OCCUPATIONAL HEALTH CLINICAL EFFECTIVENESS UNIT

REPORT FROM REGIONAL WORKSHOPS

December 2009

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With many thanks to everyone who generously gave their time to participate. The workshops were commissioned by NHS Plus as part of its implementation programme.
The invaluable help and support given by the occupational health Regional Champions contributed to the success of the workshops.

Introduction
Between 2006 and 2009, the Occupational Health Clinical Effectiveness Unit (OHCEU) and NHS Plus published the results of two national audits and six evidence-based guidelines. A national audit conference held in April 2009 was attended by over 170 occupational health practitioners who shared their views about local practice and the findings of the audits.

The next stage in the quality improvement work was a series of workshops held in nine different areas of England. These workshops were intended to:

- provide an update on NHS Plus and OHCEU guidelines and audits;
- explore the barriers experienced locally in implementing guideline recommendations;
- help participants to start local action planning to address barriers to implementation;
- identify any improvement mechanisms that participants would like the OHCEU / NHS Plus to develop and disseminate nationally;
- seek views from the Occupational Health community on future workstreams for the OHCEU;

Each workshop was led by the clinical director of the OHCEU or an audit clinical lead, supported by one or two members of the OHCEU team and the regional champion. Table 1 shows the number of occupational health practitioners who took part in each of the workshops.

Table 1 Regional workshops

Workshop location	**NHS Plus Region**	**Date**	**Number of participants**
Runcorn	North West	11 June 2009	11
Ashford	South East	15 June 2009	15
London	North & South London	24 June 2009	32
Basingstoke	South East (Central) and Oxford	1 July 2009	19
Solihull	West Midlands	3 July 2009	9
Durham	North East	6 July 2009	15
Cambridge	Anglia	9 July 2009	37
Taunton	South West	14 July 2009	23
Leeds	Yorkshire & the Humber and Trent	30 July 2009	29
TOTAL			190

Workshop organisation

Venues: NHS Plus regional champions identified a suitable venue in each region. In some cases the workshop was combined with an existing meeting date, and in other cases the workshop was organized as an additional event.

Invitees: All occupational health units providing services to NHS trusts in England were invited to register up to two participants. Those that had not participated in the audits were also encouraged to attend. In advance of each workshop we asked for volunteers to present their experience of guideline implementation locally and how they had overcome barriers to implementation. Packs containing all the published guidelines, and reports from both national audits, were distributed to all delegates at the workshops.

Programme: The workshops were designed to be interactive, with the majority of time spent in facilitated small group working. Most workshops were around 5 hours; they opened with facilitated group working, where each group chose one NHS Plus guideline to work on. The remainder of the workshop focused on the audit findings. Below is an example agenda.

10:00–10:10	Welcome – NHS Plus Regional Champion
10:10–11:00	Workshop session: How do we translate the NHS Plus/OHCEU guidelines into good practice?
11–11.20	Introduction – OHCEU Clinical Lead Headline audit results and findings of the conference voting
11.20–12:00	Presentations and discussion on participants' experiences of using audit results
12:00–12.45	Small group discussions: What have you done? What barriers do you experience?
12.45–13.30	Lunch
13.30–13.45	Feedback on group discussions
13.45–14.45	Workshop session: Action planning
14.45–15.00	Close

Small group work

To structure discussions on barriers to change, we adapted a template developed and disseminated by the National Institute for Health and Clinical Excellence. (NICE). The same template was used for the NHS Pus guideline session and the audit session. The template allowed participants to identify barriers that they had come across in their own practice, and how they had (or might) overcome them. The template categorized potential barriers, to support planning for overcoming them, into;

- awareness and knowledge
- motivation
- acceptance and beliefs
- skills
- practicalities
- barriers beyond our control

Delegates were invited to use the template to start developing local action plans, gathering practical ideas from colleagues for implementation. A copy of each form was collected at the end of the workshop. We have analysed these, along with verbal feedback noted during the workshops, looking for emerging consensus of key issues and practical examples of how these were addressed.

Findings

1. Back pain audit

Thirty four action plans were submitted for inclusion in the analysis. A common theme during discussion at the workshops, echoed in the action plans, was the need for occupational health services to set standards for practice. In particular delegates wanted unified assessment and treatment planning to ensure a consistent approach. It was recognized that achieving this would necessitate training for occupational health staff appropriate to their professional background but with a common core (table 2):

Table 2 Knowledge and approach for OH staff implementing best practice for back pain

Knowledge and approach required	**Purpose**
Guideline content	Evidence for best practice
Structured capture of clinical information	Consistency and completeness of clinical record to facilitate multidisciplinary working and audit
Identification and management of red and yellow flags	Appropriate case management to influence better outcomes
Referral pathways and follow up	Efficient involvement of appropriate expertise for better outcomes
Use of supportive IT	Shared clinical management, business monitoring and audit feedback

Several strong themes emerged from analysis of the action plans, with common barriers to implementation and a more diverse range of possible practical solutions (table 3).

Table 3 Barriers and solutions to implementing best practice in back pain

Barriers identified	**Benefits of overcoming barriers**	**Actions to overcome barriers**
Resistance to change	Demonstration of successful outcomes	Feedback on individual practice Audit (local and national)
Lack of consistency of OH practice	Confidence in doing the right thing	Adopt standard procedures for all staff to follow Use of standard assessment tools Algorithms and checklists of red/yellow flags on walls in clinical rooms
Skills development in history taking, clinical examination and recognition of symptoms and signs not core to professional training	Ability of Occupational Health Nurse Advisors to take on extended role	Training involving clinical expert Clinical supervision Mentorship Appraisal / goal setting Individual and group training to cover e.g. - guideline content - documentation required - functional back assessment - management of red flags
Professional boundaries	Improved efficiency and effectiveness	Multidisciplinary team management with triage of cases to appropriate professional
Insufficient time for consultation	Improved efficiency and effectiveness	Standardised questionnaires, completed in advance of consultation
Insufficient resources in organisation	Reductions in: - sickness absence, - ill health retirement, - civil litigation, - RIDDOR reports	Raise occupational health profile Board level business case Engagement with other teams e.g. infection control, risk & safety
GPs signing Med 3 certificates	Engagement in rehabilitation reducing sickness absence	Provide feedback, e.g. reports and letters routinely copied to GPs, possibly with a template for standard wording

A major issue is the appropriate role for different members of the multidisciplinary team, given the differences in professional training and subsequent skills development for competent back assessments. A commonly identified need was to increase the confidence of occupational health nurses in history taking, clinical examination and assimilating symptoms and signs to identify the appropriate management needed.

This opens for debate the issue of whether all members of the multidisciplinary occupational health team need these skills or whether appropriate triage can direct patients with different needs to appropriately skilled members of the team. Do all individuals with back pain who are seen in occupational health need an examination or can an adequate functional assessment be made for many (but not all) cases on history alone? No consensus was reached at the workshops and we suggest that the issue is considered at national level.

2. Long term sickness absence and depression audit

Forty action plans were submitted for the thematic analysis. Many of the knowledge gaps, barriers to implementation and solutions are common to the back pain work, but there are some condition-specific issues arising (tables 4 and 5).

Table 4 Knowledge and approach for OH staff implementing evidence based practice in managing long-term sickness absence and screening for depression

Knowledge and approach required	**Purpose**
Guideline content	Evidence for best practice
Structured capture of clinical information	Consistency and completeness of clinical record to facilitate multidisciplinary working and audit
Mental health assessment and understanding the impact of physical on mental health	Better holistic management of cases to influence better outcomes
Referral pathways and follow up	Efficient involvement of appropriate expertise for better outcomes
Use of supportive IT	Shared clinical management, business monitoring and audit feedback

Table 5 Barriers and solutions to implementing evidence based practice in managing long-term sickness absence and screening for depression

Barriers	**Benefits of overcoming barriers**	**Actions to overcome barriers**
Differences in practice between occupational physicians and nurse advisors / roles within occupational health departments	Consistency of practice between occupational physicians and occupational health nurse advisers	Training in history taking and clinical management appropriate to different symptoms and signs.
Insufficient skills in mental health assessment, including understanding the interaction between physical and mental health	Confidence in doing the right thing	Training Mentorship Clinical supervision Information e.g. leaflets, website
Understanding the rationale for evidence-based practice	Confidence in doing the right thing	Training Multidisciplinary team development Good practice reinforced by repeat audit cycles
Time available for consultations	Improved efficiency and effectiveness	Use of questionnaire in advance of consultation

Access to therapies and other local services	Improved efficiency and effectiveness in management leading to better outcomes	Knowledge gathering Liaison with GPs
Stigma accompanying mental health problems	Engagement in rehabilitation reducing sickness absence	Information for employees, managers and HR
Acceptance of assessment by clients	Engagement in rehabilitation reducing sickness absence	Robust referral system
Resistance to completing questionnaires	Improved efficiency and effectiveness	Timing of delivery and support available

Delegates wanted access to validated screening tools and cited time to develop a consistent approach and local tools as a major barrier to implementation.

3. Guidelines

Delegates worked in small groups on one of the guidelines of their choosing, and developed local action plans on the template provided. Table 6 shows the number of forms submitted on which the subsequent thematic analysis is based.

Table 6 Action plans on guideline implementation

Guideline	**Number of action plans submitted**
Upper limb disorders	12
Dermatitis	20
Latex	12
Pregnancy	22
Food handlers	1
Chronic fatigue	0
TOTAL	67

The action plans examined offered a range of information on the potential barriers to guideline implementation, including motivators for making changes, and raised issues that were common to all guidelines (table 7) and others specific to a particular guideline (table 8).

Table 7 Common themes in guideline implementation

Requirements	**Barriers**	**Benefits of overcoming barriers**
Visible leadership	Status of Occupational Health in the Trust	Raising profile for Occupational Health
Occupational Health familiarity with best evidence	Differences in practice between occupational physicians and nurse advisors	Consistency of practice across the multidisciplinary team
Support from Trust, including senior managers	Competing priorities, Lack of awareness of key issues	Clinical governance
Involvement of key groups in Trust e.g. Risk and Safety, Infection Control	Competing priorities	Patient safety Staff safety Compliance with legislation
Organisation-wide policy	Ownership across different parts of the organisation, including Human Resources and clinical directorates	Consistency of practice encouraging favourable outcomes and preventing harm
Support from staff representatives	Lack of awareness of key issues	Staff safety

Suitable training available	Resources, including time, money and people with sufficient expertise to deliver	Fulfilling CPD requirements
Staff engaged	Competing priorities, lack of understanding of rationale	Confidence in doing the right thing
Consistency with other sources of advice and guidance	Insufficient high quality research on which to base recommendations leading to different recommendations from different sources and gaps in guidance	Patient safety Staff safety Compliance with legislation
Risk assessment tool	Time to develop locally or to adapt national templates	Improved efficiency and effectiveness in assessment and management of individuals
Options for rehabilitating and redeploying staff	Insufficient flexibility in HR policies and management options	Reduced sickness absence and better deployment of staff resources

Table 8 Specific issues in implementing individual guidelines

Issue	**Upper Limb Disorders**	**Dermatitis**	**Latex**	**Pregnancy**	**Food handlers**
Compliance	Work demands risk exacerbating problems	Ownership of handcare by Infection Control often excluded OH	Reduced manual dexterity with alternative products	Compliance with Health and Safety regulations concerning exposures	Safe and hygienic practice a prerequisite. Inducements for staff may be needed
Training needed in OH	Making a diagnosis and functional assessment	History and examination required for correct management – proforma for standardisation	Skills in health surveillance for OH	Risk assessments incorporation appropriate recommendations for each trimester of pregnancy	Awareness of evidence
Skill mix available to Occupational Health	Multidiscilinary rehabilitation includes OH, Physio, OT, pain management, psychology, ergonomics	Fast track referral to dermatology			
Staff awareness and engagement	Raise awareness of benefits of prevention of reporting and early intervention	Facilitate reporting of problems – skin care campaigns helpful		Pressures on occupational health professionals to complete training competencies	Staff induction plus regular updates
Managers awareness and	Importance of prevention and early	Importance of prevention and early		Ensuring adequate cover for shifts.	Need to be ongoing

engagement	intervention	intervention – introduce hand checks for staff		Job design and flexibility	
Resources and expertise	Workstation assessments needed to ensure sound ergonomics	Procurement issues – standardisation of products available for staff	Procurement issues – range of suitable gloves available		Inducements for staff to remain off sick

In summary

The workshops generated a lot of discussion and helped educate participants about the national audit findings and the content of the evidence-based guidelines. They also provided a platform for sharing ideas around barriers to implementation. Many barriers were common across Occupational Health departments and would benefit from common approaches to solutions adapted to local circumstances.

Table 9 provides an overview of the main themes that emerged from the workshops and sets these in the context of general areas where action may achieve beneficial change. The final column gives examples of very specific actions that workshop participants had found helpful.

The main themes and areas for action are also presented diagrammatically.

Table 9 Summary of action required to embed evidence-based practice into occupational health

Themes	**Areas for action**	**Suggested specific activities**
Occupational health profile in the organization	Ensuring ongoing Board commitment Identifying active champion(s) Achieving enduring visibility OH input into all relevant organisational policies	Get involved with the development of Trust policies Regular contribution to relevant Trust-wide meetings
Influencing managers	Streamlined framework for referral Regular and helpful communication and feedback Involvement in education and training	Run workshops / fora for managers - Sickness absence management - How to get the most out of an OH referral - How to undertake a risk assessment
Knowledge of best evidence	Access to available sources of evidence based guidelines, systematic reviews and other collated research	Occupational Health services to have quality nationally produced leaflets available to supplement advice (sources include HSE, NHS Plus/OHCEU, the Back Book etc)
OH staff education and training to achieve consistency	Ensuring staff understand rationale for practice and expected outcomes Examples of areas to cover: - History taking (including how to ask difficult questions e.g. depression, alcohol, drugs and suicide) - Use of assessment tools - Examination techniques	Invite local service providers with relevant expertise (e.g. community mental health teams, physiotherapists) to undertake training for OH staff Use of departmental audits and individual staff appraisal/development reviews

	- Patient management	
Pathways for care	Achieving multidisciplinary team working Mapping local services for liaison, signposting and onward referral Engaging with local GPs	Triage referrals with direct access to specific therapies e.g. physiotherapy, psychology Specialist practitioners in occupational health e.g. mental health
Tools to structure assessment	Availability for use: - Validated questionnaires - Locally derived proformas as 'aide memoirs'	OHCEU to make available standard templates for local adaptation

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