NPCC
National Police Chiefs' Council

The National Police Wellbeing Service

College of Policing

A prospectus for change

This document describes the redesign of police occupational health to promote sustainable effectiveness.

Contents

1. Executive summary

Prospectus for Change is aimed primarily at decision makers and change agents. Police occupational health needs to change, in line with proposed police reforms, to support the policing vision 2030 and to help deliver the UK government's 'safer streets' mission. It is a well-rehearsed axiom that our people are our greatest asset. Occupational health has a mission-critical role in supporting police personnel and assisting forces in optimizing the deployment of these 'assets'.

The occupational health function is not always well understood. Chapter two sets out the occupational health proposition. It sets out what occupational health is for and describes the core specialist clinical staffing cadre required to deliver it. It discusses how a return on investment in occupational health can be considered with reference to the Productivity Review and the three widely held business case factors: legal, moral, and financial. It concludes with the premise that occupational health services specialise in promoting people performance through health and fitness. As the only clinical service within policing, it occupies a unique position within forces, and it is essential that it is integrated within the police people management ecosystem. This will ensure that it works collaboratively and responsively to support business objectives: right person, right place, right time.

Occupational health is an important component of the health and wellbeing offering. The delivery of occupational health should be planned in relation to the national health and wellbeing strategy. The five delivery areas - join well, train well, work well, live well and leave well – enable forces to focus resources using a preventative approach informed by the domains of the Blue Light Wellbeing Framework. Chapter three describes the contribution of occupational health in each of the delivery areas. Occupational health standards guide forces on the required occupational health structures and processes as well as the expected outputs. The need to address occupational health performance, for example in case management of attendance and performance concerns, and in supporting recruitment, is highlighted.

Adequate resourcing of police occupational health is central to the change process. In an era of continuing financial constraint, forces need to invest wisely in occupational health. Chapter four addresses the need to optimise delivery in order to make best use of scarce occupational health expertise where recruitment and retention are on-going challenges for forces. Staffing in occupational health should reflect organisational need which, in turn, is a function of health needs (See the GAIN model) and the management processes that determine occupational health referrals. New ways of working include adopting a distributed occupational health workforce that optimises the involvement of specialist occupational health professionals. The NPWS target operating model provides a rational approach to staffing that also links to the occupational health standards. Collaborative working between forces, linked to best use of information technology systems, is advocated. Employment models should be reviewed to determine how to obtain best value from employing occupational health doctors and occupational health nurses. Available information on occupational health spend suggests that the cost was £32 million in 2021.

Spend per force is very variable. More work is required in this area to ensure firm foundations for change.

Chapters five and six deal with the change management process and set out the immediate actions to be taken. A systemic framework for design has been adopted based on that from the Design Council. Police occupational health may be envisaged as part of an ecosystem. There are lots of elements within a policing system: police officers, police staff, students, volunteers, buildings, equipment, human resources, and the logistics of operational delivery. This is a system because the elements are interdependent, i.e. if there are insufficient police officers or if there is a technology malfunction, the system breaks down. At the core of the design framework is the Design Council double diamond, which describes a strategic approach to design. (See figure 6) The first diamond helps people understand, rather than simply assume, what the problem is. It involves speaking to people who are affected by the services. The insight gathered from the discovery phase helps define the challenge to be overcome. The second diamond encourages people to provide different answers to the defined problem. Solutions are co-designed with people with different perspectives and insights. This leads to delivery which involves testing out different solutions on a small scale (pilots). Golden threads running through the change process are leadership, storytelling and vision setting, building connections and networks, and accepting that progress is likely to be non-linear.

Actions to be taken to move the change process forwards are:

1. **Leadership and governance:** Establish an Occupational Health Change Steering Group (OHCSG)
2. **Meet with the Design Council**: The aim is to discuss the application of the systemic design framework in a police and occupational health context and to learn from their experience of its application in other settings
3. **Intelligence gathering**
4. **Quick wins and momentum building**

The challenge of this project should not be underestimated. It concerns the redesign of a service that spans 43 police organisations. This will be complex and time consuming, Work will commence in Spring 2025 and aims to complete in 2027. The design process is non-linear and therefore service improvements are expected throughout.

2. The occupational health proposition

The Oxford dictionary definition of occupational health is ‘the branch of medicine dealing with the prevention and treatment of job-related injuries and illnesses. The Health and Safety Executive refers to occupational health in the context of health and safety legislation and the duty of risk assessment. An important part of occupational health practice is concerned with how work and the work environment can impact on workers’ health, both physical and mental.[1] In simple terms, they refer to the effect of work on health and that of health on work. ACAS, on the other hand, advises that occupational health is a type of medical service that employers might wish to use to assist in the management of certain scenarios, such as:

- When an employee is struggling with their physical or mental health
- Making the right reasonable adjustments for disabled people at work
- To assist the management of an employee who has been off sick for a long time, or who is returning to work after sickness absence
- Reducing the amount of time people need to take off sick
- Compliance with Health and Safety legislation
- Controlling risks to mental health, such as too much pressure at work, bullying and harassment [2]

The Society of Occupational Medicine provides a professional view of occupational health. It describes occupational health services as being staffed by specially trained health professionals who help employers to protect and improve employee health, prevent cases of occupational disease, and increase workforce productivity and organisational performance.[3] Occupational health services may include occupational physicians (doctors), occupational health nurses, physiotherapists, counsellors and occupational health technicians. Occupational health technicians (OHT) support health and wellbeing at work as part of a clinical occupational health team through undertaking, recording, and analysing health tests, and referring to clinicians, as appropriate. OHTs may advise and educate based on clinical evidence, but they do not treat or diagnose. Multidisciplinary occupational health services may support employers to meet their responsibilities and needs to:

- Provide healthy workplaces and work to protect people from harm
- Provide early intervention to help manage sickness absence
- Improve opportunities for people to recover from illness whilst at work
- Use the workplace to promote individual health and wellbeing
- Enhance employee wellbeing and engagement

Occupational health services in the police represent an investment in the workforce to support the effectiveness, efficiency and legitimacy of policing. The effectiveness of a force is assessed in relation to how it carries out its responsibilities including cutting crime, protecting the vulnerable, tackling anti-social behaviour, and dealing with emergencies and other calls for service. Its efficiency is assessed in relation to how it provides value for money. Its legitimacy is assessed in relation to whether the force operates fairly, ethically and within the law. Central to all three parameters is the health and wellbeing of the police workforce. Whatever the resource allocation, effectiveness and efficiency is contingent on being able to deploy the right people to the right place, at the right time. Police legitimacy is dependent on the decisions made and the behaviours displayed. The Policing Productivity Review highlighted that a capable, motivated and effective workforce, operating at a high standard is central to productivity.[4] It notes that over 77% force expenditure is on staff and officer costs. Concerns have been raised about apparent wide discrepancies between forces in relation to sickness absence. Although it is acknowledged that national consolidated data received by the Home Office is often inconsistent or missing, it is suggested that there is scope to improve the overall management of sickness absence by sharing and adopting best practice. This might include the identification of key interventions and improved collection of health-related workforce data to assist in monitoring performance. Similar concerns are raised about the increasing proportion of police officers who are designated as being on adjusted duties.

The review raises a question about the correlation, or lack of it, between force spend on occupational health and 'sickness performance'. Notwithstanding the poor quality of data on which to rely when making such calculations, this question leads to a wider and important question as to the purpose of the police occupational health function. As an investment, occupational health spending should be linked to an assessment of benefits realisation. What is the business case for occupational health? It is widely held that the generic business case should reflect three key factors:

- **Legal – Compliance with health and safety and other regulations**
- **Moral – Doing the right thing ethically and morally**
- **Financial – To reduce costs or add value to the business**

The business of policing is conducted within a strong regulatory framework. Occupational health services are essential components of compliance structures that help forces meet their duties of care. Understanding the relationship between health and work, highlighted earlier, requires subject matter expertise that is part of the USP of police occupational health services. In addition to the pre-requisite specialist training and qualifications, an intimate knowledge and understanding of operational policing and of the policing culture must be a sine qua non of all police occupational health services. This ensures that the advice given is practical and appropriate and adds value to the organisation. Examples will include assisting forces with compliance, Employer Rights and Equalities legislation.

The College of Policing 'Code of Ethics' places an explicit duty on every member of the police workforce to take all necessary steps to ensure that we are physically, mentally, and emotionally fit to carry out policing roles and responsibilities and to do what we can to support our colleagues. There is a duty on managers to refer individuals to occupational health where there are concerns about health and the impact it may have on ability to perform. As emergency responders, police officers and police staff are required to approach danger and to confront a variety of threatening and unpleasant situations. A moral duty exists whereby forces will take reasonable steps to support individuals adversely affected by policing roles. There is now a legal basis underpinning this moral duty in the form of the Police Covenant. This is a pledge to do more as a nation to help those who serve this country and specifically to recognise the bravery, commitment, and sacrifices of those who work, or have worked, in policing.[5] Ensuring that police officers and staff are able to access appropriate healthcare in a timely fashion is an important role for occupational health, as the only clinical function within policing. Working in collaboration with the National Police Wellbeing Service, composite care pathways may be developed involving occupational health and NHS healthcare. This would mirror the success of the approach taken by the Armed Forces and the elaboration of the Armed Forces Covenant mentioned in the Policing Productivity Review.

The financial case for occupational health investment is predicated on maximising the attendance of fully fit officers and staff. Ill health-related costs that are typically used in considerations of return on investment (ROI) for occupational health are related to absenteeism and presenteeism.[6] There are clear lost opportunity costs associated with paying someone when they are not at work and are not productive. This may be compounded if overtime must be paid to cover the lost shift, or if agency cover must be brought in. Occupational health services have an opportunity to reduce costs by working up stream of absence to prevent absences, intervening at the time of absence to try to shorten the length of absence and working effectively in the rehabilitation process. Similarly, understanding presenteeism and intervening to reduce levels can contribute to organisational effectiveness and efficiency. This is important in the context of increasing levels of mental ill health at work and rising levels of workers with chronic conditions. However, it should be noted that calculating cost-effectiveness and ROI for occupational health is complex, not least because of the data used or because of poor data quality / methodological problems. A decision to take sick leave may be dependent on a variety of factors within or outside organisational boundaries. Presenteeism is based largely on self-report and measuring actual performance in most roles is very difficult. Nonetheless, estimates of costs to businesses of ill health are huge. Estimates for 2024 suggest that the cost of sickness absence will be £22 billion overall.[7] Another report from the Institute for Public Policy Research indicates that the hidden cost of workplace sickness (absenteeism and presenteeism) was £103 billion in 2023.[8] It is likely that a significant proportion of these costs may be attributable to mental ill health.[9]

In the absence of reliable data to inform the national picture, it is necessary to make inferences about levels of sickness absence and about true levels of police officers assigned to recuperative and adjusted duties. Home Office figures on sickness absence indicate that, as of 31st March 2023, the proportion of police officers on long term sick was 1.7%. Since 2016 levels have fluctuated between 2.0% (2016, 2020) and 1.5% (2021). The trend is not upwards. However, there are wide variations in the reported data. The national trend is for increasing rates of sickness absence since 2020. This is attributed to minor illnesses.[10] However, these figures may have been influenced by the COVID-19 pandemic.

There is an opportunity for occupational health services to work at a local and national level to gain a better understanding of sickness absence data, as well as develop optimum attendance management processes. Home office figures for officers on recuperative duties on 31st March 2023 are 4.0%. The figures have fluctuated since 2016, with a high of 4.6% in 2022. However, there is a suggestion of an upward trend. On 31st March 2023, there were 5.2% police officers on adjusted duties. This is the highest level since 2016. The proportion of officers on adjusted duties has been rising since 2019. There are notable variances in the figures reported by forces and between forces, since 2016. Again, there is a clear need for a better understanding of the figures and to develop good practice involving occupational health.

What is the police occupational health value proposition? Occupational health is the only clinical function within policing that promotes and maintains the health, safety and wellbeing of the police workforce. It specialises in promoting people performance through health and fitness. An effective occupational health service is more than the sum of its parts. It is integrated in the police ecosystem, understands the police culture and works collaboratively and responsively to support business objectives: right person, right place, right time. At force level it is the go-to service for all issues clinically relevant to the workforce. Collectively, police occupational health services are an essential component of the Policing Vision 2030.[11]

Figure 1 depicts pillar four of the Policing Vision and shows how occupational health services contribute to achieving a policing culture that will enable the workforce to meet future policing challenges. Effective occupational health provision is needed to deliver the vision of the Strategic Assessment of Workforce and the NPCC Workforce Strategy 2024. The latter notes the strategic requirement of a healthy and motivated workforce and references the national health and wellbeing strategy which considers wellbeing at all stages of the employee journey. Wellbeing is now seen as a strategic capability for police forces.[12] This will enable forces to attract and retain a representative and diverse workforce necessary to deliver modern policing.

Figure 1: Pillar four of the Policing Vision 2030

2.1 Summary

- Occupational health practice is concerned with how work and the work environment can impact on workers' health, both physical and mental
- Occupational health practitioners are specially trained health professionals who help employers to protect and improve employee health, prevent cases of occupational disease, and increase workforce productivity and organisational performance
- The business case for occupational health should reflect three key factors:
  - **Legal** – compliance with health and safety and other regulations
  - **Moral** – Doing the right thing ethically and morally
  - **Financial** – To reduce costs or add value to the business
- The Policing Productivity Review highlighted that a capable, motivated and effective workforce operating at a high standard is central to productivity. Over 77% of forces' expenditure is on staff and officer costs. Concerns have been raised about apparent wide discrepancies between forces in relation to sickness absence. Similar concerns are raised about the increasing proportion of police officers who are designated as being on adjusted duties. Effective occupational health practice will assist forces to manage these concerns.
- Occupational health services specialise in promoting people performance through health and fitness. An effective occupational health service is more than the sum of its parts. It is integrated in the police ecosystem, understands the police culture and works collaboratively and responsively to support business objectives: right person, right place, right time.

3. Occupational health delivery: Integration and rationalisation

The national health and wellbeing strategy has two strategic objectives:

a) Create, promote, and maintain the conditions for the "Police Family" – police officers and police staff, employed or volunteers, and their families - to live healthy lifestyles in healthy environments, reducing injury, illness, and suicide as far as possible, to maximise wellbeing, work ability and a sense of belonging

b) Support national initiatives to recruit and retain police officers and police staff

The police health and wellbeing strategy is based on the principles of prevention. Primary prevention involves health promotion and ill health prevention by addressing the determinants of health combined with health education. Secondary prevention focuses on the early detection of illness and early intervention to improve health outcomes. Tertiary prevention is concerned with the treatment and rehabilitation of people who become ill. This includes understanding why the illness has occurred and modifying lifestyle, working behaviours or the environment to reduce the likelihood of recurrence or the incidence of illness in others. Each element of prevention – promotion, prevention, detection, treating, and recovery – is linked to a domain of the Blue Light Wellbeing Framework (BLWF).[13] Thus, these preventative activities are aligned to organisational wellbeing behaviours: leadership, creating the environment, protecting the workforce, attendance management and resilience, respectively. Each domain of the BLWF contains a set of evidence-based standards against which forces can self-audit their preparedness. The core of the model sets out five delivery areas that relate to the Police Covenant and operational priorities: (see figure 2)

The BLWF contains an occupational health section. The standards in the latest edition of the BLWF are based on the Enhanced Occupational Health Standards that were launched in 2023. A full description of all the Occupational Health Standards may be accessed via the Oscar kilo website.[14]

National police health and wellbeing strategic model

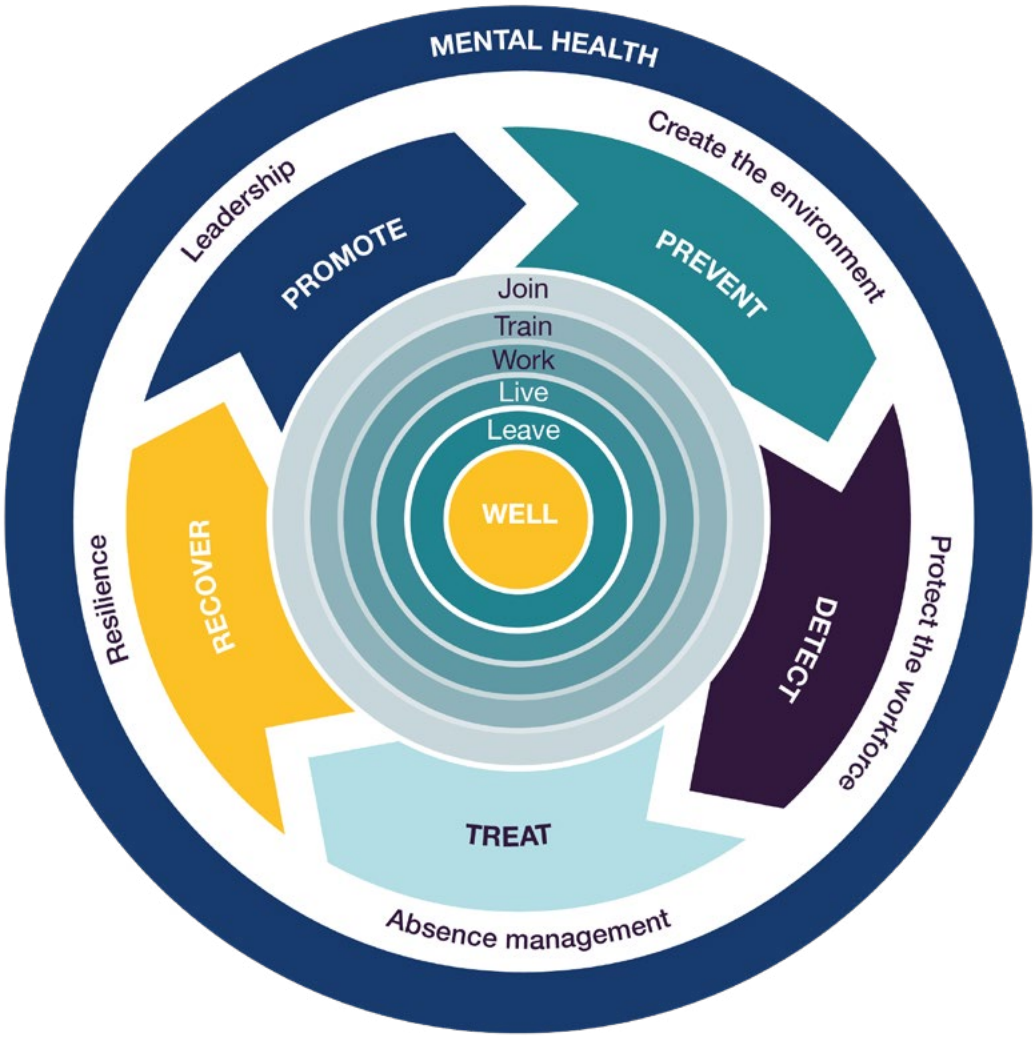

Figure 2. The police health and wellbeing strategic model

As a preventative specialty, occupational health has a role in each of the preventative aspects of the health and wellbeing strategy. If the occupational health value proposition is to be realised, it is important that occupational health services are expected and facilitated to be proactive in their service delivery. These principles of prevention should underpin service level agreements, or contracts for service, and be golden threads running through each occupational health interaction. The contribution of occupational health to the five delivery areas will be described below.

3.1 Join well

JOIN WELL

The Police Uplift Programme (PUP), which started in 2020, placed police occupational health under a spotlight.[15] Police forces had to meet recruitment targets and faced being fined if they missed them. Occupational health services had to adapt their processes to expedite health assessments while maintaining standards. The PUP initiative highlighted the need for current relevant occupational health guidance on the assessment of police officer applicants. Home Office medical standards guidelines for police recruitment are still being referred to although they were published in 2004 and both occupational medicine and policing have moved on since then.

New standards were launched in 2025. They introduced a clear functional framework of assessment of suitability to be a police officer with defined areas of risk to be assessed. They will assist forces in balancing the duties of care relating to health and safety and equality legislation. The new guidance illustrates well the collaborative and integrative approach that occupational health will adopt with the creation of Appointment Panels (Fit to Proceed Panels). These multidisciplinary panels will have the responsibility for making appointment decisions based on occupational advice. The decision-making process will weigh clinical and operational factors in deciding whether a police officer applicant will be suitable. This will include assessing whether the provision of reasonable workplace adjustments is possible. Although the guidance has been written specifically for the assessment of police officers, the structures and principles of practice that will be introduced will be relevant for the assessment of all joiners.

3.2 Train well

TRAIN WELL

Successful recruitment and retention of police officers and staff is essential to meet the aspirations of the Policing Vision 2030. Part of this is an increasing recognition that we are, and should be, drawing talent from both neurotypical and neurodiverse people in the population. Neurodiversity is a challenge both for police forces, where people have been expected to fit systems, and for occupational health, where the overlap of medical and social models of disability may create uncertainties about role. The guidance on assessing police officer applicants addresses this and offers advice about assessment and workplace adjustments.

We now understand neurodiversity as a concept that brain differences are natural variations. Each person has a brain that is unique to them.[16] Variations in the performance of brains may be relevant to the functional requirements of policing. It should be recognised that there may be considerable benefits from having a police workforce that includes neurodivergent individuals. The variations in brain performance mean that there may be enhanced performance in areas important

to policing, such as attention to detail, strong technical abilities, high levels of concentration and steadfastness, creativity, and the ability to view the 'bigger picture'. Nonetheless, such conditions may be associated with impairment in certain settings and environments and may constitute a workplace disability for which reasonable adjustments should be explored. This is a developing area of practice where occupational health practitioners can assist police forces develop appropriate multidisciplinary systems, thereby adding value.

Arguably, mental wellbeing has become the number one concern for the police. There are many 'challenge and hindrance stressors'. Trauma-related mental ill health is a cause of considerable morbidity affecting organisational resilience. The stigma of mental ill health has, until recently, prevented the development of an effective culture of wellbeing in the police. However, over the past decade, the mindset has changed and the need to promote and protect good mental health has emerged, as well as the need to support people who are adversely affected by poor mental health.

A national trauma-support model has been developed. (See figure 3) The model links to the workforce prioritisation guidance has been published.[17] Education about mental health, particularly trauma-related ill health now forms part of the training curriculum for police officer entrants and police staff induction, as well as for manager training. Occupational health should contribute to this with advice on understanding symptoms and behaviours, how to seek help and available treatments and support.

3.3 Work well

WORK WELL

It is now generally accepted that work is good for physical and mental health and wellbeing; the provisos being that the research findings relate to average or group effects, the beneficial health effects depend on the nature and the quality of work and there is a social context.[18] The 2023 annual survey of police forces, in England and Wales, found that a large proportion of the police workforce continues to find their work meaningful, and they remain motivated to invest their personal energy into serving the public.[19] However, there are aspects of policing that have the potential to undermine wellbeing. Occupational health should be an integral part of every force's health risk assessment. This should be done in conjunction with the health and safety department as part of the control of risks to health, both physical and psychological.

Assaults on police personnel are concerning. The trend appears to be an increase in the number of assaults year on year, although better recording of data might be an explanation. Data obtained through the Home Office Annual Data Requirement process shows that for the financial year 2022/23, there were around 40,000 assaults recorded against police officers (including Police Community Support Officers). Almost one-third (30%) of assaults (some 12,000 incidents) are associated with injuries, which vary in the degree of damage caused. Of the 70% of assaults

not causing a physical injury, many, however, are associated with psychological distress and, in some cases, mental ill health, especially where there are repeat victims. Occupational health has an important role to play in developing care pathways to support injured officers and staff. Whilst the responsibility for continuing healthcare rests with the national health service, occupational health services can be proactive in engaging with different parts of the NHS to raise awareness of police-specific healthcare needs and to encourage timely access to relevant services. The Police Covenant has laid a foundation for this engagement and work is ongoing to facilitate an improved interface between police occupational health and NHS healthcare. Priority areas include the care of police personnel when they present to Accident and Emergency (A and E) departments and access to mental health services. The results of a pilot to develop a toolkit for forces to engage with NHS commissioners may be found on the Oscar Kilo website.[20] There are already examples of occupational health services engaging with their local A and E departments to agree protocols for the care and management of blood-borne viruses.

Mental ill health is now a major concern. There are obvious and specific stressors that include dealing with murders and suicides, road traffic accidents and being assaulted. However, modern policing is increasingly dominated by societal ills manifested by domestic violence, drug-related offences, mental ill health, and sexual abuse. For many police officers and staff there is a continual daily exposure to one or more of the above. Other stressors are not police-specific, although they may be typical of working for an emergency service. For example, shift working is a requirement for most of the workforce and it is not unusual for shifts to extend beyond the expected end time.

The UK's first survey to assess trauma management and working conditions in UK policing engaged with 18,175 officers and staff across the UK between October and December 2018. Headline findings of the Job and the Life study included that around one in five (19.4%) of those screened had either probable post-traumatic stress disorder (PTSD) (7.5%) or probable complex PTSD (11.9%).[21] These statistics were the first estimates for police PTSD prevalence in the UK and the first for complex PTSD in the world. For comparison, a US study of police officers in 2013 reported PTSD rates of 15% in men and 18% in women, using the Post-Traumatic Stress Disorder Checklist-Civilian Version (PCL-C).[22] Understanding the incidence and prevalence rates of PTSD is challenging because of the diagnostic criteria (which keep changing) and the choice of survey techniques. Nevertheless, the above estimates suggest that trauma-related illness is a substantial challenge for the police.

National health surveillance data for mental health conditions in policing, obtained since 2019, has demonstrated the prevalence of anxiety, depression and PTSD in personnel working in roles associated with significant psychological stressors, especially psychological trauma. Self-reports from 23,970 personnel show that 27% of respondents had scores of 5 or more for anxiety and 34% of respondents had a score of 3 or more for depression on the Goldberg Anxiety/Depression scale, suggesting clinically significant symptoms. The prevalence rate for PTSD (primary trauma) was the same as reported in the Job and the Life survey. For comparison, levels of symptoms in the public are anxiety 3.5%; depression 8%–12%; and PTSD 3%.[23]

Figure 3 demonstrates how occupational health can play an integrated role in supporting individuals and forces to mitigate the adverse effects of trauma.

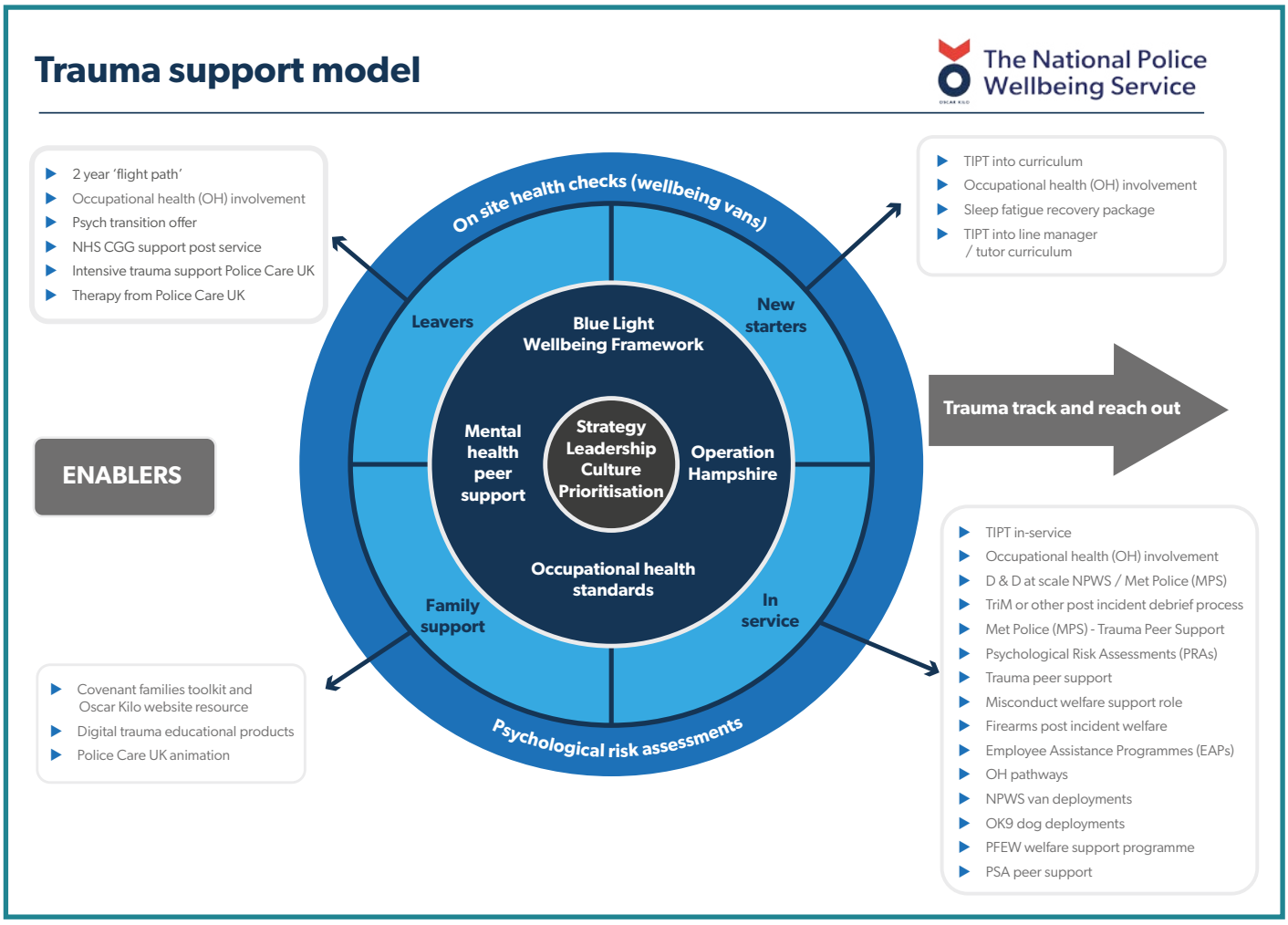

Figure 3. Trauma support model. (Workforce prioritisation guidance)

The trauma support model envisages support throughout the "employment journey". As far as possible, selection of police personnel will exclude job applicants who are clearly unsuitable to join the police. Following appointment, the training and probationary period is critically important for preparing people for the demands of the job and inculcating healthy and informed behaviours. Personal resilience is a cornerstone of a preventative approach to minimising ill health. However, no-one can be considered "immune" from the potentially negative and pervasive effects of police-related psychological trauma. Everyone has a unique backstory and an individual set of coping strategies and resources, which may be overwhelmed in particular circumstances. Individuals, and those around them, must be able to recognise when things are going awry and be able to seek help.

Once in service, a variety of resources and services are available to support officers and staff. Much of it is of a non-clinical nature. The importance of being able to have conversations and of the support of colleagues cannot be overstated. It has been shown that positive indicators of job quality such as doing meaningful work, support from colleagues and managers, work–life balance, job security, and promotion prospects, are protective against developing mental health conditions, such as PTSD. Conversely, absence of those job-quality indicators typically predicts around half the rate of complex PTSD.[24] Occupational health is the go-to service when there are indications that signs of strain and not coping are becoming indicative of illness. Occupational health assessments can identify early indications of illness leading to advice on work changes or treatments to aid recovery. Health surveillance (a scheme of repeated health checks which are used to identify ill health caused by work) is fundamental to occupational health practice. An example is the participation in the psychological surveillance programme offered by the National Police Wellbeing Service (NPWS). Stage one of the health surveillance is the completion of a questionnaire that is designed to screen for symptoms that might be indicative of mental ill health in individuals working in roles deemed to put them at increased risk of psychological trauma exposure. Stage two is the clinical assessment of individuals whose answers suggest the possibility of a mental illness. This is performed by suitably trained occupational health practitioners. This affords the possibility of in-depth discussions about both health and about work or other stressors. An ensuing support plan can be proposed which might include workplace adjustments and/or treatment. Most treatments involve a re-evaluation of work-life balance and lifestyle changes, possibly supplemented by taking therapy. Occupational health practitioners adopt a role akin to the conductor of an orchestra comprising multiple health and wellbeing interventions.

Suicide is an emotive topic in policing. A national suicide prevention action plan was launched in 2024 for police in England and Wales. The plan asks police forces to provide services for their officers and staff where those who need support with mental health or who are at risk of suicide feel able to ask for help and have access to support.[25] Areas identified in the Action Plan where progress might be made include the creation of safe environments, education and support, data recording, research, work-related risk assessment, organisational learning, postvention support, family support and the provision of a crisis line. Whilst not everyone who dies by suicide has a known mental health condition, many do. As a clinical service, it is important that occupational health is accessible to those officers and staff who need help. Occupational health can be an oasis of calm and safety for people who are in crisis and occupational practitioners are a critical link between the workplace and healthcare. Although occupational health is not an emergency healthcare service, there may be occasions when an intervention is necessary to safeguard a person at risk whose life is in danger. Developing a relationship between occupational health and mental health services, especially NHS psychiatric services will assist appropriate management of people who in crisis.

Many people associate occupational health with its tertiary prevention role, that is treatment and recovery. In the police health and wellbeing strategic model this links with absence management and resilience. Evidence-based standards within the absence management of the BLWF refer to the components of a good attendance management policy and the need for good data collection to inform a suitable assessment and intervention model, such as the police GAIN model.[26] Because of current concerns about the costs of sickness absence, there is an opportunity to review, and where

necessary improve, referrals to occupational health and to optimize attendance management. Examples of good practice may be found from the Oscar Kilo award winners. Winners of the 2024 absence management award was Nottinghamshire Police for the support that they have put in place for those on maternity leave. The runners up were Gwent Police for their work on understanding sickness absence. The runners up in the occupational health category were West Yorkshire Police for their review of the management referral process within their occupational health unit. Future development work will explore the role of occupational health within an overarching support package as well as the performance of occupational health departments in the delivery of cost-effective and efficient services, building effective triage of referrals and case management aligned to business priorities.

The development work should include a review of the use of recuperative and adjusted duties in forces. Circular 010/2015 introduced changes to the management of limited duties as set out in the Police (Amendment) Regulations 2015 (SI 2015/455) and supporting determinations.[27] Implementation of the changes was supported by guidance.[28] The use of recuperative duties supports rehabilitation back to full duties and full hours (for which an individual is paid) using workplace adjustments, such as a graduated return to work whilst on full pay. The period of time allowed for this support is six months, or up to 12 months, in exceptional circumstances. Options available at the of the period of recuperative duties include:

- **Return to full duties**
- **A request for part-time or flexible working. An officer would then be paid for the hours worked**
- **Ill health retirement**
- **Action under the Police (Performance) Regulations**
- **Being placed on adjusted duties**

Adjusted duties are defined as duties that fall short of full deployment whereby workplace adjustments have been made to overcome barriers to working. In addition, officers must be working on a regular basis and be working the full number of hours for which he/she is paid. This might be in a full-time or part-time role. These arrangements could be long term but are subject to review, at least annually. As has been noted, there are noticeable inter-force variations in the numbers of officers recorded as being on either recuperative or adjusted duties. In addition, the percentage of officers recorded as being on adjusted duties is rising raising concerns about the impact on force resilience. Where necessary and appropriate, the role of occupational health as part of an integrated best practice approach to the management of limited duties should be explored.

3.4 Live well

LIVE WELL

For many, policing is a 24/7 lifestyle. Shiftwork is associated with impaired performance and the development of health conditions. Sleep disturbance, which has knock-on implications on the wellbeing of personnel who become chronically sleep deprived, may increase the risk of accidents, change behaviours and lead to long term health problems. The SAFER (Sleep, Alertness and Fatigue in Emergency Responders) programme was developed by Professor Steve Lockley and colleagues at the university of Surrey in conjunction with the NPWS.[29]

The initial programme was designed to address high levels of sleepiness in UK policing and to explore levels of sleep disorder risk. A high prevalence of sleep disorder risk was found, with more than half of the participants (57%) screening positive for the risk of at least one sleep disorder. Obstructive sleep apnoea was most prevalent, with 43.7% of participants screening positive for this condition, followed by insomnia (22.3%) and shiftwork disorder (23.8% of those participants who reported working three nightshifts in the previous month). Those who screened positive for at least one of these disorders had more than seven-times the risk of reporting excessive sleepiness, three-times the risk of poor heath, and more than double the risk of depression or burnout. Occupational health has an important role to play in fatigue risk management, including the identification of sleep disorders and associated health conditions.[30]

Police officers and some police staff roles are associated with an increased risk of work-related cardiovascular disease.[31] In one US study, 441 sudden cardiac deaths were recorded in police officers, between 1984 and 2010, with activities such as restraint, pursuit, physical training and medical rescue operations identified as risk activities.[32] Metabolic syndrome (occurrence of at least three of the following: elevated body mass index, blood triglycerides or blood sugar, high blood pressure and low levels of high-density lipoprotein cholesterol) is associated with shiftwork.[33] Occupational health and wellbeing interventions should be considered, as metabolic syndrome was found to be 8% higher in US police officers compared to the general population, with the prevalence of shiftwork, night work and low sleep duration among the identified risk factors.[34] Health education and health screening initiatives may be facilitated by use of the Oscar Kilo wellbeing vans.[35]

The importance of gender-specific health problems in policing must be recognised, especially as some impact on work ability and wellbeing at work. The British Association of Women in Policing and the Police Federation of England and Wales have been strong advocates for better awareness of and training in conditions such as the menopause and pregnancy-related issues. The College of Policing has published guidance on managing the menopause in the workplace.[36] Issues such as peri-natal mental health and endometriosis have come to the fore. Merseyside Police was the first police force to become an endometriosis employer. Men's health is now a United Nations public health priority with respect to universal health coverage and health-related sustainable development goals. The concern is that strong beliefs, norms, attitudes and stereotypes of masculinity are harmful for men's health. The Police Federation of England and Wales has designated 2025 as a year of men's health. This presents an opportunity

for occupational health services to be proactive in this area. Suicide is the biggest cause of death in men younger than 50 years of age and the risks of cardiovascular diseases and certain cancers are greater in men. Prostate cancer is a concern amongst police officers and staff. Cancer Research UK report that there are 199,000 new cases of cancer in men every year. There were 55,093 new cases of prostate cancer each year between 2017 and 2019, with the highest incidence in the age range 75 – 79 years. Prostate Cancer UK highlights three risks: being over 50 years of age, a family history of prostate cancer and being black. Although current screening methods are not ideal, a targeted approach to screening can be justified.

3.5 Leave well

LEAVE WELL

Support for those who leave the police is as important as supporting joiners. It forms part of the psychological contract that exists with people, many of whom put their health, and indeed their lives, at risk to protect communities. It is also a commitment by the Police Covenant to extend wellbeing provision to former members of the police workforce. Liaison with healthcare providers may be necessary to ensure ongoing support of medical conditions that have arisen as a consequence of police work.

Early-retirement processes are determined by the respective pensions schemes relevant to roles and the employing forces. There are different pension schemes for police staff (e.g., the Local Government Pension Scheme and civil service schemes). Police officer medical retirement is governed by specific regulations – currently, the Police Pensions Regulations 2015. New guidance and a toolkit will assist occupational health services in 2025.

3.6 Summary

- The police health and wellbeing strategy links to domains of the BLWF
- The BLWF contains an occupational health section. The standards in the latest edition of the BLWF are based on the Enhanced Occupational Health Standards that were launched in 2023
- As a preventative specialty, occupational health has a role in each of the preventative aspects of the health and wellbeing strategy. The principles of prevention should underpin service level agreements, or contracts for service, and be golden threads running through each occupational health interaction
- New standards for the occupational health assessment of police officer applicants were launched in 2025. They will assist forces in balancing the duties of care relating to health and safety and equality legislation
- Occupational health can contribute to supporting the wellbeing of people new to policing with advice on understanding symptoms and behaviours related to mental ill health and how to seek help and available treatments and support

- Understanding and supporting neurodiversity is a developing area of occupational health practice
- It is now generally accepted that work is good for physical and mental health and wellbeing. However, the beneficial health effects depend on the nature and the quality of work. Occupational health should be an integral part of every force's health risk assessment. This should be done in conjunction with the health and safety department as part of the control of risks to health, both physical and psychological
- Because of current concerns about the costs of sickness absence, there is an opportunity to review, and where necessary improve, referrals to occupational health and to optimize attendance management
- For many, policing is a 24/7 lifestyle. Occupational health interventions should support fatigue risk management and health conditions that are not necessarily caused by work but can impact on work performance, or which are public health concerns.
- Support for those who leave the police is as important as supporting joiners. It forms part of the psychological contract that exists with people, many of whom put their health, and indeed their lives, at risk to protect communities

4. Occupational health delivery: Resourcing

Occupational health services should be structured and resourced in order to effectively and efficiently deliver the interventions described in the previous chapter, following with the principle that form follows function. Born in architecture, this phrase has given rise to a philosophy that design should reflect the primary purpose of a structure. Inherent is a focus on efficiency and user experience. It is important, therefore, to be clear about the purpose of occupational health in the police. Another dimension that is associated with this principle is sustainability. In architectural terms this refers to minimising waste and creating lasting and durable designs. From an occupational health perspective, this is about the recruitment and retention of expertise and the maintenance of services that are familiar and accessible to, and welcomed by, the workforce.

It is clear from the preceding chapter that the primary purpose of police occupational health is to assist forces to promote people performance through health and fitness and, thereby, meet their legal, moral and financial duties of governance. This is achieved within the health and wellbeing framework of the health and wellbeing strategy. At its core, the occupational health function is delivered based on clinical assessments relating to the relationship between work and health. It goes without saying, therefore, that occupational health staffing must include clinicians who have the necessary competencies to fulfil this core element. It is also evident that occupational health structures and processes must be efficient, effective and accessible. This means ensuring that customers and clients of occupational health services understand the role, the modus operandi and how to make best use of the service. It also means that occupational health services should implement systems to optimise performance by matching problem type and complexity with appropriate expertise and experience. Barriers to service inputs and outputs should be minimised. Of course, there is a finite resource allocated by forces to occupational health which means that the balance between demand and capacity must be managed carefully and reviewed periodically.

Police occupational health is facing a recruitment and retention crisis. Many forces report vacancies that are hard to fill. The current situation can be explained by consideration of both external and internal factors.

4.1 External factors

1. **A national shortage of suitably trained occupational health specialists in the United Kingdom.** There is consequent competition for good candidates to fill vacancies
2. **The reputation of police OH amongst the national OH community.** OH in the police is perceived as a Cinderella service. There is also a negative perception amongst doctors relating to reported individual cases of bullying and intimidation of Selected Medical Practitioners (SMPs) in relation to the medical retirement and injury on duty assessment processes
3. **The reputation of policing following a series of high-profile cases casting doubt on the culture of policing**

4.2 Internal factors

1. **A lack of understanding of the nature of OH services.** This may lead to sub-optimal commissioning of services and inappropriate staffing models
2. **Management of OH services.** There is anecdotal evidence of increased turnover of staff, poor attendance, and sub-optimal performance management due to ineffective or inappropriate management
3. **Resourcing.** Clinical pay scales do not map across well to police staff pay scales. This has led to an under-investment in staffing structures required to deliver the required services and good clinical governance. This has been compounded by the financial pressures facing police forces
4. **Demographics.** Research has shown that many OH doctors and nurses in the police are near to, or within five years of, retirement

A recent survey of police occupational health services (33 responses representing 40 forces) found that most forces have less than one full time equivalent doctor (24/33). Only four forces have a full time Force Medical Advisor (FMA). 28 respondents outsourced their FMA provision, or it was from a blended service, for example provided by a council. Forces typically have two full time equivalent occupational health nurses, with a range of one to more than five. A small number of forces employ other nursing staff, including 11 forces who use mental health nurses. In contrast to the FMA employment, occupational health nurses are usually part of an in-house service (27/33). Most respondents had a physiotherapy provision where, in most cases, it was outsourced. Provision of counselling or psychotherapy was the norm (32/33). This was usually outsourced or from a blended service. Six respondents had an in-house service. 28 respondents had an Employee Assistance Provider (EAP). An earlier survey, carried out in 2021, found that the average spend on occupational health by 27 forces was £744,977. Force sizes varied considerably from 45,592 to 1287. Reported levels of expenditure ranged from just over £6 million to £133,333. Subject to the need to verify the accuracy of the reported figures, it might be assumed that the overall spend on occupational health across 43 forces was in the region of £32 million per annum, in 2021.

Resourcing of occupational health should reflect organisational needs. The BLWF advocates using the GAIN model to assist forces to understand employee status with respect to wellbeing. (See earlier) This model has been developed in a policing environment to provide a simple illustration of where the workforce operated. GAIN stands for general analysis, interventions and needs. The model envisages the wellbeing of the workforce as being represented by a pyramid. At the base there is the proportion of the workforce who are well and fully engaged with the force. Above this are three segments representing reducing wellbeing and engagement. At the top of the pyramid are those in crisis, disengaged and in need of support and treatment. Proactive interventions seek to minimize the numbers who reach crisis point. In forces where there is a strong wellbeing culture, everybody will benefit from this proactive approach. However, early identification of people who are struggling to cope and early interventions are key to reducing presenteeism and sickness absence. The relevance of the GAIN model to assessing occupational health resourcing can be seen in figure 4. As a preventative function occupational health has a role to play at all levels of the GAIN model. However, as a clinical function, occupational health will be required particularly when struggling to cope manifests as illness and disease. There are also legal duties as part of health and safety risk management. Planning the form of the occupational health service will be contingent on its function within the overarching multidisciplinary support for wellbeing provided by the organisation.

The NPWS has provided guidance on the staffing of OH services to enable them to meet police OH standards. These are quality standards against which provision may be assessed.

Currently, the benchmark standards are the Enhanced Standards.[37]

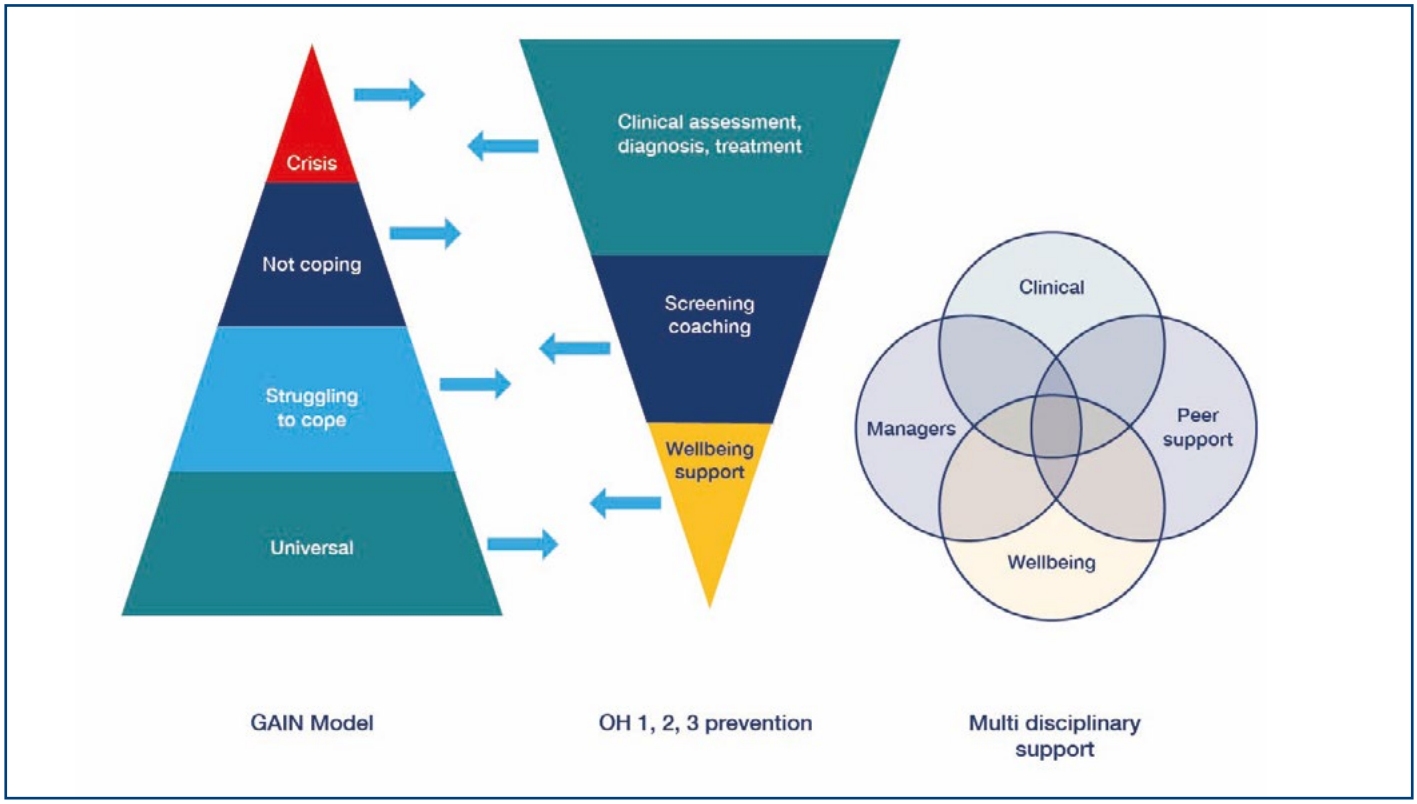

Figure 4. Using the GAIN model to plan occupational health requirements

The standards map across to industry-wide occupational health standards that have been developed by the Faculty of Occupational Medicine (FOM), part of the Royal College of Physicians of London. They are built on Foundation Standards, introduced in 2019. The FOM offers an accreditation system called SEQOHS.[38]

Occupational health standards are the building blocks of consistency of practice across policing. They ensure that all users will receive a minimum standard of care. Adherence to OH standards will ensure that important principles will underpin OH provision. These are that:

There should be a strong focus on clinically led evidence-based practice
Occupational health provision should be equitable
Occupational health provision should be accessible
Occupational health provision should be impartial
Occupational health provision should be accountable
Occupational health services should be approachable and receptive to both the employer and the users of the service

4.3 Target operating model

To assist police forces the NPWS has developed a target operating model of occupational health delivery and resourcing.[39] Whilst recognizing that there is no one-size-fits-all staffing model, this guidance enables police forces to plan their staffing needs according to the size of the force and the assessment of workforce need, the obligation to comply with the published occupational health standards, and the model of delivery. Refer to the Oscar Kilo website to view tables 1 and 2. Table 1 describes different levels of service and cites the relevant standards that should be met. Service levels 1 and 1+ would now be regarded as falling below a minimum standard of OH provision and all police OH services should be at least meeting service level 2 – aligned to the Foundation OH standards. However, it should be noted that, since the launch of the Enhanced OH Standards, in March 2023, the direction of travel is to achieve service level 3. Alignment with the Enhanced OH standards should be achieved by 2025. Proposed staffing levels for the respective service levels are shown in table 2. The guidance represents a starting point for considering the individual needs of police forces. It is based on the prevalent operating model of one occupational health service per force. Looking to the future, alternative models should be explored. There are already examples of one occupational health service for more than one force. Forces in alliance include Devon and Cornwall and Dorset Police, Surrey and Sussex Police, Kent and Essex Police, and Bedfordshire Police with Cambridgeshire and Hertfordshire Constabularies. As some individual forces have comparatively small working populations, there is merit in exploring how to achieve a critical mass of expertise in operating models that will support the occupational health function.

Figure 5 depicts a potential future staffing model for police occupational health. An important feature is the optimization of specialist occupational health expertise. To achieve this a tiered assessment is used based on a hierarchy of expertise within a distributed workforce.

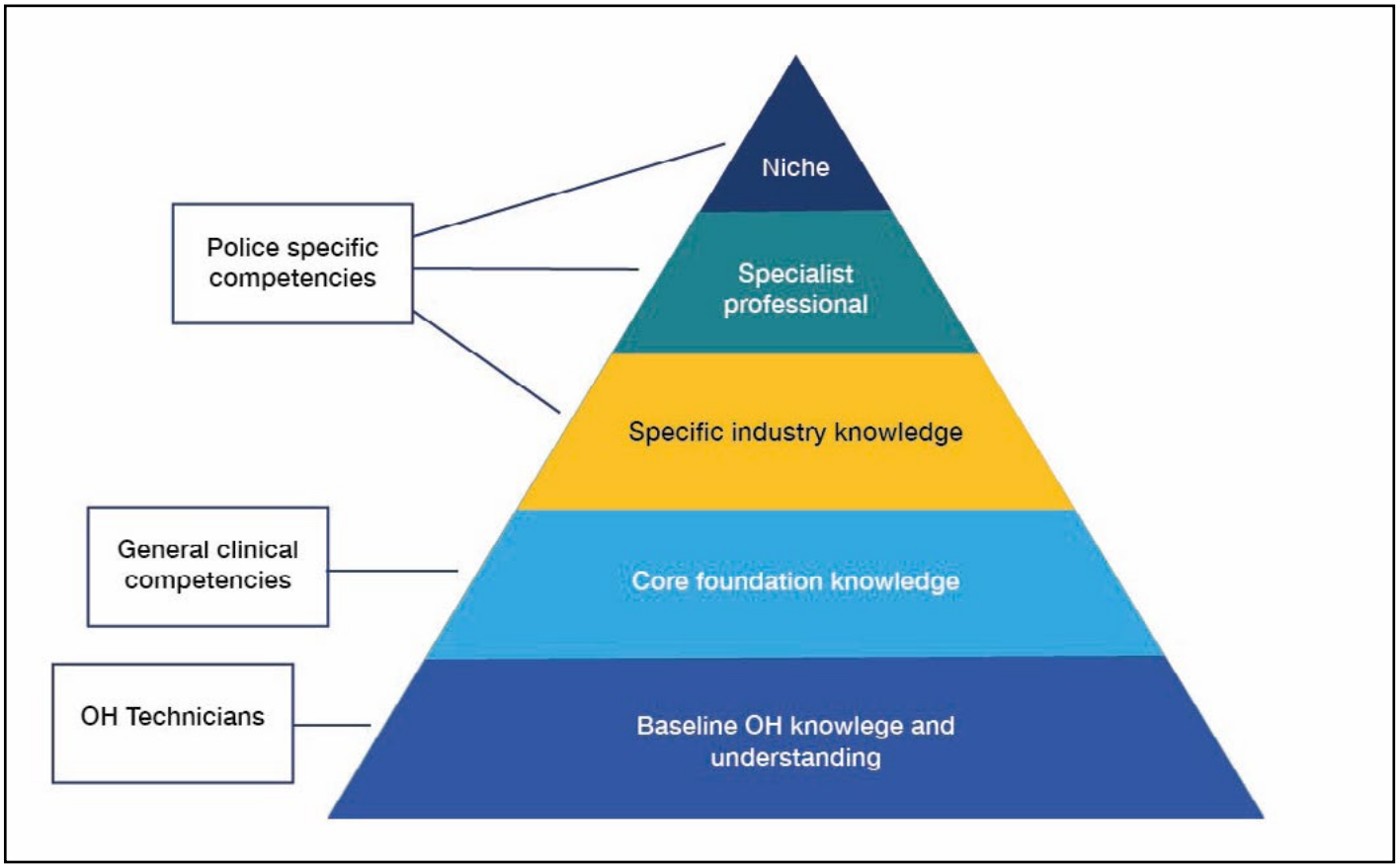

Figure 5. A distributed occupational health staffing structure (After Hashtroudi)

A distributed workforce can mean a distributed skill set and distributed geographically, making use of technology to facilitate user access and matching clinical issue severity and complexity to the appropriate level of competency and experience. Occupational technicians, non-clinical practitioners who received additional training to perform certain clinical tasks under supervision, are an important addition to the occupational health resource as they can perform non-complex tasks scrutinizing information and obtaining additional information, where necessary and appropriate. Clinical staff, for example nurses without occupational health nurse training, can operate at the next tier of assessment and management. Non-occupational health-trained staff can give advice about clinical matters and advise about occupational health matters, in consultation with trained occupational health practitioners. An example might be a registered mental health nurse whose training provides competencies relating to the assessment and clinical management of mental health conditions, usually of patients in hospital with severe illnesses.

All occupational health services will need to contain occupational health nursing and occupational medical expertise, or access to it. Clinical governance requirements mean that there must be at least one specialist occupational health nurse and a specialist occupational physician. At the top of the staffing pyramid there will be a small number of personnel with niche expertise. An example in policing might be particular knowledge and expertise in the occupational health aspects of firearms or other areas of specialist policing.

In the post-pandemic world of occupational health, it is now the norm to conduct some clinical consultations via the internet. This means that the location of occupational health practitioners is not necessarily a pre-requisite for recruitment. There are numerous examples of routine consultations being carried out by occupational health practitioners who are working remotely. There is also an example of a nurse bank that comprises nurses who can work remotely. They have been through police vetting and can respond to requests to work at short notice. The possibility of this being rolled out to other forces is being explored.

Police reform is high on the government's agenda. Whilst this is not a new topic, the recent announcement by the Home Secretary included reference to a new National Centre of Policing.[40] This presents an opportunity to redesign occupational health delivery. The possibility of a national people hub within the National Centre, linked to a police Performance Unit, also part of the announcement, will embed wellbeing as a critical component of performance, and bring forward the Police Foundation's call for wellbeing to be a strategic capability. In order to find an affordable solution to the provision of quality assured occupational health services and to create critical masses of expertise, to address supply side issues in resourcing, cooperation between police forces must be considered. A future structure that combines national, regional and local delivery elements is a plausible and attractive vision.

4.4 Summary

- Occupational health services should be structured and resourced in order to effectively and efficiently deliver the interventions identified in the national health and wellbeing strategy
- At its core, the occupational health function is delivered based on clinical assessments relating to the relationship between work and health. It goes without saying, therefore, that occupational health staffing must include clinicians who have the necessary competencies to fulfil this core element
- It is essential to ensure that customers and clients of occupational health services understand the role, the modus operandi and how to make best use of the service.
- Occupational health services should implement systems to optimise performance by matching problem type and complexity with appropriate expertise and experience.
- Barriers to service inputs and outputs should be minimised
- Police occupational health is facing a recruitment and retention crisis. The current situation can be explained by consideration of both external and internal factors
- A survey of occupational health services found small numbers of full-time equivalent doctors and nurses in most forces. More work will be required to assess the ratios of doctors and nurses to population numbers and current demands for services
- Reported data from a 2021 survey suggests that the mean spend on occupational health was £744,977 per annum per force. This equates to an estimated overall spending of almost £32 million by 43 Home Office affiliated forces
- Resourcing of occupational health should reflect organisational needs. The BLWF advocates using the GAIN model to assist forces to understand employee status with respect to wellbeing. There are also legal duties as part of health and safety risk management
- The NPWS has provided guidance on the staffing of occupational health services to enable them to meet police occupational health standards
- A target operating model enables police forces to plan their staffing needs according to the size of the force and the assessment of workforce need, the obligation to comply with the published occupational health standards, and the model of delivery.
- A potential future staffing model for police occupational health addresses the need to optimise the use of specialist occupational health expertise
- The recent announcement by the Home Secretary about a new National Centre of Policing presents an opportunity to redesign occupational health delivery. A future structure that combines national, regional and local delivery elements is a plausible and attractive vision

5. Design for change

Police occupational health must change to support the Police Covenant, to achieve pillar 4 of the Policing Vision 2030 and to provide cost-effective services to police forces. This will require a systemic redesign. Continuing with the same mind set about delivery and resourcing is doomed to repeat the same problems and risks a terminal spiral of decline. A systemic mindset requires us to behave differently, to question the received way of running projects and setting up collaboration spaces.[41] Systemic design is the acknowledgement of complexity and interconnectedness throughout the design thinking and doing process. It is both a mindset and a methodology - considering the structures and beliefs that underpin a challenge. It asks both designers and non-designers to radically reimagine and create new ways of living. Borrowing from the UK Design Council's systemic framework for Design for Planet, police occupational health may be envisaged as part of an ecosystem. There are lots of elements within a policing system: police officers, police staff, students, volunteers, buildings, equipment, human resources, and the logistics of operational delivery. This is a system because the elements are interdependent, i.e. if there are insufficient police officers or if there is a technology malfunction, the system breaks down. Designing an effective occupational health means embracing the "chaos" of at least 43 different systems and accepting the discomfort that it brings when driving transformational change. The framework discards a linear, disconnected way of seeing the world and effecting change.

At the core of the design framework is the Design Council double diamond, which describes a strategic approach to design. (See figure 6)

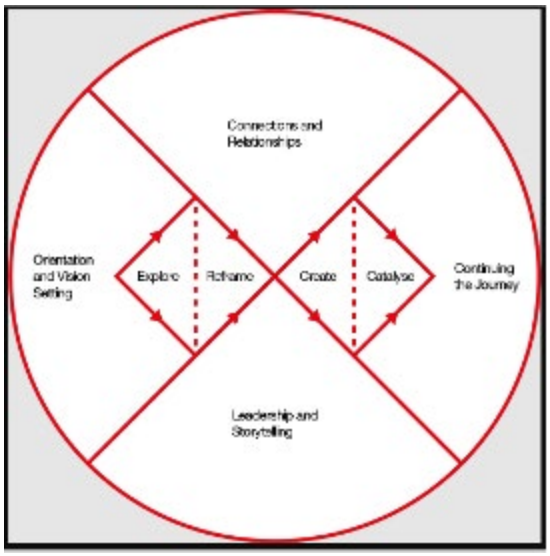

Figure 6. Systemic design framework (Design Council)

The first diamond helps people understand, rather than simply assume, what the problem is. It involves speaking to people who are affected by the services. The insight gathered from the discovery phase helps define the challenge to be overcome. The second diamond encourages people to provide different answers to the defined problem. Solutions are co-designed with people with different perspectives and insights. This leads to delivery which involves testing out different solutions on a small scale (pilots). The framework expands the design process to encompass "invisible activities": orientation and vision setting, connections and relationships, leadership and storytelling, and continuing the journey.

Systemic design requires four core roles: systems thinking, leadership and storytelling, designing and connecting / convening.

- Systems thinker: Someone who can see how everything is interconnected and who can zoom between the micro and macro
- Leader and storyteller: Someone who can tell a great story about what might be possible and why this is important, get buy-in from all levels and has the tenacity to see the work through
- Designer and maker: Someone who understands the power of design and innovation tools, has the technical and creative skills to make things happen and puts these to use early on in the work
- Connecter and convener: Someone who has good relationships can create spaces where people from different backgrounds come together and joins the dots to create a bigger movement

Of course, participants are likely to have some or all of the above attributes. However, this check list may be used to evaluate the composition of working groups, as appropriate.

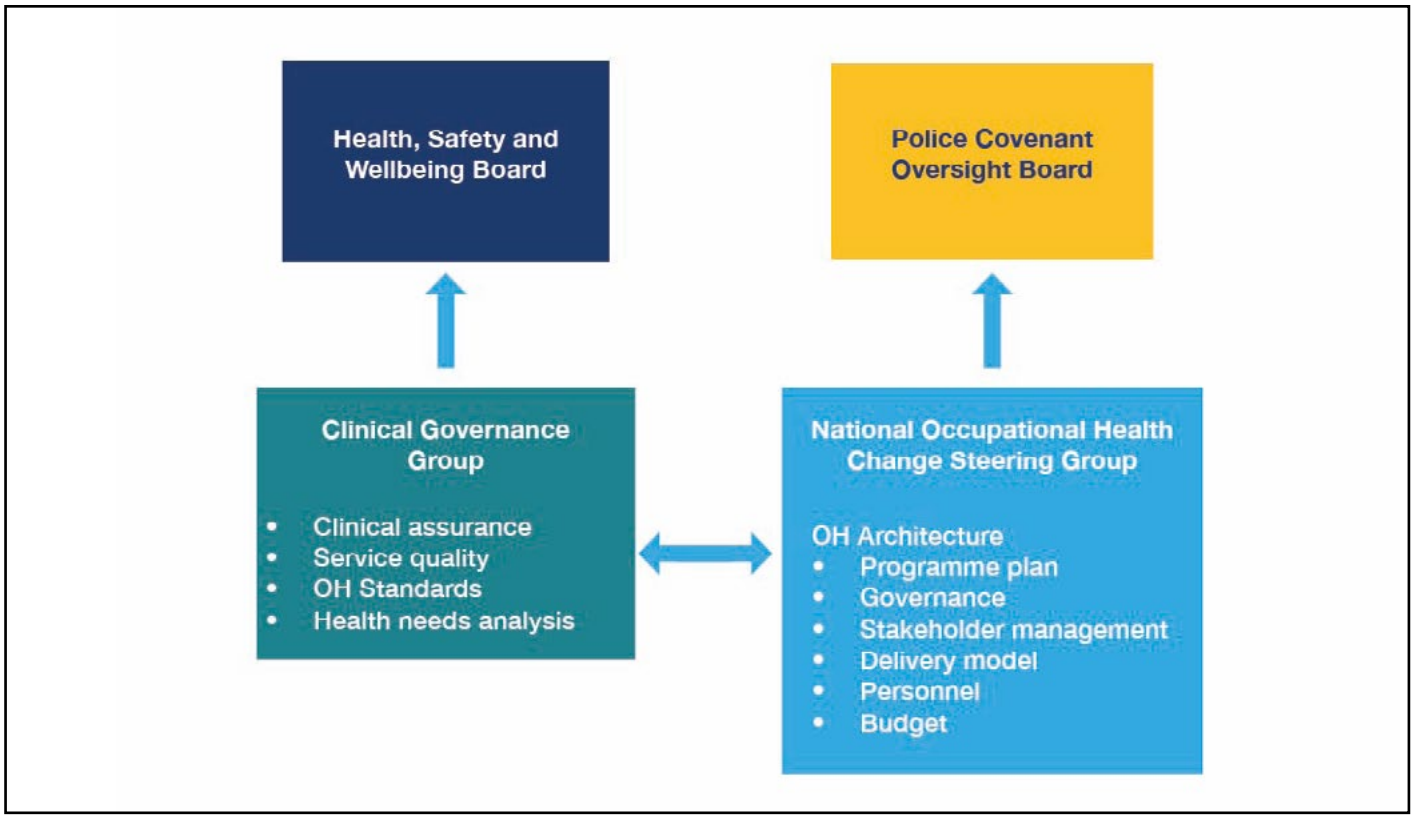

Figure 7. Blueprint for transformational change in police occupational health

Systemic redesign requires national leadership and governance. It is proposed that the leadership responsibilities lie with the NPCC, with oversight from the PCOB, given the importance to achieving the priorities of the Police Covenant. There are two main elements of the design: the occupational health architecture which will be the responsibility of a multidisciplinary group containing the above roles plus other necessary knowledge and expertise, such as financial planning, and the provision of occupational health services and quality assurance through the Clinical Governance Group.

The initial focus will be on the first diamond – explore and reframe. The discovery phase will involve a strategic analysis of the occupational health function and delivery. (See figure 8)

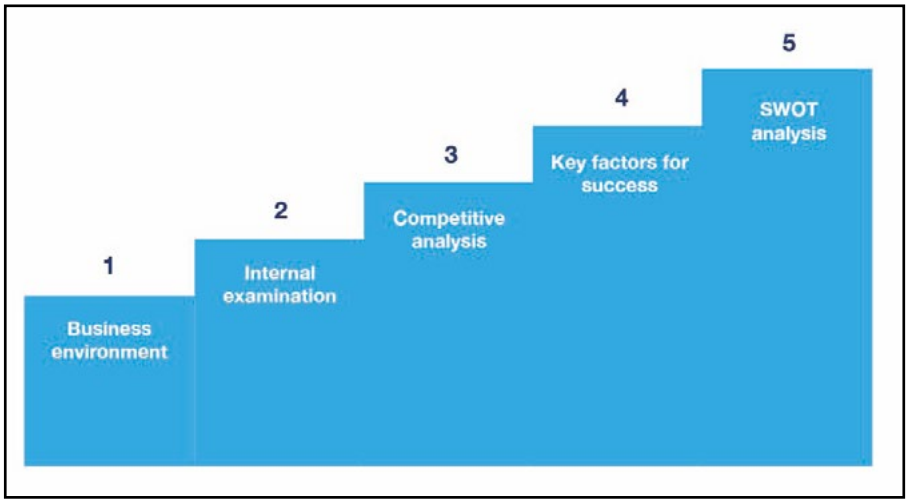

Figure 8. Five-step process for strategic analysis (From Offensive Marketing. An action guide to gaining competitive advantage[42])

Understanding the business environment will require a qualitative and quantitative analysis using a PESTEL-type approach. As has been noted elsewhere, the lack of reliable workforce data, including health data, makes this a challenge. However, as has been described earlier, there is a body of evidence that demonstrates the work-related health issues to be addressed.

Internal examination could take the form of a series of audits. (See figure 9)

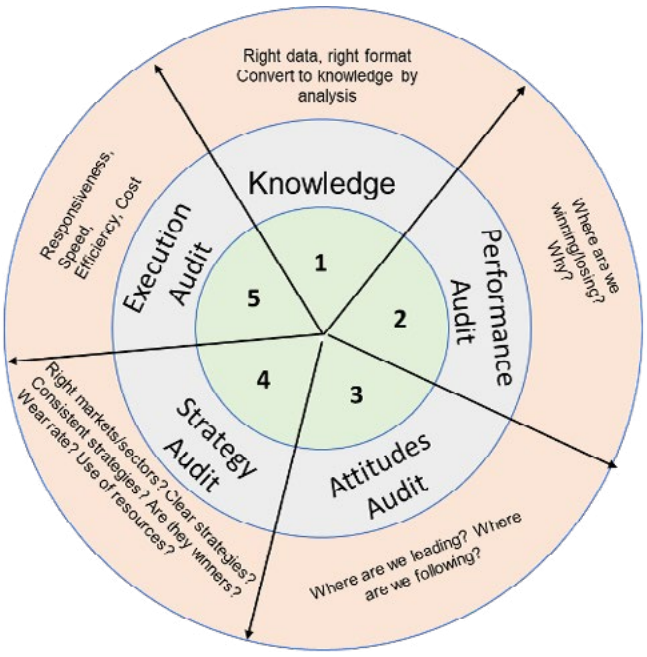

Figure 9. Model of internal examination. (From Offensive Marketing)

The design process must look at systems to obtain knowledge. This overlaps with work being carried out by the NPWS. A performance audit should focus on where occupational health services are succeeding, despite the financial constraints, and why. An attitudes audit is concerned with attitudes and beliefs within occupational health services (what are the differences between leaders and followers?) and those external to occupational health services (what is it for, is it credible, is it confidential?). A strategy audit will look at current local (force) strategies for occupational health in the context of organisational health and wellbeing strategies. This audit is a microcosm of this national work to understand local delivery and resourcing based on health needs assessments. Clear service level agreements, or contracts, with agreed KPIs underpin the execution audit, where there will be an assessment of the performance of occupational health services, and cost effectiveness.

Competitive analysis looks at the competition, that is how is occupational health delivered in other industries – public and private sectors. What seems to work well? How might different approaches be applied to policing?

Key factors for success highlight what really matters to police forces compared to what is attractive or what is nice to have. This will help to define the real challenges and will lead to developing the new offering.

A comprehensive SWOT analysis will be a key aspect of the discovery phase. A preliminary informal survey of organisational executives responsible for the oversight of occupational health has revealed interesting findings. This was a qualitative survey using purposeful sampling to include leaders from forces in England and Wales with in-house or contracted out occupational health services. (See annexes 1 and 2) Using word association, a general sense of opinion about occupational health can be seen in annex 1. Perceptions were generally negative ranging from being considered to be a red risk to being reactive, obstructive and too sickness orientated. Annex 2 presents word clouds from a brief and high level S.W.O.T. analysis. The strengths of occupational health services were predominantly the people, including clinical expertise, passion for the job and focusing on mental health. In a minority of cases, good levels of service existed linked to a good relationship between the force and the provider and a strong service level agreement and use of KPIs. Respondents generally welcomed services with a proactive approach. Weaknesses included poor leadership, low levels of capacity and long waiting times for people to be seen and being too reactive. A frequent theme was an apparent lack of awareness of business priorities when delivering services or when providing advice. Every respondent saw opportunities for occupational health linked to new ways of working. This might be being more proactive, especially addressing mental ill health and integrating occupational health and wellbeing services. However, activity should be aligned to a business health needs assessment. Systems should be responsive to business needs. Regional collaboration, within a national framework setting standards and advising about what good looks like, was suggested by several respondents. The threats to occupational health related to the financial environment and an inability to make the business case for investment. There were concerns about inability to recruit occupational health personnel linked to force finance, lack of a career structure and an already diminished critical mass of expertise. Some respondents were looking to procure specialist services to help them manage trauma-related mental ill health.

The next step – define and reframe – will utilise the results from the different elements of the discovery phase. Orientation and vision setting should ensure that there is clarity of purpose and process at government level and across relevant NPCC structures. This should be linked to leadership and the need for storytelling to engage at different levels of organisations and to try to include different parts of the policing ecosystem. A communications strategy will be needed that acknowledges the diversity of stakeholders in the formulation of messages, channels of communication and the timing of their presentation.

5.1 Summary

- Police occupational health will require a systemic redesign
- Borrowing from the UK Design Council's systemic framework for Design for Planet, police occupational health may be envisaged as part of an ecosystem
- At the core of the design framework is the Design Council double diamond, which describes a strategic approach to design
- Systemic design requires four core roles: systems thinking, leadership and storytelling, designing and connecting / convening
- It is proposed that the leadership responsibilities for occupational health change lie with the NPCC, with oversight from the PCOB, given the importance to achieving the priorities of the Police Covenant
- There are two main elements of the design: the occupational health architecture which will be the responsibility of a multidisciplinary group containing the above roles plus other necessary knowledge and expertise, such as financial planning, and the provision of occupational health services and quality assurance through the Clinical Governance Group
- The initial focus will be on the first diamond – explore and reframe. The discovery phase will involve a strategic analysis of the occupational health function and delivery
- A comprehensive SWOT analysis will be a key aspect of the discovery phase
- A preliminary informal survey of organisational executives responsible for the oversight of occupational health has revealed interesting findings. (See annexes 1 and 2)
- Phase 2 – define and reframe – will utilise the results from the different elements of the discovery phase. Orientation and vision setting should ensure that there is clarity of purpose and process at government level and across relevant NPCC structures.
- The design process will not be linear. Work can begin on addressing some of the more evident issues facing occupational health.

6.Next steps

6.1 Leadership and governance

The design of, and changes in, occupational health will be led by an Occupational Health Change Steering Group (OHCSG). This will be chaired by an NPCC-appointed Assistant Chief Constable or Assistant Chief Officer.

The group members will have, collectively, competencies in:

- **systems thinking and change**
- **leadership and storytelling**
- **designing**
- **connecting / convening**
- **finance**
- **occupational health services**
- **human resources**

Occupational health processes and procedures will be designed in collaboration with the occupational health practitioner network and sub-groups and overseen by the Clinical Governance Group.

The OHCSG will develop a project plan following the design principles of explore, reframe, create and catalyse. Understanding the issues and problems will enable them to be described and/or reframed. Discovery will be in the from of both quantitative (where available) and qualitative data collection. Formulating solutions will take best practice from across policing and from other industrial sectors – pubic and private.

Redesigning police occupational health will also incorporate other design principles of being people centred, good communication, collaboration and co-creation and repeated iterations.

6.2 Engage with the Design Council

A Prospectus for change will be shared with members of the Design Council with a request to meet them to discuss the proposed approach to designing a new police occupational health service. The aim will be to discuss the application of the systemic design framework in a police and occupational health context and to learn from their experience of its application in other settings.

6.3 Intelligence gathering

We need a better understanding of the reasons behind the comments made about occupational health in annexes 1 and 2. To prepare for the establishment of the OHCSG group, there will be deep dives into issues such as occupational health performance, for example referrals to occupational health, looking at demands, resourcing, and procedures. A preliminary financial analysis will be performed based on data collected in 2021.

It seems clear that part of a new occupational health landscape will involve collaborative working between police forces. We will conduct a “lessons learned” survey of those forces that are already collaborating, for example Devon and Cornwall / Dorset Police, Surrey / Sussex Police and Bedfordshire, Cambridgeshire and Hertfordshire constabularies and of forces that used to collaborate – Leicestershire, Nottinghamshire, Derbyshire, Lincolnshire and Northamptonshire.

Blue Light Commercial are beginning work on a project to develop procurement frameworks for force medical officers, physiotherapy, counselling and psychological screening. This will include developing requirement under these lots, spend analysis and market analysis.

6.4 Quick wins and momentum building

A Prospectus for change is about winning hearts and minds. It is recognised that, whilst the long-term solution for an effective and sustainable police occupational health landscape requires fundamental redesign, there will be quick wins available that do not require transformational change. Better processes and procedures that optimise outputs from existing service structures and personnel will ease pressures on services and forces.

7. Annexes

7.1 Police SLT – OH Word Association

7.2 Police SLT - S.W.O.T. Analysis

7.2.1 Strengths

7.2.2 Weaknesses

7.2.3 Opportunities

7.2.4 Threats

7.3 References

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