

**SUMMARY OF DISCUSSION****Second plenary meeting of the Public Health Commission****07.30 Friday 23 January 2009****100 Victoria Embankment, London (Unilever House)****Attendees:**

Chairman - Dave Lewis  
 Commission - Baroness Peta Buscombe, Helen McCallum, Professor David Coggon, Dr Nick Sherron, Mark Leverton, Fred Turok, Jeremy Beadles, Michael Livingston, Lucy Neville-Rofe, Douglas Smallwood.  
 Apologies - Paul Kelly, Professor Simon Capewell.  
 Secretariat - George Gordon, Tom Denyard, Leanne Gorin, Danielle Hayward-Bradley (Unilever); Martin Le Jeune (Open Road)

Item	Minutes	Actions
1 Chairman's Welcome		
2 Introductions	<p>All Commission members introduced themselves and the chairman introduced the Secretariat. The subject and format of meeting were discussed. Update on consultation responses received. The Chairman invited Commission members to solicit further consultation responses via their own networks.</p>	*Commission members
3 Working methods	<p>The proposed working plan was introduced by the Chairman and discussed. Commission members emphasised their wish to take a fully-integrated approach to the subjects in the Responsibility Deal. It was agreed in particular that the Commission should look at interventions that addressed people on a holistic basis, reflecting their lifestyles, rather than separate interventions that would lack effectiveness.</p>	
4 Workplace Health: the issues. Led by Prof. David Coggon	<p>Background/Introduction from Professor David Coggon</p> <p>Focus on three areas where there was scope for useful gains: 1) diet, physical activity, alcohol consumption; 2) how employers could best exploit external Occupational Health (OH) advice; and 3) promoting the positive psychological benefits of work.</p> <p>With regard to 1), employers were interested in short-term gains whereas the government had a longer time-horizon – interventions needed to reflect that</p> <p>2) was an issue particularly for SMEs. In approaching it, the Commission should acknowledge the work done by government in the light of the Black report and build on that</p> <p>The rise of work incapacity attributed to mental health problems was probably as much to do with removing the stigma formerly attached to those conditions as an increase in stress at work. Presenting interventions as promoting the positive psychological benefits of work may be better than</p>	

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<p>5 First Expert: Dr Paul Litchfield - Health promotion in relation to alcohol, diet and exercise</p>	<p>programmes badged as protecting workers from harmful stress.</p> <p>Dr Litchfield outlined the main issues in workplace health promotion:</p> <p>Heart disease, chronic respiratory disease and cancer were the leading causes of death nationally, but musculoskeletal disorders and mental health problems were the two biggest contributors to sickness absence and impaired productivity.</p> <p>The workplace is an effective venue for health promotion particularly for (middle-aged and younger) men.</p> <p>Workplace interventions are most effective with commitment from management and partnership from employees.</p> <p>Incentives did help and the integration of programmes for behavioural change in a broader context of change produces better results.</p> <p>Branding was critical (e.g. BT's 'Workfit' which saw a 35% reduction in absenteeism)</p> <p>Healthy work environments should not be thought of as occupational health, just ways of benefiting employees.</p> <p>In discussion the following points were made:</p> <p>It was critical not to cut OH programmes in a downturn</p> <p>Focus should be as much on boosting productivity in the healthy population as the unwell.</p> <p>Effective communication was key</p> <p>To medicalise what is a normal activity (staying healthy and fit) encouraged dependency, which was dangerous</p> <p>Using modern technology facilitated self-help and offered a way of delivering messages cost-effectively</p> <p>Reaching SMEs was important via established networks and using the language of improved business, not improved health</p> <p>Most of the evidence on the effectiveness and cost-effectiveness of health-promoting interventions in the workplace is limited in its scientific rigour. The few published business cases come from (mainly large) companies in various countries, and ROI will vary according to whether the employer pays the cost of general health care (as in the USA).</p> <p>In trying to modify behaviour, whether of employers or employees, it will often be best to aim for progressive rather than major step change. Progressive change can be self-reinforcing – e.g. it is easier to give up smoking when fewer colleagues and friends smoke.</p> <p>Group attitudes and behaviours are an important influence on individuals, and can be a useful target for interventions.</p> <p>Competition between teams can be a useful motivator.</p> <p>Environmental circumstances should be conducive to the changes in behaviour that are desired, but</p>	<p>Further evidence / case studies to be gathered by Leanne Gorin.</p>

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6 Commission Expert: Professor David Coggon- Optimising the use of Occupational Health advice and 'Getting employees back to work'	<p>changing the environment (e.g. providing healthy options on menus in the canteen) is not usually enough to alter behaviour on its own, and good communication is vital. Integrating interventions with other programmes of change (e.g. on safety, customer service etc.) increases their success.</p> <p>The main short-term benefits to employers from healthier lifestyles come from a reduction in the adverse impact of musculoskeletal disorders and minor mental health problems on attendance and productivity. Impact on, for example, diabetes and coronary heart disease tends to be longer term. Benefits occur both from prevention of illness and also from helping people to stay in work with illness. In the absence of Government incentives, interventions need to be relatively inexpensive.</p> <p>Going back to work should be incorporated as part of an employee's rehabilitation. Employer interaction with sources of healthcare advice is needed in order to avoid the cost to the community of persistent ill-health. Key points were:</p> <p>Good management and employee relations were a basic starting-point for successful strategies. Advice for employers on communication was required Partnerships needed between employers and GPs – if GPs had the capacity and on this views differed Advice on how to manage people and their tasks and a flexible approach to the ways in which people can work offered major benefits Sick pay – sometimes this was so good that it can be beneficial for an employee to be unwell</p> <p>In discussion the following points were made (includes input from Ewan MacDonald who was unable to attend the meeting):</p> <p>GPs were on overload and there was limited potential in turning them into occupational health resources (but some members believe that a lot more can be achieved than at present through simple changes in GPs' approach). If advice were to be dispensed to small businesses it should use persuasive arguments and avoid duplication of advice sources Work is generally beneficial for health, and timely return to work can assist and accelerate rehabilitation from illness and injury. Avoidable sickness absence is a cost to employers, and ultimately to the community at large. These points are recognised in the Black report, and the Government's response to the report includes plans for better training of GPs (already ongoing), fit notes to replace sick notes, and piloting of models for geographically based "fit for work" services. To maximise the benefits from these initiatives, employers must fully exploit the advice that is available to them. Furthermore, appropriate engagement by employers will encourage GPs and other providers of advice on work and health to become more involved. Best practice requires partnership between the employer, employee and GP or other health care</p>	

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7	<p>Second Expert: Professor Tom Cox – Promotion of Psychological Health at work</p>	<p>Professor Cox made the following points:                      SMEs could not afford the time or money for professional advice                      80% mental health cases were caused by pressures external to work                      Interventions had to go with the grain of workplace structures and use team co-operation and team rivalries to drive improvements                      There were no quick fixes                      Most mental health issues were general depression or stress rather than psychoses etc: it was a major mistake to regard these as the subject for medical-level interventions and self-help was frequently the best answer                      The health promotion industry had a vested interest in exaggerating the scale of the problem                      Designing work to reduce the triggers for mental health problems was cheaper than subsequent intervention</p> <p>In discussion the following points were made:                      Incentives and rewards were important in promoting change – but not necessarily financial – and could work with both employers and employees                      Mental health impacts importantly on productivity beyond its effects on attendance at work.                      The focus should be more on the psychological benefits of work and less on the hazards of stressful work.                      The main requirement is for good management. Over-medicalisation should be avoided.                      Most organisations are already doing things, but outcomes tend not to be formally evaluated and reported, perhaps in some cases because of fears about impact on competitiveness.                      Strategies must be tailored to the organisation, including its size.</p>			
8	<p>General Discussion</p>	<p>In discussion the following points were made:                      Workplace activity was fundamental because of the potential it offered to reach otherwise hard-to-reach groups                      The Commission should seek more examples of interventions which had resulted in real health improvements                      The message of aspiration was more likely to work than coercion                      There was no potential in approaches that suggested that all employers were the same                      The Commission should look at what could be achieved in the real workplace, not naively assume that we could drive improvement in all groups at once                      In the end information was something that employees would choose to act on or not</p>			

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A.O.B	<p>Ways of communication with SMEs were suggested: TV storylines, large company sponsors            Messages should be conveyed through the home environment too, the route to SMEs was through the community.            Employers had to ensure that all changes in the workplace contributed to the momentum.            Proposals needed to be realistic and cost effective.            There was potential in having larger businesses mentoring small ones in their supply chains or in their locality            There needed to be a much more systematic exploration of the potential of new technology in this area</p> <p>In conclusion the chairman thanked the Commission members for a useful and positive discussion. It was important to remember that the Commission had to focus on what was practical and recall that its brief was to suggest ways of partnership between government and employers. It could not hope to solve all policy issues.</p>	<p>See separate paper (PHC/2009/06) for record of ideas for further exploration</p>
	None.	