffiths, A. (2007). ***Implementation of the Management Standards for Work-Related Stress: Process Evaluation***. Nottingham: University of Nottingham.
Tyers, C., Broughton, A., Denvir, A., Wilson, S., & O'Regan, S., (2009). ***Organisational Responses to the HSE Management Standards for Work-related stress. Progress of the Sector Implementation Plan***. Bootle: HSE Books.
56. Mellor, N., & Webster, J. (2011). ***A Process Review of a Corporate Health and Well-Being Strategy***. DWP Case Study. Buxton Derbyshire: Health and Safety Laboratory
57. Herrera-Sánchez, I. M., León-Pérez, J. M., & León-Rubio, J. M. (2017). Steps to ensure a successful Implementation of occupational health and safety interventions at an organizational level. ***Frontiers in Psychology***, 8, 2135.

58. Ammendolia, C., Côté, P., Cancelliere, C., Cassidy, J. D., Hartvigsen, J., Boyle, E., ... & Amick, B. (2016). Healthy and productive workers: using intervention mapping to design a workplace health promotion and wellness program to improve presenteeism. ***BMC Public Health***, 16(1), 1190.
59. Campbell, Q. (2014). 12. Developing and implementing corporate wellness programs: lessons from the firing line. In Burke, R.J. & Richardsen, A.M (Eds.), ***Corporate Wellness Programs: Linking Employee and Organizational Health*** (pp 257-276). Cheltenham UK: Elgar.
60 Biron, C., & Karanika-Murray, M. (2014). Process evaluation for organizational stress and well-being interventions: Implications for theory, method, and practice. ***International Journal of Stress Management***, 21, 85-111.
61. Rasmussen, C.D.N., Højberg, H., Bengtsen, E., & Jørgensen, M.B. (2018). Identifying knowledge gaps between practice and research for implementation components of sustainable interventions to improve the working environment–A rapid review. ***Applied Ergonomics***, 67, 178-192. 62. von Thiele Schwarz, U., Lundmark, R., & Hasson, H. (2016). The dynamic integrated evaluation model (DIEM): achieving sustainability in organizational intervention through a participatory evaluation approach. ***Stress and Health***, 32, 285-293.
63. Kendall, N., Burton, K., Lunt, J., Mellor, N., Daniels, K. (2016). ***Development of an Intervention Toolbox for Common Health Problems in the Workplace.*** Bootle: HSE Books.

Frameworks from Research

Researchers have developed numerous frameworks to help researchers evaluate factors that may facilitate or hinder the implementation of workplace health and wellbeing initiatives. The factors identified in these frameworks can help practitioners target potential sources of help or pre-empt problems from certain quarters.

Egan and colleagues[64] produced a thematic checklist based on a systematic review of the literature. Included in this checklist were:

1. Motivation – reason for intervention/management decision;
2. Theory of change – was intervention design influenced by this;
3. Implementation context;
4. Experience – competence of implementers, and participants if they were performing new roles;
5. Planning consultations – use of participative processes during planning;
6. Delivery collaborations – use of participative processes during implementation;
7. Manager support;
8. Employee support;
9. Availability of resources.

Similar checklists have been produced by Nielsen and Randal and Fridrich and colleagues as part of wider evaluation frameworks.[65]

Nielsen and Randall's list of factors to evaluate has three overarching themes:

1. Intervention design and implementation;
2. Intervention context;
3. Participants' mental models.

Within intervention design and implementation, Nielsen and Randall's framework particularly highlights the role of key decision makers, change agents, middle managers, external consultants and employees participating in the activities involved in the intervention. Issues connected to context relate to where and when changes are made and prevailing culture and conditions. Mental models refers to stakeholder understandings of the intervention, readiness for change, experience with similar interventions and the degree of sharedness of mental models amongst stakeholders.

Fridrich and colleagues also highlighted the role of context. As with some of the practice models described in the previous section, Fridrich and colleagues propose (researcher-evaluated) workplace health and wellbeing programmes and specific interventions follow three sequential stages: the preparation phase (planning and persuading), the action cycle phase (making changes) and the appropriation phase (ensuring the sustainability of changes).

Several other literature reviews converge on the importance of the context of the organisation, management support and capabilities, positive worker attitudes to any workplace health and wellbeing activities. introduced, and the fit between new workplace health and wellbeing activities and existing processes and systems.[66]

64. Egan, M., Bambra, C., Petticrew, M., & Whitehead, M. (2009). Reviewing evidence on complex social interventions: appraising implementation in systematic reviews of the health effects of organisational-level workplace interventions. ***Journal of Epidemiology & Community Health***, 63, 4-11.
65. Fridrich, A., Jenny, G. J., & Bauer, G. F. (2015). The context, process, and outcome evaluation model for organisational health interventions. ***BioMed Research International.***
66. Nielsen, K., & Randall, R. (2013). Opening the black box: Presenting a model for evaluating organizational-level interventions. ***European Journal of Work and Organizational Psychology***, 22, 601-617.
Hoefsmit, N., Houkes, I., & Nijhuis, F. J. (2012). Intervention characteristics that facilitate return to work after sickness absence: a systematic literature review. ***Journal of Occupational Rehabilitation***, 22, 462-477.
Murta, S. G., Sanderson, K., & Oldenburg, B. (2007). Process evaluation in occupational stress management programs: a systematic review. ***American Journal of Health Promotion***, 21, 248-254.
Passey, D. G., Brown, M. C., Hammerback, K., Harris, J. R., & Hannon, P. A. (2018). Managers' support for employee wellness programs: An integrative review. ***American Journal of Health Promotion***, 32, 1789-1799.
Rojatz, D., Merchant, A., & Nitsch, M. (2016). Factors influencing workplace health promotion intervention: a qualitative systematic review. ***Health Promotion International***, 32, 831-839.
Wierenga, D., Engbers, L. H., Van Empelen, P., Duijts, S., Hildebrandt, V. H., & Van Mechelen, W. (2013). What is actually measured in process evaluations for worksite health promotion programs: a systematic review. ***BMC public health***, 13, 1190.

Evidence on the Role of Expert Practitioners

Although practitioner and research oriented frameworks offer some insights into what makes an attractive and implementable workplace health and wellbeing activity or programme, there exists very little evidence on the role of practitioners with expert knowledge, namely occupational health and human resources professionals. Indeed, we were only able to find evidence from six studies, and the analysis of the roles of expert professionals in these papers was limited.[67] This necessarily limits the evidence base and conclusions we can draw.

It does appear from the existing literature that it is important for human resources and occupational health professionals to engage actively with intended changes.[68] It also appears important that there is communication between occupational health and human resources to ensure integration of activities and convergence of expectations on the roles of different actors.[69] Conflict between expert practitioners and other stakeholders can hinder the success of health and wellbeing activities.[70] Not surprisingly, commitment of necessary levels of resourcing also appears to be important for success.[71]

67. This is part of the work Daniels and others are conducting for the What Works Centre for Wellbeing.
68. Augustsson, H., Schwarz, U. V., Stenfors-Hayes, T. & Hasson, H. (2015). Investigating variations in implementation fidelity of an organizational-level occupational health intervention. International Journal of Behavioral Medicine, 22, 345-355.
Biron, C., Gatrell, C. & Cooper, C. L. (2010) Autopsy of a failure: evaluating process and contextual issues in an organizational-level work stress intervention. International Journal of Stress Management, 17, 135-158.
Busch, C., Koch, T., Clasen, J., Winkler, E. & Vowinkel, J. (2017) Evaluation of an organizational health intervention for low-skilled workers and immigrants. Human Relations, 70, 994-1016.
69. Brakenridge, C. L., Fjeldsoe, B. S., Young, D. C., Winkler, E. A., Dunstan, D. W., Straker, L. M. & Healy, G. N. (2016) Evaluating the effectiveness of organisational-level strategies with or without an activity tracker to reduce office workers' sitting time: a cluster-randomised trial. International Journal of Behavioral Nutrition, 13(1:115).
Hasson, H., Villaume, K., von Thiele Schwarz, U. & Palm, K. (2014) Managing implementation: roles of line managers, senior managers, and human resource professionals in an occupational health intervention. Journal of Occupational and Environmental Medicine, 56, 58-65.
70. Greasley, K. & Edwards, P. (2015). When do health and well-being interventions work? Managerial commitment and context. Economic and Industrial Democracy, 36, 355-377.
71. Hasson, H., Villaume, K., von Thiele Schwarz, U. & Palm, K. (2014) Managing implementation: roles of line managers, senior managers, and human resource professionals in an occupational health intervention. Journal of Occupational and Environmental Medicine, 56, 58-65.

Conclusions

Both practice and research evaluation frameworks do provide checklists of factors to consider when implementing workplace health and wellbeing initiatives, and in many cases, also prescribe a sequence of actions to follow. These action sequences are held to progress in a logical and linear sequence, with any feedback loops confined to specific decision nodes of implementation. Nothing in the models delineates a specific set of knowledge, skills, and competences required by occupational health professionals, nor human resources professionals. Moreover, there is a limited scientific evidence base on expert implementers.

Nevertheless, from the frameworks and evidence that do exist, it is possible to infer a tentative outline of the kind of knowledge, skills and competences required by occupational health practitioners to implement effective workplace health and wellbeing initiatives and programmes.

First, both practice and research evaluation frameworks highlight the roles of multiple stakeholders and securing their engagement and commitment to resourcing – specifically senior managers. Relevant skills here would revolve around communication and consultation, involving stakeholders in decisions, skills in persuasion and skills in building the capacity in others to deliver changes. The small number of studies that does exist also indicate the importance of communication, integrating activities with other stakeholders, clarifying roles and expectation, managing conflict effectively and resourcing. Also relevant might be organisational skills, especially around data collection, analysis and organising steering group meetings.

Practice and some research evaluation frameworks highlight the use of planned sequences of activities and tend to portray workplace health and wellbeing interventions as progressing in a linear sequential fashion. Relevant skills here relate to planning, resourcing and problem-solving (for when plans do not work as intended and adaptations need to be made).

There are also elements in some of the models of integrating new practices into existing systems and practices, which would indicate the importance of awareness of wider business systems, as well as consultation with others. However, none of the frameworks or existing research considers what actions to take when existing systems and practices are harmful, and how to challenge those practices.

5. SKILLS AND COMPETENCES FOR WORKPLACE WELLBEING – INSIDER VIEWS

The previous chapter highlights limited direct evidence on the knowledge, skills and competences required by occupational health practitioners. Even so, the chapter does indicate some of the factors that could be considered and reinforces the conclusions of chapter 3 on where there may be opportunities to develop capability. Chapter 2 also indicates some of the knowledge required of the content of evidence-based initiatives and actions.

To address the problem of a limited evidence base and to move thinking further forward, we therefore decided to conduct interviews with a small set of expert practitioners. First, we wanted to hear the views of occupational health practitioners with significant experience of implementing workplace health and wellbeing interventions. To this end, we conducted interviews with six expert practitioners working for organisations, three working as leads for in-house occupational health services (two private sector, one public sector), two working for occupational health providers delivering out-sourced services to the private and public sectors, and one working within an in-house occupational health service (private sector). We were also interested in the views of professional groups that work most closely with occupational health professionals, most often human resources professionals. We spoke with four human resources professionals from private sector organisations, with employee health, wellbeing and/or engagement as part of their remit. We also spoke with a director of a private sector organisation with board level responsibility for health, safety and wellbeing.

Using a semi-structured interview approach, we focused the conversations on informant experiences of introducing new health and wellbeing initiatives or programmes. We asked questions concerning:

a. who made the case for change and how the case was made;

b. the procedures for ensuring management and implementation of the initiative or programme;

c. how any barriers were overcome and opportunities realised;

d. how adaptations were made if things went wrong;

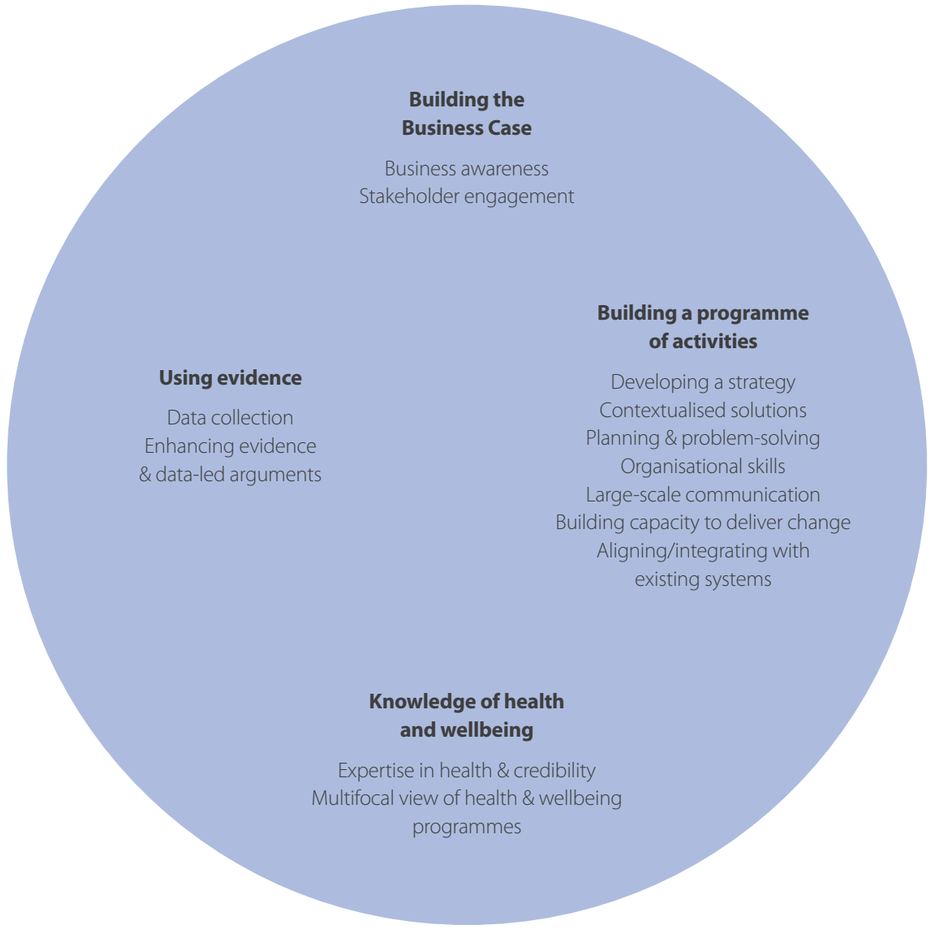
e. how impact was evaluated.

We also asked human resources professionals about the organisational arrangements for occupational health and the role of occupational health practitioners/providers in making changes. To conclude the conversation, we asked about the skills required of occupational health practitioners to meet the major challenges of the next five years and especially those skills that would differentiate good occupational health practitioners from exceptional occupational health practitioners.

Findings

Four major areas of knowledge, skills and competences were apparent in the conversations with the expert practitioners. Within each area, more detailed information was provided on specific kinds of knowledge or actions in each area. The four major areas concern: a) building the business case for health and wellbeing; b) using evidence; c) knowledge of health and wellbeing; and d) building a programme of activities. The areas are summarised in the diagram on the next page, and includes an area not mentioned explicitly by experts but highlighted in earlier chapters in this report.

Figure 1. Key areas of knowledge, skills and competences



Note: Aligning/integrating health and wellbeing programmes with existing systems was not mentioned by any of the experts we interviewed, but is included in a number of frameworks reviewed in the previous chapter.

Building the Business Case for Health and Wellbeing

Building the business case requires knowledge and skills in how to craft a persuasive argument, which also involves use of data (see next section), and rests on awareness of the business environment and engaging with stakeholders in the right way and the right order. The business case can be used to secure resources to build an effective programme of workplace health and wellbeing initiatives.

Business awareness is the baseline for making a case in the manner that will be understandable to and credible with a range of stakeholders in the organisation. Business awareness entails understanding the specific context of the organisation, awareness of commercial and other key concerns, perspectives of and relationships between key stakeholders and the 'language' of that organisation. Obtaining this awareness can be particularly problematic for outsourced service providers, especially at the tender stage, although that awareness is valued by service commissioners. Having awareness of how and where a business operates gives occupational health practitioners a point of entry to conversations with key decision makers on how health and wellbeing programmes can help businesses take advantages of opportunities or mitigate against specific threats. More generic or decontextualised arguments are most likely to be resisted. Awareness of a business is something that has to evolve and involves anticipating how organisations, their environments and ways of working will change, and appreciating current and emerging strategic threats and opportunities.

Engaging with stakeholders involves knowing who to engage and knowing how to engage. Again, this can be difficult for outsourced service providers. Key stakeholders will vary from organisation to organisation, and rarely if ever means just engaging with the Chief Executive or other senior managers: Indeed, in some cases, it may not even be necessary to engage with senior managers first. The key thing is about knowing who has influence and getting them involved in building the case and working together. Very often this can be the people who manage and are accountable for those key aspects of the business that deliver value (e.g. operations managers), as well as those with an obvious remit or interest in issues related to health and wellbeing (e.g. safety professionals, human resources professionals with responsibility for employee engagement or equality, diversity and inclusion). Involving employees or employee representatives is widely recommended in the research literature (see previous chapter).

Knowing how to engage appears to be a critical skill set, as it is the means to tackle cynicism. Knowing how to engage rests on empathy and persuasion. Being empathic to the current and future needs and perspectives of different stakeholders enables persuasion to be built on how a programme of health and wellbeing initiatives can address their interests and concerns. Other elements of persuasion involve: a) having a clear and concise 'elevator pitch' that can be used to bring conversations with stakeholders around to discussing the benefits of health and wellbeing programmes, and/or the risks of not taking action; b) being well informed so that credible, evidence-based answers can be provided to questions (see 'knowledge of health and wellbeing' below); and c) moving rapidly from working with early adopters to creating 'converts' out of influential individuals who were initially sceptical or cynical. Converts are especially persuasive because a change in attitude to health and wellbeing signals to others the credibility of the case being made.

The business case itself needs a strong evidential and persuasive foundation. It is insufficient to build the business case solely on return on investment calculations, for two reasons. First, it could be the case that other activities not connected to health and wellbeing (or even harmful to health and wellbeing) would have larger short-term returns on investments, leading to a lower priority for health and wellbeing. Second, occupational health practitioners are unlikely to have the same level of knowledge of financial matters as general and financial managers: in this case, there is a risk that any arguments based purely on financial matters will be unpicked. A more persuasive case would also feature arguments based on core business values, and the fit of a health and wellbeing programme with those values. If the business case is so persuasive that improvements in health and wellbeing are incorporated into managers' performance objectives and annual reporting, then the impact on health and wellbeing would become mainstreamed in all major business decisions.

Using Evidence

The business case and the programme of health and wellbeing initiatives should be evidence-led. Therefore gathering, interpreting and using evidence are foundational skills.

The challenges listed by our expert informants were not so much around collecting data, as absence rates, employee surveys, service use and the like are routinely collected by larger organisations and occupational health providers. The challenge seemed to be more about selecting the most compelling and rigorous data to collect for a specific business or context, and focusing efforts on those data. This may mean using external experts in some instances. Data can then be used to help make the business case, to assess the results of pilot initiatives and to identify barriers to implementation.

The business case can include data-led arguments around, for example, reductions in sickness absence rates, improvements in employee engagement, quality and safety. Data can be used to identify current problems, or can be used to extrapolate trends and identify future threats and opportunities. It is important that the data-led arguments are specific to the business and address business needs, risks or values: such specific data-led arguments are thought to be more convincing than generic arguments based on, for example, UK-wide statistics on lost working days gathered by government departments or professional institutions. It is also important not to over-sell the strength of the data and to acknowledge the limitations, but at the same time have robust explanations for why the data used are the most compelling available.

Data-led arguments need to be presented in a manner that is comprehensible to the intended audience. This can mean developing separate communications around the same message for different audiences. Data-led arguments also need to be enhanced to make them engaging and attractive. Figures and diagrams can help in presentations and documents. A key technique to enhance data-led arguments is to create a narrative around personal health and wellbeing stories, which illustrate the lived experience of workers in the organisation.

Knowledge of Health and Wellbeing

Very much aligned with using evidence is occupational health practitioners' knowledge of health and wellbeing. This relates to technical knowledge of health, wellbeing and specific conditions. It also relates to knowledge of how to use evidence to assess the credibility of different options and knowing how to distinguish between what is scientifically credible and 'snake-oil'. Occupational health practitioners' knowledge of health and wellbeing, which is evidenced by academic and professional qualifications, also enables occupational health practitioners to have the credibility to make such judgements.

In spite of this knowledge and credibility, it is also important to move beyond the medical model and a traditional focus on rehabilitation and health surveillance. In broad terms, this would mean having a wider view of health and wellbeing and developing proactive, preventive initiatives and positive workplace cultures in addition to reactive/case referral processes.

A wider view of health and wellbeing would entail taking a broad view of wellbeing (see chapter 1). Our expert informants mentioned physical wellbeing, mental wellbeing, social wellbeing, financial wellbeing, life skills, workplace culture and employee engagement. They also noted that occupational health practitioners need knowledge and skills to develop both preventive and reactive initiatives that are strategic and integrated (see chapter 2 for five areas where initiatives can be targeted).

Because of their expert knowledge and credibility, occupational health practitioners may be well placed to take a role in contributing to health and wellbeing strategy development, connecting initiatives and the governance of workplace health and wellbeing programmes.

Building a Programme of Activities

As noted in the previous section, workplace health and wellbeing programmes need to take a broad approach and cover preventive and proactive initiatives as well as reactive initiatives focused on rehabilitation. A balance does need to be made between having a programme of activities that is sufficiently broad to address the concerns of a diverse workforce but is sufficiently focused on resourcing those initiatives that have the best chance of addressing key needs successfully. Occupational health practitioners also need the change management skills to negotiate with stakeholders, to build capacity to deliver changes, develop relevant governance structures and to provide a framework on how to embed workplace wellbeing initiatives into everyday workplace practices and processes. This means having and communicating a clear strategy, how that strategy addresses specific business and individual needs and the steps in implementing that strategy.

One key element in developing an integrated strategy is managing the tension between the need for contextualised solutions to specific issues in one part of the business or for one group of individuals and having a common framework to embed changes across the business. On the one hand, a common framework is needed to enable co-ordination and so that people know of the range of services available to them. On the other hand, initiatives are more likely to be successful and engaging if they address issues relevant to a particular group in ways that are appropriate for that group. Our expert informants pointed to two ways in which this tension can be managed. One way is to have a company-wide steering group and a series of smaller working groups for specific issues, worksites or types of worker. These smaller groups have ownership of initiatives implemented in their area of concern. The company wide steering group may then have oversight, connect different working groups together where there is overlap and provide advice, targets and resources for the working groups. A second way is much more limited and much less strategic, in that occupational health practitioners would act in an advisory role only to different parts of the business.

The more strategic approach clearly requires forward planning about, for example, what evidence to collect, which initiatives to select and resource, and which resources to deploy and when and where to deploy them. Businesses change and plans often do not work as intended. As well as contingency planning, scanning for, anticipating and mitigating against risks, occupational health practitioners need the flexibility to change plans and communications when they are not working. It also requires a lot of patience and resilience, as comprehensive health and wellbeing strategies can take many months to establish and are in need of maintenance and periodic refreshment.

As noted above, strategic approaches to health and wellbeing require effective governance. For occupational health practitioners that take lead roles in the governance of such programmes, skills are needed in the organisation of steering groups or other committees, chairing those groups, co-ordinating activities and monitoring the progress of those activities. As articulated by one of our experts, the effective organisation of steering groups can drive implementation and create real change, as opposed to just being a 'tick-box' exercise.

Skills in co-ordinating large-scale communication are needed for several reasons. First, communication is a means of signposting to employees to the services on offer. Second, communication provides a basis for branding of the entire wellbeing programme, creating a sense that different initiatives are part of a coherent whole. Third, communication is a means of demonstrating care and inclusion for employees. Fourth, large-scale communication can act as a means to encourage conversations about wellbeing in the workplace, and therefore help to enable changes in workplace cultures.

Large-scale communication may be especially problematic for outsourced providers, who may not have ready access to in-house communications. Notwithstanding, our experts mentioned the reach of digital communications but also the importance of interactive and face-to-face communication (which can be virtual, through for example webinars). Interactive communication is important for obtaining feedback but also demonstrates inclusion and care more than impersonal digital communication.

One expert also noted that workplace wellbeing champions can be used for face-to-face and interactive communication about wellbeing initiatives. Our experts also noted that communication needs to be tailored for specific audiences, and can be made engaging by making communications easy to attend to (e.g. including communication with pay cheques as opposed to sending mass emails) and attractive (e.g. using infographics).

Occupational health practitioners cannot deliver change by themselves. Instead building the capacity to deliver change requires co-ordination with other professionals, most particularly for more proactive and preventive approaches that can entail making changes to job design, working practices and processes. Our experts mentioned other specialists that are often used as consultants, such as occupational psychologists, ergonomists, physiologists and sports scientists. Within organisations, relevant professionals include human resources, operations, facilities and safety managers. For occupational health practitioners, their specialist professional knowledge is a useful lever in negotiating the content of programmes. Occupational health professionals also need to know the limits of their own knowledge and when to signpost to other professional groups.

Line managers are another key group in delivering change. Large-scale communications can be targeted at line managers. In addition, occupational health practitioners may work with human resources professionals to ensure line managers have adequate training in health and wellbeing matters and people management skills (see chapter 2).

Although something that is described in the literature as good practice, aligning/integrating new initiatives with existing systems, structures and processes was not mentioned explicitly by our experts. Indeed, some of our expert informants noted the importance of openly challenging and changing maladaptive systems, structures and processes. However, two informants did note the importance of incremental development of health and wellbeing programmes, in which new health and wellbeing practices build on existing good practice.

Conclusions

From conversations with expert practitioners, we have identified four broad areas of the knowledge, skills and competences required by occupational health practitioners to introduce and implement workplace health and wellbeing programmes. Within these four broad areas, more specific themes emerged. Within these more specific themes, there was a great deal of overlap with themes in the scientific literature, although our experts placed much less emphasis on formal planning and linear change processes and the requirement to integrate health and wellbeing practices into existing business processes, systems and structures. Our experts placed more emphasis on business awareness, engaging with a range of stakeholders, enhancing data-led arguments with personal stories, using large-scale communication and developing contextualised solutions. Our experts also emphasised the importance of multifaceted approaches that include proactive and preventive elements.

6. SUMMARY AND OVERALL CONCLUSIONS

We have presented wellbeing as a composite construct comprising of more specific elements (e.g. subjective wellbeing) and with fuzzy distinctions between health and wellbeing. In this sense, occupational health practitioners have a role to add value to workplace wellbeing, because programmes of workplace activities should address health and wellbeing broadly. This inevitably means working closely with other professional groups for two reasons. First, the more proactive and preventive actions might be tied closely into activities around management development, cultural transformation, job redesign, flexible working, employee benefits and diversity and inclusion. Second, the benefits of health and wellbeing programmes might not be realised in explicitly health outcomes like sickness absence, but may be indexed by employee engagement and retention or employer attractiveness in the labour market.

On the basis of a limited literature base (chapter 4) and interviews with expert informants (chapter 5), we have identified four major areas of knowledge, skills and competences required by occupational health practitioners to implement workplace health and wellbeing programmes, with more specific themes within these major areas (chapter 5, figure 1). These major areas relate to: a) building the business case for health and wellbeing; b) acquiring and using evidence; c) knowledge of health and wellbeing; and d) building and sustaining a programme of activities.

One of the areas relates specifically to knowledge of 'what': this is knowledge of health and wellbeing. As well as knowledge of specific conditions and treatments, knowledge of health and wellbeing also subsumes knowledge of five areas to address workplace wellbeing in its broader sense (see chapter 2). These five areas relate to management capabilities, improving job quality, enhancing social relationships at work, workplace health promotion and providing support for workers coping with health conditions and/or life stresses. Data collected by the Society of Occupational Medicine (SOM) (chapter 3) and our expert informants (chapter 5) indicates particular opportunities for developing integrated and coherent programmes of activities that involve proactive and preventive elements around management capabilities, improving job quality and enhancing social relationships at work.

The other three major areas of knowledge, skills and competences relate to knowledge of how to implement programmes. As chapter 4 indicates, the scientific literature in this area is sparse and based on prescriptive and largely linear change models rather than detailed empirical evidence on what happens in practice. In this report, we have aimed to provide a point of focus for reflection and on-going research on the knowledge, skills and competences needed by occupational health practitioners to contribute to successful workplace wellbeing initiatives. Although we have identified an initial classification of major areas of the knowledge, skills and competences, we cannot claim this to be a definitive list.

We envisage further research would make revisions to this initial list as more sources of evidence are collated. However, it is clear from the available evidence that in addition to technical and functional knowledge of health conditions and the ability to appraise evidence critically, occupational health practitioners can add value to workplace health and wellbeing programmes by acquiring and using skills related to change management processes. Specific challenges in developing such skills across the occupational health professions may relate to adding new material into what may be already crowded curricula in academic and professional qualifications.

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