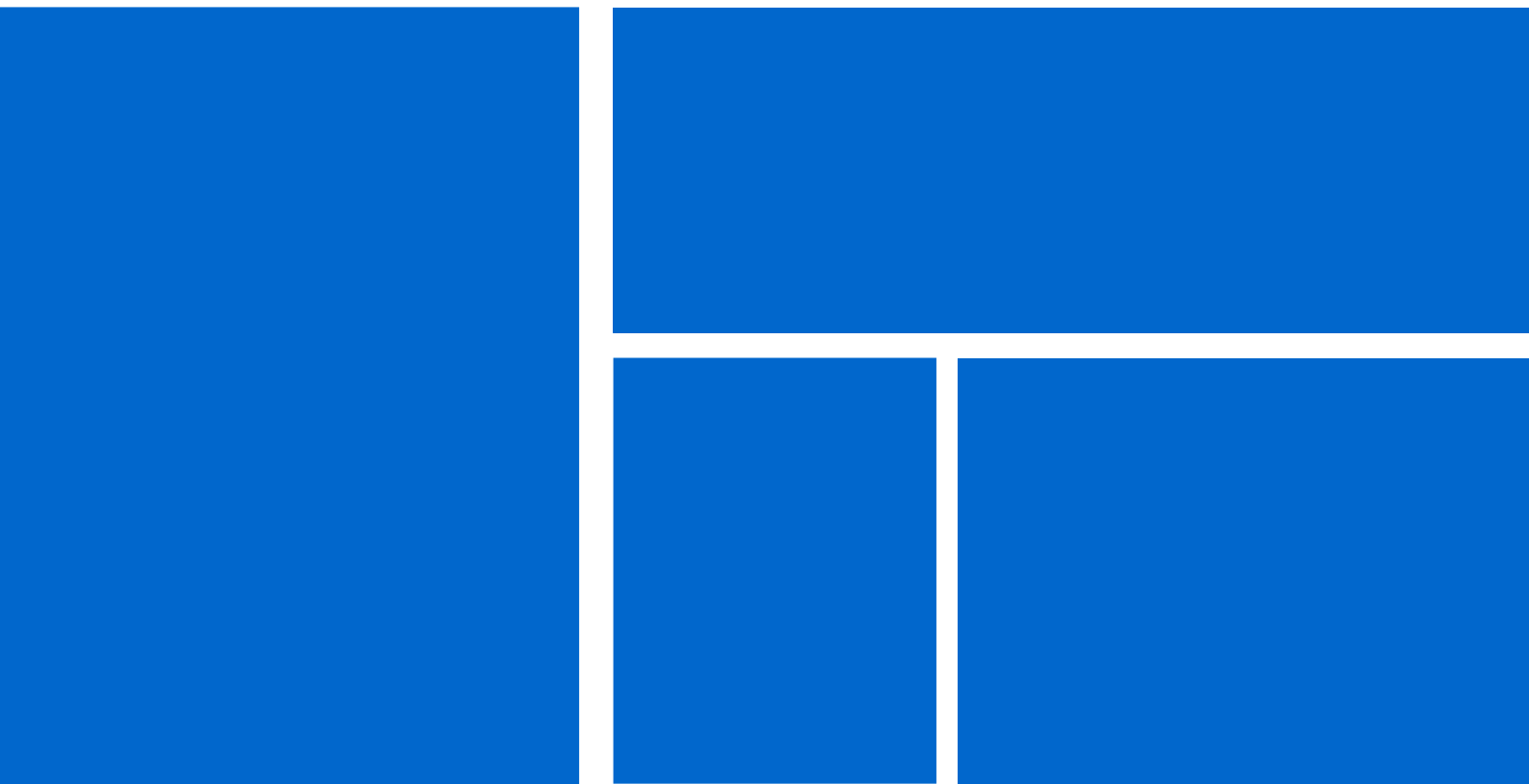


Healthy Staff, Better Care for Patients

**Realignment of Occupational Health Services
to the NHS in England**



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Realignment of Occupational Health Services

1. The Government has stated its clear commitment to improving the health and well-being of staff in both the Health White paper *Equity and Excellence: Liberating the NHS, July 2010*, and the Public Health White Paper *Healthy Lives, Healthy People: Our Strategy for Public Health in England, December 2010*. The latter also makes reference to the need to be proactive in improving the quality of and speeding up access to occupational health services. Furthermore, the pledges in the Responsibility Deal¹, particularly in relation to health at work and physical activity, articulate a vision that the NHS can aspire to and which would enable the healthcare sector to be recognised as an exemplar.
2. Our vision is that suppliers of occupational health services to healthcare staff should play a key role in the delivery of safe, effective and efficient patient care through promoting and protecting the health of staff. However, Dr Steve Boorman highlighted concerns about current health and well-being services in the NHS in his 2009 review². To achieve this vision, existing occupational health services need to be realigned and developed in order to:
 - provide services to prevent staff becoming ill or injured at work.
 - actively promote health and well-being in the workplace.
 - maximise access to and retention of work through timely rehabilitation services.
3. Previous attempts to modernise occupational health services have failed due to a lack of prioritisation and poor delivery systems across the NHS. This report highlights the urgent need for change to provide healthcare staff and services with the occupational health expertise and support needed to meet expectations and achieve exemplar status for the NHS.
4. The proposals in this report have been developed working with key internal and external stakeholders, and following an engagement process led by NHS Employers and the ten Strategic Health Authorities. Strong endorsement for the direction of travel has been provided by influential stakeholders in the public sector, industry, universities and the NHS. Diverse views from a wide range of individuals and organisations have been taken on board. More details of specific findings from the review that informed this report are available on the NHS Employers organisation website. An [Improvement Framework for Health and Well-being](#) sits alongside this report and will support Boards in establishing a culture that promotes staff health and well-being.
5. The proposals fall broadly into three areas:
 - Minimum service levels for occupational health services.
 - Occupational health data collection and information sharing.
 - Engagement of and with occupational health services.

¹ <http://www.dh.gov.uk/en/Publichealth/Publichealthresponsibilitydeal/index.htm> The pledges have been developed by the health and work network, but some collective Physical Activity pledges from the Physical Activity network also relate to the health and well-being of employees (e.g. encouraging active travel). Organisations are encouraged to sign up to as many as possible.

² NHS Health and Well-being Final Report November 2009

Minimum service levels for occupational health services.

6. While occupational health services for healthcare staff can be delivered by a variety of providers, it is essential that they meet a minimum specification based on the six core services.
 - Prevention – of ill health caused or exacerbated by work.
 - Timely intervention – easy and early treatment for the main causes of sickness absence in the NHS.
 - Rehabilitation – to help staff stay at work or return to work after illness.
 - Health assessments for work – to help manage attendance, retirement and related matters.
 - Promotion of health and well-being – using work as a means to improve health and well-being and using the workplace to promote health.
 - Teaching and training – encouraging staff and managers to support staff health and well-being.
7. Some existing services lack the scale necessary to achieve the full range of services and will need to change to meet the minimum specification.
8. All occupational health services must work towards the Faculty of Occupational Medicine accreditation, including a series of quality levels specific to the NHS. They should achieve this or be ready to do so by March 2012.
9. Clear contracts setting out the services required, the quality and delivery levels expected, together with the cost are imperative. In the future, procurement of occupational health services is likely to take place across a number of services.
10. NHS organisations should develop the organisational model for their occupational health services that suits the needs of their locality and meets the challenges that geography imposes on accessibility. However, any model adopted should adhere to a set of principles that outline the characteristics of the service:
 - Strong and demonstrable focus on a high quality, clinically-led and evidence-based service.
 - An equitable and accessible service.
 - Impartial, approachable and receptive to both clients and employer.
 - Contribute to improved organisational productivity.
 - Work in partnership with all healthcare services and within the community.
 - Underpinned by innovation.
 - Offer diversity and depth of specialisation and training opportunities.
11. The preferred model needs to ensure that existing staff resources are deployed efficiently using the skills of the whole team more effectively.

12. Consideration should be given to piloting the appointment of occupational health professionals to a number of local public health teams where they could take lead responsibility for advising on occupational health matters.
13. In order to improve the level of understanding of the impact of the workplace on the health and care of patients and improve communication between them, trainee doctors in key specialties should have the opportunity of a clinical attachment to an occupational health department as part of their training. A complimentary arrangement for occupational health trainees would also be helpful.
14. Occupational health services need to have the resource to train both doctors and nurses to specialist level, particularly as there are indications that the NHS may become the main trainer of the next generation of occupational health professionals. This points again to the need for larger units. Scaling up will also allow a degree of sub-specialisation e.g. in blood borne viruses, for the benefit of staff. Effective procurement of occupational health services must be planned carefully, with further work undertaken to forecast the future demand for and supply of occupational health physicians, nurses and other staff that will be required to support tomorrow's healthcare sector and the developing public health agenda.
15. Occupational health services have suffered over the years from a lack of development in the academic base. This is evident in the lack of published literature from the UK and the slow progress in the advancement of clinical practice and the development of policy. The academic base should be strengthened.
16. The NHS should act on the outcome of the 2003 Public Accounts Committee's recommendation to fast track healthcare staff, as not to do so but pay them to be on sick leave is an untenable position.

Occupational health data collection and information sharing.

17. The current variability in data management across occupational health services makes clinical governance and audit difficult. The collection of information and review of data should be used to:
 - Assess and monitor the health and well-being of the trust workforce.
 - Monitor the activities of the occupational health service.
 - Monitor the quality of the occupational health care.
18. Trusts should receive regular reporting on the work of occupational health services. Key Performance Indicators should be reported at a senior level with Trust Boards having the opportunity on a periodic basis to discuss high level data. This will help drive improvements in performance through greater transparency and improved dialogue with healthcare services.

Engagement of and with occupational health services.

19. Occupational health services need to take a more proactive leadership role and to engage with managers and staff representatives to align their services to the delivery of high quality patient care, to HR strategies and NHS Constitution pledges. This will involve exploiting established mechanisms for engagement, involvement and statutory engagement with the

NHS including the various partnership forums/joint negotiating consultative committees and health and safety committees. As many of those staff essential to this process may not have the skills to do so effectively, training and tailored toolkits should be made available to all levels of staff.

20. All occupational health services should develop an annual business plan articulating the range of services required and how they will be promoted and marketed.
21. If these recommendations are successfully implemented the NHS will make a significant step forward in achieving the Quality Innovation Productivity and Prevention £555 million productivity savings by 2013. This increased productivity would ensure that the future financial position of the NHS is placed on a far more sustainable footing in the years to come, where the service will have to balance the challenge of funding limitations, increasing demands on service provision and ever-stretching care quality targets.

Summary Recommendations

Minimum service levels for occupational health services

1. It is essential that occupational health services for healthcare staff meet a minimum specification based on the six core services of prevention, timely intervention, rehabilitation, health assessments for work, promotion of health and well-being and teaching and training.
2. All occupational health services must work towards Faculty of Occupational Medicine accreditation, including a series of quality levels specific to the NHS. They should achieve this, or be ready to do so, by March 2012.
3. Clear contracts are necessary setting out the services required, the quality and delivery levels expected, together with the cost.
4. NHS organisations should develop the organisational model for their occupational health services that suits the needs of their locality and meets the challenges that geography imposes on accessibility. However, any model adopted should adhere to a set of principles that outline the characteristics of the service:
 - Strong and demonstrable focus on a high quality, clinically-led and evidence-based service.
 - An equitable and accessible service.
 - Impartial, approachable and receptive to both clients and employer.
 - Contribute to improved organisational productivity.
 - Work in partnership with all healthcare services and within the community.
 - Underpinned by innovation.
 - Offer diversity and depth of specialisation and training opportunities.
5. The preferred model needs to ensure that existing staff resources are deployed efficiently using the skills of the whole team more effectively.

6. Consideration should be given to piloting the appointment of occupational health professionals to a number of local public health teams where they could take lead responsibility for advising on occupational health matters.
7. Trainee doctors, in key specialties, should have the opportunity of a clinical attachment to an occupational health department as part of their training. A complimentary arrangement for occupational health trainees would also be helpful.
8. Occupational health services need to have the resource to train both doctors and nurses to specialist level. Effective procurement of occupational health professionals must be planned carefully.
9. The academic base for occupational health services should be strengthened.
10. The NHS should act on the outcome of the 2003 Public Accounts Committee's recommendation to fast track healthcare staff.

Occupational health data collection and information sharing

11. The collection of information and review of data should be used to:
 - Assess and monitor the health and well-being of the trust workforce.
 - Monitor the activities of the occupational health service.
 - Monitor the quality of the occupational health care.
12. Trusts should receive regular reporting on the work of occupational health services. Key Performance Indicators should be reported at a senior level with Trust Boards having the opportunity on a periodic basis to discuss high level data.

Engagement of and with occupational health services.

13. Occupational health services need to take a more proactive leadership role and engage with managers and staff representatives to align their services to the delivery of high quality patient care, HR strategies and NHS Constitution pledges.
14. Training and tailored toolkits should be made available, to all levels of staff, to help provide effective engagement skills.
15. All occupational health services should develop an annual business plan articulating the range of services required and how they will be promoted and marketed.