A Short Guide to the Future Consolidation of NHS Occupational Health Services
Consolidating NHS OH Services: FAQs

What is the policy of the NHS Health at Work Network Board towards consolidation of NHS OH services?

- The Network Board believes that NHS occupational health provider organisations should be large enough to offer:
  - Access to OH specialist medical and nursing staff
  - Support for clinical training and continuing professional development
  - Integrated services including physiotherapy and counselling
  - Appropriate information technology to support audit and development

The growing body of evidence and compelling clinical governance and economic arguments suggest that achieving these standards will require the OH service to serve a staff population of 10,000 or above. The Board believes that NHS OH organisations which cannot meet these criteria, should actively explore consolidation on the basis of the two models set out in this guide.

Why consolidate OH services?

- There is a growing body of evidence that staff health and wellbeing is associated with a multi-disciplinary approach. It is more cost effective to create teams that serve many Trusts.

Our service is good. Do I need to change?

- Yes. Many OH services are good but the evidence suggests they could be even better. Most of the better units could contribute even more to improve health and wellbeing, to audit and research, and to training and development, if they were bigger. In addition, levers for change might include the need to achieve SEQOHS accreditation, improving health and wellbeing of staff to obtain better staff survey results, improving sickness absence management or preparation for market testing services.

Who should lead the consolidation and future service?

- Consolidating services needs effective clinical leadership and effective service management. Evidence suggests it is essential to appoint a lead clinician, a lead nurse, and a manager with overall responsibility for operation of the network.

Which model of consolidation is the best?

- There is no single model of occupational health service that has been shown to be most effective. Both hosted collaborative services and managed clinical networks have attractive features.

How big should OH units be?

- Research conducted for NHS North West showed that larger units serving more than four Trusts were better resourced and had specialist clinical staff, better access to physiotherapy, made better use of information technology and were more likely to be compliant with SEQOHS standards. There is a lack of research evidence into occupational health outcomes, but it is conceivable that there are likely to be advantages in even bigger services.
What is the correct skills mix?

- Once again, there is a lack of good research in this area. Professional regulation requires that OH professionals should practice within appropriately supervised teams, which should comprise at least a consultant (accredited specialist) in occupational medicine and a nurse with a specialist OH nursing qualification and registration. The clinical team may include other doctors and nurses and OH technicians; counsellors and CBT practitioners and physical therapists. The wider team includes well trained administrative staff and may include safety practitioners and occupational hygienists, although this is unusual in the NHS.

Do I need to involve stakeholders and staff?

- Yes. Engaging stakeholders (managers and staff) in the design and delivery of the service is essential and required by the SEQOHS service accreditation standards recommended in the Boorman Review.

What is the cost?

- Some OH services are effective and cost-effective. In these cases consolidation should improve effectiveness without additional cost. Some OH services are not fit for purpose. In these cases additional investment in staff health and wellbeing may be necessary.
Introduction

This short guide to the consolidation of NHS Occupational Health services, draws upon the available evidence in setting out the case for change; identifies the benefits of consolidation, sets out the two main options and provides a road map for first steps.

The guide has been published by the NHS Health at Work Network which represents and promotes 150 NHS Occupational Health services. The guide is designed for occupational health clinicians, managers and staff and importantly, HR directors and HR managers in the NHS. We hope the guide will promote discussion within local networks, a review of the current demand for and configuration of local services and, where a different configuration will lead to an improved service to NHS staff, a well planned and executed transition.

Context

The 452 statutory NHS organisations in England are currently served by 160 NHS occupational health services. A range of reviews and reports over the past 10 years have pointed to wide variations in the quality of service delivery. Recent developments in terms of the Boorman Review and introduction of national Accreditation standards for occupational health providers have prompted renewed thinking about the configuration of NHS Occupational Health services. Finally, the 2012/13 Operating Framework for the NHS reinforces the financial pressure on OH services to deliver real term savings.

This paper is particularly based upon the report, ‘The Future Configuration of NHS Occupational Health Services’ prepared by Helen Kirk and published by NHS Plus in September 2010 and on presentations at a Reconfiguration Conference held in 2011. The full paper is available to members through www.nhshealthatwork.co.uk.

The Case for Change

In her report Working for a Healthier Tomorrow Carol Black identified an expanded role for occupational health. She identified a need to re-configure occupational health services to address challenges including uneven provision, inconsistent quality, and a diminishing workforce.

“If we are to change fundamentally the way we support the health of working age people, then we have to address a number of challenges which face Occupational Health as it is currently configured.”

Carol Black: Working for a Healthier Tomorrow

Following this report Steve Boorman was commissioned to lead a Review of NHS Staff Health and Wellbeing. His Interim Report identified a number of concerns with the health and well-being services currently available to NHS staff:

- Variations in service standards and specifications
- Inconsistency in the range of and access to services
- Inadequate resourcing
- Lack of consultation with staff about the services

The Interim Report suggested a need for “remodelling of occupational health services”.

The Report noted concern about the “relatively low numbers of medical consultants in occupational medicine and about their distribution” and went on to propose regional
consultants in both occupational medicine and occupational health nursing. Regional consultants have also been recommended by the Faculty of Occupational Medicine.¹

“At the heart of our vision [is] the concept of a comprehensive, proactive staff health and well-being service, commissioned and delivered to common standards and in consultation with staff and their representatives.”

Steve Boorman: Final Report

There is considerable financial and other pressure on all organisations to improve efficiency. The short-comings in NHS OH services, reported by Boorman, offer the scope to improve both effectiveness and cost-effectiveness.

“We also saw scope for re-engineering some aspects of routine occupational health service provision ... to improve efficiency and to free specialist staff to tackle more complex cases”

Steve Boorman: Final Report

In the Final Report the review recommended core staff health and well-being services should be provided to nationally specified standards. In support of this the FOM has led the publication of standards for safe, appropriate and effective quality services by occupational health services (SEQOHS). The Boorman Review had identified variability in NHS services and a lack of involvement of service users and more recent research has confirmed that not all NHS OH provider units currently comply with these standards (Ford, Kirk and Denman 2010).

In addition, NHS Plus has led the development of a quality strategy for NHS OH units that is founded on the SEQOHS standards but goes further in defining specific standards of service for aspects of high importance to the NHS (eg. speed of access and reports and clinical quality). There has been wide consultation on the quality strategy with NHS OH units and a cohort of Quality Strategy Facilitators has been recruited to help units demonstrate compliance with existing and emergent standards.

The need to improve and reconfigure OH services has been a consistent message in Dame Carol Black’s report, Steve Boorman’s report, the Faculty of Occupational Medicine’s strategy review, the NHS Plus Quality Strategy, and in research commissioned by NHS North West.

An added pressure is the financial expectation expressed in The Operating Framework for the NHS in England 2012/13. In his introduction to the document Sir David Nicholson, Chief Executive states:

‘The scale and nature of that challenge, requiring us to make up to £20 billion of efficiency savings by 2014/15 to invest in meeting demand and improving quality, mean that all parts of the NHS will need to take bold, long term measures in 2012/13 to secure sustainable change. The role of innovation, too often the forgotten element of QIPP, will be critical. Rapidly spreading changes that improve quality and productivity to all parts of the NHS will be crucial.’

Current OH provision for NHS staff is highly fragmented – in the North West for example there are thirty one separate providers. There is a similar picture across the NHS in England. In contrast Scotland has only a few providers and Wales is preparing to introduce a single service for the whole country.

¹ Future directions for occupational health care in the UK: A strategic overview FOM January 2010
The fragmentation is so extensive there are many examples of multiple services in very close proximity (especially in major urban areas) and many examples of Trusts that are on the same site but supported by different providers. In some cases NHS staff on one site where there is an OH unit receive their OH support from a completely different location.

The fragmentation is compounded by persistent difficulties with diverse information systems and the sharing of patient information between providers (as staff move from one Trust to another).

Finally according to Chris Jefferies, Director of Workforce and Education at North West SHA, research in the North West in 2010 suggests:

- Limited integration of OH services into overall clinical strategy of providers
- Buildings and facilities often substandard
- SLAs frequently not in place
- 15% of organisations have no access to a specialist nurse
- 22% of organisations have no access to a doctor on the Specialist Register
- 48% of organisations have no access to physiotherapy

The current configuration reflects historical procurement. The fragmentation and lack of strategic organisation is a recipe for ineffective, inefficient, poor quality care that does not build confidence in colleagues, patients and stakeholders, and in some cases is potentially unsafe.

The consolidation of NHS occupational health services offers the opportunity of professional leadership united by a common vision of strategic development, stakeholder engagement and high quality clinical services. Such a consolidation can offer:

- A strong and demonstrable focus on a high quality, clinically led and evidence based service
- An equitable and accessible service
- A service that is impartial, approachable and receptive to both clients and employer
- Improved organisational productivity and efficiency
- The scope for innovation
- Diversity and depth of specialisation
- The opportunity to contribute to the training and education of professional staff

**The Way Forward**

The case for change is a strong one. A strong NHS requires a strong quality-assured occupational health service to promote and maintain the health and wellbeing of its staff in order to meet the Nicholson challenge “to do more with less”. Change will benefit both the NHS and occupational health, which will be able to up its game and be more influential as a clinical specialty within healthcare. Compliance with national standards is fundamental to being a credible clinical specialty. There is an accumulating body of evidence that a sizeable minority of NHS occupational health services are unable to comply with SEQOHS standards and that others are struggling to do so. There seems little doubt that for NHS occupational health, size does matter. Chris Jeffries, Director of Workforce at the North West SHA concluded, based on a research carried out in that region, that larger OH providers are significantly more likely to:

- Meet SEQOHS standards
- Employ specialist staff
- Provide integrated access to physiotherapy and counselling
• Make more use of IT

Provider organisation should be large enough to offer:

• Access to OH specialist medical and nursing staff
• Support for clinical training and continuing professional development
• Integrated services including physiotherapy and counselling
• Services to a large number of NHS trusts
• Appropriate information technology to support audit and development

Any model of occupational health must be capable of delivering clinical excellence. This is in the best interest of the employer/purchaser as well as the employee/patient. This has long been accepted in the USA where occupational health services have long held much wider responsibilities for all the health care needed by workers.

“We are on the verge of transformation of our delivery system from just being a reactive and illness oriented medical care system to also being a proactive and wellness oriented health care system”

Loeppke 2006

It is also in the best interests of occupational health, which needs a sustainable foundation on which to build its future. Barry Lane, General Manager of Avon Partnership OHS has reported the benefits of his area collaborative service as;

• Improved service to Partners
• Increased efficiency
• Greater consistency
• Greater customer contact
• Free resources to broaden client base

Potential Models of Consolidation

The NHS Health and Work Network Board has recommended two models of consolidation; Managed Clinical Networks and Area Collaborative Services.

Managed Clinical Networks

A Managed Clinical Network comprises a number of NHS provider units co-operating under a formal agreement. The individual units and staff remain within their host organisations. Usually each Trust contributes to a fund to employ a small Network Management Team hosted by one of the organisations.

Formal managed clinical networks (MCNs) have become commonplace in the past decade and provide a structural framework for the organisation and development of local clinical services (in other specialties but not in occupational health).

There is now sufficient experience with MCNs for studies to have examined their value.

Managed clinical networks have recently been shown to improve the quality of care (without the need for additional resources). Improvements were enabled by effective information systems. (Greene et al 2009) A list of benefits can be seen in box 1.

---

2 The research identified benefits in units supporting more than four Trusts. However, there are likely to be advantages in even bigger services but there were no such current services to investigate.
Box 1: Benefits of managed clinical networks (from Wall and Boggust 2003)

- Potential for seamless patient care
- Integrated care across existing professional and health-care boundaries
- Agreed care protocols and pathways across the network area
- Diversity of professional contributions
- More equitable service provision for patients
- Prevention of duplication of effort and resources
- Multi-professional and multisite working
- Teamwork and collaboration
- Flexibility and dynamism
- Evolution and change

MCNs need to be effectively led. A key enabler was network leadership by enthusiastic clinicians, with a clear vision for an effective and equitable system of care, and a commitment to collaboration demonstrated by leadership being shared between specialists and general practitioners. (Gorman et al 2003 also reported that it was essential to appoint a lead clinician and manager with overall responsibility for operation of the network and a lead nurse).

However, Managed Clinical Networks take time to develop. In one Scottish example for cardiac services the network took a full two years to set up and become accepted into local structures (Hamilton et al 2005).

NHS Scotland has published a detailed guide to implementation of MCNs.3 In 2003, the NHS Service Delivery and Organisation published key lessons for those establishing MCNs these included:

- Have a clear mission statement
- Have unambiguous rules of engagement
- Ensure stakeholders gain ownership of the network
- Consider formalised agreements to facilitate ownership
- Actively engage respected professional leaders
- Avoid network capture by a professional elite or dominant organisation
- Ensure that professionals allow network managers to manage and govern their activities.

The effectiveness of managed clinical networks has been examined in a comprehensive research project for the National Institute for Health Research that describes successes and failures. A number of correlates with high performance were found (Box 2).

Box 2: Correlates of high performance in MCNs (Ferlie et al 2009)

- Clear national policy framework with resources/targets
- Local customisation
- Strong research and evidence base
- Service improvement agenda
- Only one sector – no private or social care involvement
- Highly graded staff with a large support team (so high staffing costs)
- Strong clinician involvement

---

- Stability in composition
- Mixed ‘soft’ and ‘hard’ approaches to managing the network
- Strong influence built from expertise, advice and boundary spanning

Although this is a proven model for health services provision there are no current examples of Managed Clinical Networks in occupational health.

**Area Collaborative Service**

An area collaborative service is a single provider unit hosted by one Trust that serves a large number of partners. It is usually formed through the merger of a number of existing provider units.

Area collaborative services were successfully established in the NHS in Avon in 2001 and more recently in Cheshire. These larger services support a number of NHS organisations that have come together to establish a better service for all stakeholders. Features of both services can be found in boxes 3 and 4.

**Box 3: Area collaborative service – Cheshire Occupational Health Service**

The Cheshire Occupational Health Service was established during 2008 as a collaborative service. The Service is hosted by Mid Cheshire Hospitals Foundation Trust and serves East Cheshire NHS Trust, and two PCTs. COHS now also provides the OH service to The Christie NHS Foundation Trust. The team of a 0.6 WTE consultant in occupational medicine, five specialist OH nurses, and colleagues, provide the OH support for about 12,500 NHS staff.

A detailed review of occupational health was commissioned in September 2007. After designing the new service the Trusts entered a formal (consultation) process to populate the new, unified service. Staff representatives were consulted. Managers and Executives from each of the Trusts were involved in considering the future need and the model pursued.

Three overarching strategic objectives have been identified:
- Deliver a world class service meeting business needs.
- Provide a sustainable service aligned to the strategic direction of the collaborative partners
- Drive the health & wellbeing agenda for collaborative and partner organisations.

Consultation with key stakeholders at the outset was crucial because COHS were keen not to present a ‘fait accompli’ but wanted the stakeholders to actually have a say in shaping the new service. A Cheshire Occupational Health Service (COHS) Steering Group was established, chaired by the Chief Executive and with executives and leaders from other Trusts. The Steering Group met for the first time in 2009 and continues to review performance on a quarterly basis. In addition a Stakeholder Group was established in 2009 with a broader range of representatives from the partner organisations to provide feedback and guidance for the service.

COHS have made sure that occupational health has become an integral part of broader wellbeing strategies in each of the partner organisations. There is coherent plan to improve the health of the workforce and COHS works closely with HR, managers, and employee representatives. Following the re-launch the team’s reputation has quickly become second to none winning the host Trust’s Team of the Year award in its first year.
Box 4: Area collaborative service – Avon Partnership

Avon Partnership Occupational Health Service (APOHS)

Avon Partnership Occupational Health Service has 2.6 WTE consultants in occupational medicine and 8 specialist OH nurses that together with colleagues (in administration, general nursing, physiotherapy and counselling) support about 25,000 NHS staff and a range of local external customers.

It was formed in October 2001, bringing together the Occupational Health Departments of University Hospitals Bristol NHS Foundation Trust, North Bristol Trust and Weston Area Health NHS Trust.

The stated aims were:
• To provide a high quality, cost effective occupational health support to staff;
• To achieve a more equitable core standard of service across the local NHS;
• To improve the access of occupational health services to staff;
• To improve performance in the management of disability of staff; and,
• To create a centre of excellence derived from high quality clinical leadership and governance, education, research into and development of local occupational health services.

Critical enablers for the formation of the Partnership were:
• Strong clinical leadership
• Top level buy in
• Support OH doctors, nurses and service managers
• Expert independent facilitation

The experience of the Partnership is that delivering the vision takes time. The Partnership recently changed its commissioning arrangements to a per capita fee and has recently completed the necessary service level agreements. The Partnership is still trying to implement an information system that provides more effective data sharing across venues.

Characteristics of these examples are aspirational leadership, partnership working with Trusts, employment of a critical mass of multi-disciplinary expertise that can deliver cost-effective quality services. Although it takes time and commitment to establish such services, the outcome is a well-perceived service providing job satisfaction for clinicians.

Another example of a hosted collaborative/partnership service may be seen in Scotland. NHS Scotland employs about 160,000 staff (more than most English SHA regions but less
than the NHS in either the North West or London). The OH service is provided by a few providers serving either a single region with a large NHS workforce (eg Greater Glasgow) or group of regions with smaller workforces.

The strengths and weaknesses of Area Combined Services can be seen in box 5.

**Box 5: Strengths and Weaknesses of Area Combined Services**

<table>
<thead>
<tr>
<th>Area Combined Service</th>
<th>Strengths (internal)</th>
<th>Weaknesses (internal)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Can be matched to area commissioning networks</td>
<td>Ownership is dependent on excellent stakeholder engagement</td>
</tr>
<tr>
<td></td>
<td>Enable a reputation for excellent quality service</td>
<td>OH staff and patients risk feeling separate to partner Trusts</td>
</tr>
<tr>
<td></td>
<td>Simple management structure</td>
<td>Geographical area might be very large to provide critical mass in rural areas</td>
</tr>
<tr>
<td></td>
<td>Common IT (once in place) and good internal communications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consistent services and prices over a large geographical area</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Easy to offer and agree new service lines with commissioners</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enables an effective skills mix and subspecialisation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continuity of OH care as NHS staff move around regional Trusts (eg trainees)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enables work on strategic goals which require collaborative effort</td>
<td></td>
</tr>
</tbody>
</table>

**Workforce Issues**

There are three key issues that must be addressed going forward to ensure the capacity and capability of the occupational health workforce:

- Recruitment and retention of specialist staff
- Appropriate skill mix and use of resources
- Training and development of the workforce

Reconfiguration of services and innovative use of technology is likely to lead to the development of new ways of working, which will call into question the sustainability of conventional workforce models and skill sets. There will be opportunities to redesign training curricula and to take advantage of moves to include interprofessional training into the training of specialists of the future. Occupational health services must position themselves to take advantage of such opportunities. Large occupational health services will have the capacity and expertise to train doctors, nurses and other disciplines and will be able to attract funding to do this. This will be the life blood of occupational health and will be essential to counter the predicted attrition rate of current specialists, given the age profile of the profession.
Next Steps

As the first step, it is recommended that this paper is discussed by local networks of Occupational Health leaders and HR Directors to consider the scope for improvement in the delivery of occupational health and wellbeing services through the consolidation of local services.

Evidence suggests that early dialogue between local HR leaders and OH leaders is critical in establishing rapport and a shared vision and in developing a project initiation plan.

A number of themes have emerged that are found in all the successful configurations described in this report:

**Leadership:** It is imperative to have strong clinical and service leadership to reconfigure service. This should be underpinned by support from the CEOs and Boards.

**Engagement:** Successful services engage stakeholders. [Staff involvement is included in the SEQOHS standards that were accepted as a Boorman recommendation]. The necessity of top level commitment and engagement from Chief Executives, Medical Directors and Nursing Directors, as well as Directors of Workforce, should be self evident. However, engagement of Finance Directors should not be overlooked. OH service users (including staff representatives) must also be involved in developing OH services.

**Time:** It takes time to build a new service and for it to bed in. Tenacity and patience are essential.

Lessons from service re-engineering and anecdotal reports to NHS Plus have identified the following challenges to change;

- Whilst many organisations recognise the need to reconfigure services, there is a lack of knowledge and experience in the system of the ‘how’
- Prioritisation of Occupational Health at a time of major structural change and significant financial restraint
- Differing levels of enthusiasm for change amongst organisations and professionals

The first step is to develop clarity of purpose. It is essential that the question “what’s in it for us?” can be answered. This can be achieved through an exploratory meeting or workshop. Facilitation support for such exploratory discussions is available free of charge during 2012 from NHS Plus. Contact wendy.coleman@nhs.net

Once clarity of purpose has been identified, the next step is to develop a **Project Initiation Document** which sets out the approach to the management of the consolidation project including governance, decisions, steering group membership, project objectives and major milestones.

An example Project Initiation Document is attached at Annex 1. Kind permission has been given by the Cheshire Occupational Health Collaborative Project to share their approach.

**Further support**

Further support can be obtained from Professor John Harrison, Dr Richard Preece, Andrew Gilbey and Keith Johnston at NHS Plus. NHS Plus promotes the benefits of good health at work and helps to build healthy and productive workforces.
The NHS Health at Work Network is a network of 150 NHS occupational health services dedicated to ensuring that the NHS has a healthy, motivated workforce that is able to provide the best possible patient care.  http://www.nhshealthatwork.co.uk/
# OCCUPATIONAL HEALTH COLLABORATIVE

## PROJECT INITIATION DOCUMENT

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Occupational Health Collaborative Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager</td>
<td>Jane Haire</td>
</tr>
<tr>
<td>Version:</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>1.1</td>
</tr>
<tr>
<td>Release Date:</td>
<td>15th September 2011</td>
</tr>
<tr>
<td></td>
<td>Amended 3rd October 2011</td>
</tr>
<tr>
<td>Author:</td>
<td>Jane Haire, Associate Director – HR Projects</td>
</tr>
<tr>
<td>Version changes</td>
<td>Changes made in this version to Project Benefits. Added “Sustainability for NHS organisations with the ability to deliver regional training”</td>
</tr>
</tbody>
</table>

## Purpose of this document

To establish the Occupational Health Collaborative Project for Cheshire and Wirral QIPP footprint, detailing the approach to the management of the project, governance, decisions, steering group membership, project objectives and major milestones.

## Document History

<table>
<thead>
<tr>
<th>Revision date</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Approvals

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally Campbell</td>
<td>Project Director Director of HR &amp; OD – Cheshire HR Service</td>
<td>Sept 2011</td>
<td>Approved by email</td>
</tr>
</tbody>
</table>

## DISTRIBUTION

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheshire HR Service</td>
<td>Jane Haire</td>
<td>Associate Director – HR Projects</td>
</tr>
<tr>
<td>NHS North West</td>
<td>Libby Sedgley</td>
<td>OH Programme Manager</td>
</tr>
<tr>
<td>5 Boroughs Partnership NHS Foundation Trust</td>
<td>Tracy Hill</td>
<td>HR &amp; OD Director</td>
</tr>
<tr>
<td>Cheshire &amp; Wirral Partnership Foundation Trust</td>
<td>Roger Nielsen</td>
<td>HR Director</td>
</tr>
<tr>
<td>Countess of Chester</td>
<td>Susan Young</td>
<td>HR Director</td>
</tr>
<tr>
<td>East Cheshire Hospital NHS Trust/Cheshire HR Service</td>
<td>Sally Campbell</td>
<td>HR Director</td>
</tr>
<tr>
<td>Mid Cheshire Foundation Trust</td>
<td>Rachel Alcock</td>
<td>HR Director</td>
</tr>
<tr>
<td>Warrington &amp; Halton Hospitals Foundation Trust</td>
<td>Sheila Samuels</td>
<td>HR Director</td>
</tr>
<tr>
<td>Wirral University Hospitals Foundation Trust</td>
<td>Sue Green</td>
<td>HR Director</td>
</tr>
</tbody>
</table>

...
1. **Introduction**

In 2010 NHS North West commissioned a review of Occupational Health and related services for the NHS workforce. This review identified substantial differences in the services offered to staff and has prompted organisations to work together to explore how services could develop to meet the changing demands of our customers in a way that provides a sustainable, flexible, cost effective and fit for purpose service. Ultimately better occupational health services should lead to improved staff health, attendance and therefore productivity.

Within Cheshire and Wirral a number of the HR Directors and Occupational Health professionals have agreed to work together on a feasibility study to consider how a larger collaborative service could work. We already have some strong occupational health services across the area and want to build on this to create even stronger sustainable services, which could potentially be through a collaborative approach.

2. **Project Details**

**Key Deliverables of the Project**

To undertake a review of Occupational Health Services (OH) in Cheshire and Wirral and recommend a new service delivery model that provides efficiencies and improves services to staff health, attendance and workforce productivity across partner organisations. The aims for a new collaborative service will be to provide high performing quality, cost effective, equitable and accessible occupational health services.

**Project Objectives**

1. To understand the range of Occupational Health services, including all sub-specialties within participating organisations across the Cheshire and Wirral NHS footprint.
2. To gather information on models of delivery for OH services in other areas and utilise these to inform proposals;
3. To propose a collaborative working model which best supports the needs of the participating organisations;
4. To outline options for change (including costs, risks and benefits) and recommend a preferred option;
5. To make recommendations for a way forward (e.g. high level implementation).

**Project Benefits**

A number of strategic and service level benefits are perceived of a collaborative service. At strategic level these include:

- Delivery of a wide range of high quality staff health and wellbeing services that are provided to nationally specified standards (SEQOHS), fully aligned to the public health priorities and local wellbeing strategies and meet the Boorman Standards.
- Supporting the delivery of safe, effective and efficient patient care through promoting and protecting the health of staff through the provision of effective and efficient services.
- Support improved and more consistent performance on staff health and well-being, staff satisfaction, reduced costs of sickness absence and contribute to QIPP savings
- Be well positioned to meet CQC essential quality and safety levels and registration requirements
- Sustainability for NHS providers with the ability to deliver regional training
At a service level the perceived benefits include:

- Delivery of high volume services in the right place, by the right people making the best use of technology
- Increased utilisation of combined skills and knowledge
- Fully utilising a wide range of skill mix freeing up specialist staff to tackle more complex cases
- Greater sustainability/resilience and business continuity
- Reduced service delivery costs
- Potential for income generation
- Greater flexibility to deal with different levels of demand
- Better use of premises and IT systems

**Project Scope**

The project will cover all Occupational Health services as identified by the participating organisations as follows:

- 5 Boroughs Partnership NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Countess of Chester NHS Foundation Trust
- East Cheshire Hospital NHS Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust

**Project Funding**

NHS North West has provided funding £40,000 for the project. Opportunities for additional funding will be explored during the course of the project.

3. **Project Relationships & Governance**

**Project Governance**

The Project Steering Group will report on progress to the NHS North West.

**Project Sponsor**

The project will be sponsored by the Director of HR, Cheshire HR Service.

**Project Manager**

The project will be managed by the Associate Director – HR Projects, Cheshire HR Service and will report to the Director of HR, Cheshire HR Service.

**Project Steering Group**

The Project Steering Group will meet monthly and core membership will be as follows:

- HR Director, Countess of Chester NHS Foundation Trust (Steering Group Chair)
- HR Director, Cheshire HR Service (Project Director)
- Associate Director – HR Projects (Project Manager)
- HR Director, 5 Boroughs Partnership NHS Foundation Trust
- HR Director, Cheshire and Wirral Partnership NHS Foundation Trust
Annex 1 - Project Initiation Document

- HR Director, East Cheshire Hospital NHS Trust
- HR Director, Mid Cheshire Hospitals NHS Foundation Trust
- HR Director, Warrington and Halton Hospitals NHS Foundation Trust
- HR Director, Wirral University Teaching Hospital NHS Foundation Trust

The level of external occupational health expertise will be agreed at the first Steering Group meeting.

Additional Project Input

- Expert IT and finance input will be required during the project.
- Expert occupational health input will be required during the project.

Project Assumptions

- All participating Trusts will be asked to provide factual information on range of services, developments and current costs.
- All participating Trusts will be asked to treat all shared information as confidential unless expressly stated.
- All participating Trusts to share financial aspirations for the project.
- All participating Trusts will be involved in the development/approval of the preferred option to present to Trust Boards for decision.

Risk and Issue Management

Project risks will be managed by the Project Steering Group. Project Issues will be managed by the Project Manager unless escalation is required to the Project Director/Project Steering Group.

Communication Plan

A communication plan has been developed to ensure that key stakeholders are kept up to date with the development of the project, and a summary of this is shown below.

- Inform key stakeholders on progress of the project.
- Engage Occupational Health Managers in the scoping of current provision and the design of the OH collaborative proposal.
- Meet with Occupational Health teams to discuss the project and provide opportunity for discussion.
- Update reports to North West SHA.
- Present the project to the wider Occupational Health Managers Network to gain views from wider OH community.
- Prepare formal report to the Steering Group for Trust Boards.

---

Phase 1: Project Initiation (August 2011)
Phase 2: Project Scoping (September - October 2011)
Phase 3: Design/Options Appraisal (October - November 2011)
Phase 4: Proposal (December - January 2012)
**Major Milestones**

The high level project plan has been developed to show detailed task groups for the project. The plan will be managed by the Project Manager, progress reported to the Project Steering Group and issues/concerns escalated to the Project Director. It does not cover an implementation plan. This will be written if approval for a collaborative is given. A summary of the project plan is shown below:

<table>
<thead>
<tr>
<th>DATE</th>
<th>MILESTONE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHASE 1 – PROJECT INITIATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid August 2011</td>
<td>Confirm participating organisations involvement</td>
<td>Complete</td>
</tr>
<tr>
<td>Mid September</td>
<td>Project Established</td>
<td>Awaiting</td>
</tr>
<tr>
<td></td>
<td>• Set up monthly steering group meetings</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>• Project initiation documentation approved</td>
<td>Awaiting</td>
</tr>
<tr>
<td></td>
<td>• Outline project plan agreed</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>• Project deadlines agreed</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>• Outline communication plan written</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>• First communication briefing issued</td>
<td></td>
</tr>
<tr>
<td><strong>PHASE 2 – SCOPING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>September – October 2011</td>
<td>Collect detailed information from OH Departments</td>
<td>Commenced</td>
</tr>
<tr>
<td></td>
<td>• Financial details of current provision</td>
<td>Commenced</td>
</tr>
<tr>
<td></td>
<td>• Review of other OH services models</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identify OH service standards and benchmark</td>
<td></td>
</tr>
<tr>
<td></td>
<td>participating organisations against these</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Involve relevant OH staff in scoping out their</td>
<td></td>
</tr>
<tr>
<td></td>
<td>current services, SWOT etc – workshops etc</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Undertake IT scoping</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bid for additional SHA funding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Attend OH Managers networking meeting in Cheshire and Merseyside</td>
<td></td>
</tr>
<tr>
<td><strong>PHASE 3 – DESIGN/OPTIONS APPRAISAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>October – November 2011</td>
<td>Development of possible options / Design workshops</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Shortlist of options identified and tested</td>
<td></td>
</tr>
<tr>
<td></td>
<td>amongst participating organisations and expert</td>
<td></td>
</tr>
<tr>
<td></td>
<td>input</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Preferred option recommended to Project</td>
<td></td>
</tr>
<tr>
<td></td>
<td>steering group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Detailed preferred option prepared for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>presentation to organisations via HR Directors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(service provision model, costs/structures,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>profit and risk sharing, governance)</td>
<td></td>
</tr>
<tr>
<td><strong>PHASE 4 – PROPOSAL AND PROJECT SIGN OFF</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>December - January 2012</td>
<td>Project signed off by Steering Group and if</td>
<td></td>
</tr>
<tr>
<td></td>
<td>applicable moved to new Project Implementation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project.</td>
<td></td>
</tr>
</tbody>
</table>