

Growing a healthier tomorrow

Looking after the health and wellbeing of our people by growing NHS occupational health services together.

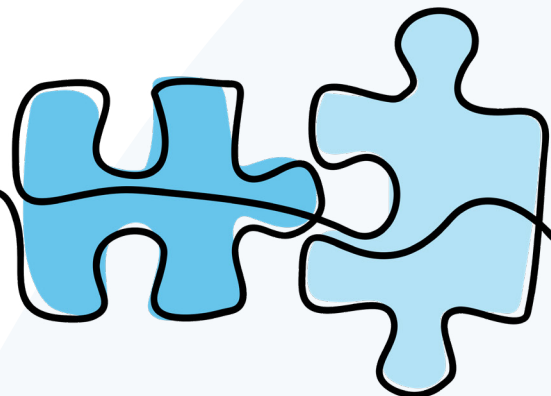
People Promise



Acknowledgements

We would like to thank occupational health (OH) colleagues and their service users for their support and involvement, as well as colleagues from the wider health sector, for their willingness to share their experiences and insight with a view to making change. Without them, this discussion document would not have been possible.

We would also like to thank Dr Steve Boorman, as the lead expert in this discussion document, and the individuals and organisations detailed in Appendix 1 for sharing expertise to develop the evidence presented here to begin the journey of co-design for the Growing Occupational Health programme.



Summary

If healthcare staff are to provide excellent care to patients, they need to receive excellent support themselves. Occupational health (OH) and health and wellbeing (HWB) play an important role in making sure staff get the support they need to do their jobs and to flourish in them.

In 2021, in response to the People Plan, NHS England and Improvement launched the Growing OH programme, to develop and empower NHS-delivered OH services to be integrated, strategic, and proactive organisational partners.

The programme started with a review of occupational health in the NHS, which NHS England and Improvement commissioned Dr Steven Boorman CBE to carry out. The initial research for this discussion document, with OH colleagues and experts in the field, highlighted ten key areas for service improvement shown in the visual below. These are presented as discussion points that we wish to explore with our stakeholders and the OH community to further develop and refine the Growing OH programme, collaboratively.

Proposed Vision

...supporting the health and wellbeing of our NHS people by growing and developing NHS Occupational Health services and our OH people to reach their full potential as strategic, integrated, and proactive organisational partners.

Proposed actions for discussion

...Grow a strategic and trusted OH voice

...enable OH to be a trusted, strategic, and integrated organisational partner

...Grow our OH services

...support system wide service innovation and improvement in OH?

...enable equality of access to services that meet the needs of all our diverse NHS people

...increase the focus on proactive and preventative care?

...design and embrace future models of multi-disciplinary service delivery

...enhance service standards, quality, measurement, and consistency?

...better use technology effectively, to support service delivery

...Grow our OH people

...empower OH leadership, service improvement and innovation

...increase OH workforce capacity and capability?

...Grow from the pandemic

...empower OH to both strategically and operationally support recovery from the pandemic?

... enable a co-design, service improvement, and learning-focused approach?

...and what are we missing?

The core principle of Growing OH is to work in partnership with OH service professionals and other stakeholders, putting them in the driving seat to create empowered, future-facing, and proactive services that meet the current and evolving needs of the NHS workforce.

The programme will run during the 2021/22 financial year, gathering, and sharing learning. The resulting findings – divided into 'easy fixes' and 'ideas to develop and grow' – will inform the case for future investment and service transformation.

This discussion document outlines the starting point for our journey. We will be seeking stakeholders to help us further shape the vision and drivers for improvement from the Growing OH programme.

Find out more and get involved with shaping this programme of work collaboratively at:
www.nhshealthatwork.co.uk/growingoh.asp



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Foreword

This discussion document sets out the findings from a much-needed review of occupational health in the NHS, which we asked Dr Steven Boorman CBE to carry out in early 2021.

It has two key aims: to encourage occupational health (OH) services to participate in thinking through new ways of meeting our future needs and to stimulate ideas and discussion to co-design a new model for the service, in a programme called Growing OH.

The report sets out insights into where we are now and is designed to be used as a springboard to help OH professionals, along with boards, managers, and those who use their services, to explore ideas to shape the future OH.

Dr Boorman authored the 2009 Boorman review – still in many ways the definitive document for OH professionals today. Since then, much progress has been made in OH provision within the NHS. But we know we need to do more, and the pandemic has brought that need into sharp relief. So, once again, we sought Steve's input to gain a snapshot of OH in the NHS today and help us identify what needs to be done to maintain the focus on 'looking after our people', as set out in the People Plan.

This work is built on a strong platform in that we have already begun engaging with the occupational health community, who are supportive of this initiative. The report itself is designed to support our people – in OH and beyond – along this journey.

Part one of the report sets the ambitions for the Growing OH programme, along with the context and current state of play in key areas of service improvement. Part two sets out the evidence around key themes highlighted through the programme, including where we have learnt that improvements are needed, both in the immediate future and the longer term.

The report is the start of a process designed to be used by colleagues in OH and beyond, to inform and stimulate discussion, to help us reflect on the current situation, and to open up to possibilities of what things could be like in future, with the right investment.

You can find out more and get involved with shaping this programme of work collaboratively with us at:

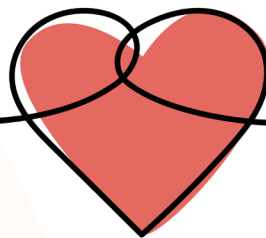
www.nhshealthatwork.co.uk/GrowingOH.asp

John Drew

Director of Staff Engagement and Experience
NHS England and NHS Improvement

Part one

Setting the scene



We are
compassionate
and **inclusive**



We are
safe and
healthy

Introduction

This discussion document is the starting point on our journey to grow occupational health (OH) services. This introduction sets out the case for investing in OH and explains how ideas about wellbeing have changed – especially since the experience of responding to the pandemic.

If healthcare staff are to provide excellent care to patients, they need to receive excellent support themselves. Where staff do not believe that their organisations care for them, a range of problems can arise – including not being proactive in asking for help, increased sickness, as well as difficulties recruiting and retaining staff. Occupational health (OH) and health and wellbeing (HWB) play an important role in making sure staff get the support they need to do their jobs and to flourish in them.

This is particularly the case in the NHS, where many staff work in physically and psychologically challenging conditions – and never more so than during the COVID-19 pandemic. This period has seen many NHS organisations respond with empathy and agility, with OH teams developing innovative ways to support their colleagues. As we move towards the recovery phase, there is a great need to build on this focus and momentum, to ensure a healthy, sustainable workforce going forward.

The work shared in this discussion document is a key strand of the national NHS England and Improvement health and wellbeing programme for NHS staff, which includes statements around the need to:

- ensure Wellbeing Guardians and boards are supported and champion health and wellbeing consistently within organisations
- equip line managers and teams with the tools they need to take ownership of health and wellbeing and that supportive, compassionate, health and wellbeing conversations take place routinely
- continue to deploy evidence-based interventions on mental health that staff can access rapidly through mental health hubs; and have a focus on occupational health becoming an integral part of a preventive approach.

The case for investing in OH

The original recommendations within the 2009 NHS Health and Wellbeing Report into improving the wellbeing of the health workforce, led by Dr Boorman, are yet to be fully realised. This is despite highlighting the clear evidence that better employee health is associated with improved organisational efficiency, improved performance and, most importantly, improved patient outcomes.

NHS England and Improvement have been working with Dr Steve Boorman and our national strategic partners to set out the case for investing in our OH services, why this is so important and what change is needed. The overall aim is for OH services to become integrated, strategic organisational partners that are empowered to improve the HWB of our NHS people.

New perceptions of health and wellbeing

The pandemic has changed how we perceive health and wellbeing. It has placed greater emphasis on how caring for our NHS people enables them to care for others. It has also enabled our OH colleagues to 'step up' and rise to the challenge of supporting the health and wellbeing needs of our NHS people under extremely challenging conditions. But this challenge has also exposed how these services are often reactive and unable to reach their full potential in supporting the health and wellbeing of our people.

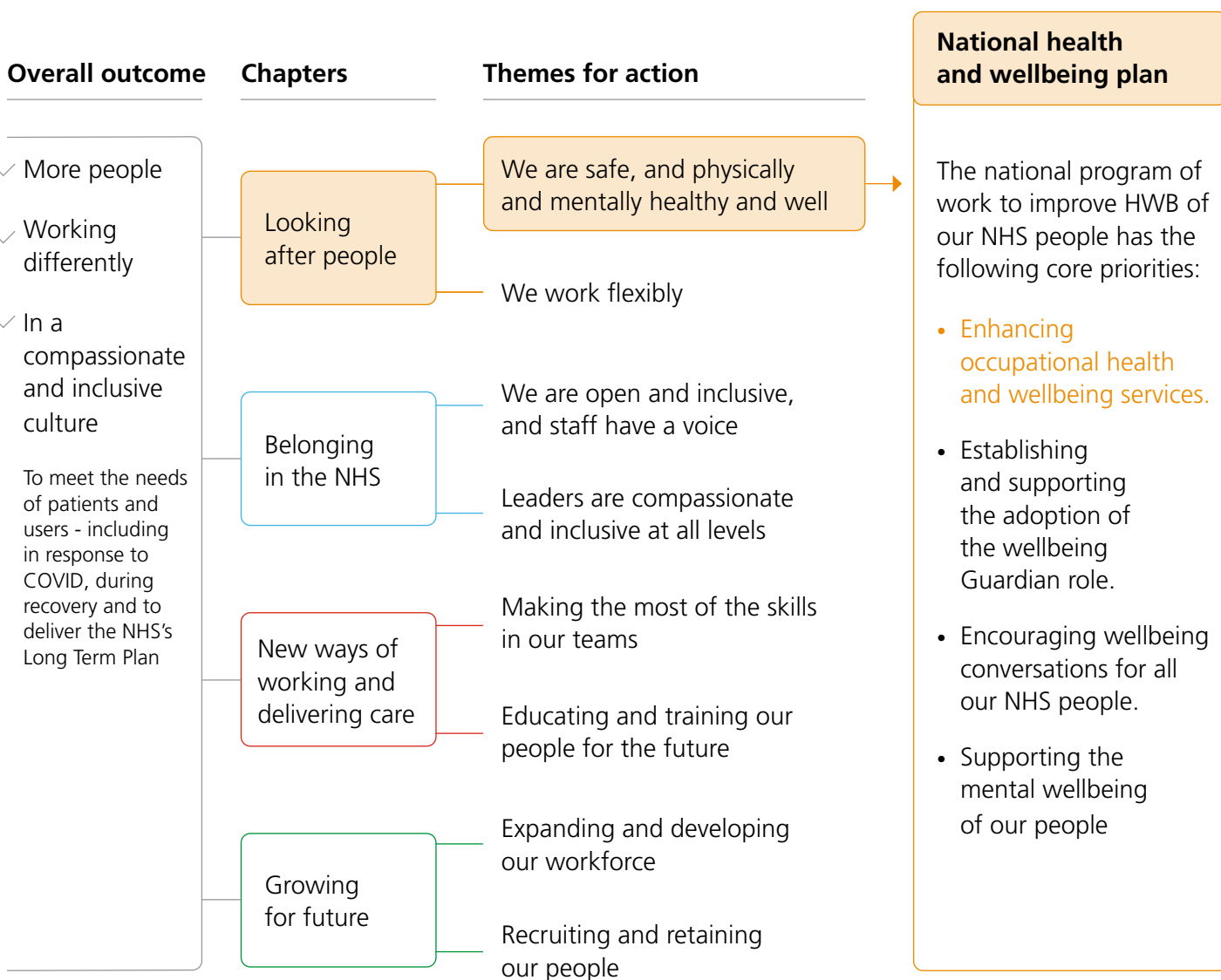
Recent co-design work with a diversity of stakeholders to evolve the NHS Health and Wellbeing Framework, recognised the need to move away from a culture of managing sickness absence. This is a reactive approach that often comes too late and can lead to presenteeism. Instead, we need to create a culture of wellbeing that proactively focuses on prevention and culture change to support the wellbeing needs of our NHS people. The NHS People Plan recognises the importance of creating a culture of wellbeing and OH is a vital partner to achieve this.

Developing OH through co-design

Figure 1, below, sets out how the Growing OH programme is designed to develop and empower NHS-delivered OH services to reach their full potential as integrated, strategic, and proactive organisational partners, linking to the NHS People Plan. There are four chapters within the People Plan and Growing OH sits within the 'looking after our people' chapter and 'we are safe, physically and mentally healthy, and well' theme for action.

Figure 1: The Growing OH programme: overview

Supporting the NHS People Plan 2021-22



The Growing OH programme was designed with the leading support of Dr Boorman and the wider support from our strategic partners including: the Faculty of Occupational Medicine, Society of Occupational Medicine, NHS Health at Work Network (formerly NHS Plus), NHS Health and Wellbeing Expert Advisory Board, Social Partnership Forum members, the Council for Work and Health and through a variety of stakeholder engagement mechanisms within the national Health and Wellbeing Programme.

The programme will run during the 2021/22 financial year, gathering and sharing learning. The resulting findings will inform the case for future investment and service transformation.

About this discussion document

Dr Steve Boorman was commissioned by the national health and wellbeing team within the People Directorate of NHS England and Improvement to consider current OH services and identify opportunities for supporting and developing them in future. The document sets out areas for discussion about how NHS leaders might deliver high quality OH and health and wellbeing support for their staff – based on engagement with key stakeholders within and outside the NHS.

This discussion document provides the context for the starting point of this journey and as a springboard for discussion as we move forward into engagement, co-design, and co-delivery with our OH colleagues. It is intended to be read by stakeholders to provide context when engaging with the Growing OH programme of work.

2. Context

This section sets out how OH and health and wellbeing have been viewed in the NHS in recent years. It describes the role of OH in the COVID-19 pandemic and the resulting increased awareness of health and wellbeing among NHS staff. Finally, it sets out the growing evidence of the benefits of OH.

In many NHS organisations, OH is viewed as a 'breakdown service', an overhead or a backroom function. The past decade has seen reduced provision with NHS organisations struggling to control costs. Services have been driven by local need and investment decisions, resulting in huge variation in provision and ability to shape a preventive approach.

Despite these challenges there have been good examples of proactive work, including immunisation, vaccination, and placement advice. But OH, has largely focussed on making sure employers meet their basic statutory duty of care. As a result, much OH work has been largely reactive – for example, with referrals from managers whose staff are sick and face the challenge of returning to physically and psychologically demanding work, or to support difficult decisions relating to people who are long-term sick. This has created a distorted perception of the OH function among some staff.

The pandemic

In many NHS organisations, the pandemic has increased visibility of the role and contribution of OH services. The value of strong, proactive OH has started to come to the fore, with organisations gaining a better understanding of the role of OH services in reducing risk and maintaining staff health and wellbeing.

During the pandemic, the challenge of maintaining NHS services amid extreme uncertainty and rapidly changing events has pushed OH into the spotlight. There has been a renewed focus within the NHS and, through media coverage, among the wider public on the health needs and potential vulnerability of our staff. Enhanced and more visible OH and clearer communication has changed the perception and increased the level of trust in OH services. Senior NHS leaders and managers have had far better contact and engagement with OH colleagues to meet the needs and duties of care to staff.

As we look ahead towards recovery from the pandemic, it is vital that we build on this level of stakeholder engagement and partnership working.

Health and wellbeing in the NHS

Health and wellbeing is not simply the absence of ill health or injury. Staff with good health and wellbeing feel their needs are understood and supported, including factors that may lie outside the workplace, such as relationship issues or financial worries in the family.

Before the pandemic there was much variation in maturity of health and wellbeing, even among trusts committed to improving staff experience in this field. But the pandemic has changed the landscape. To maintain patient care, trusts have needed to mobilise OH support in many key areas, including:

- immediate advice on appropriate personal protective equipment (PPE) and biosecurity
- placement advice for vulnerable staff, carers and people with possible symptoms or close exposure to the virus
- testing and interpreting results
- vaccination
- supporting the management of sick staff in less predictable environments
- supporting staff exposed regularly to distressing situations.

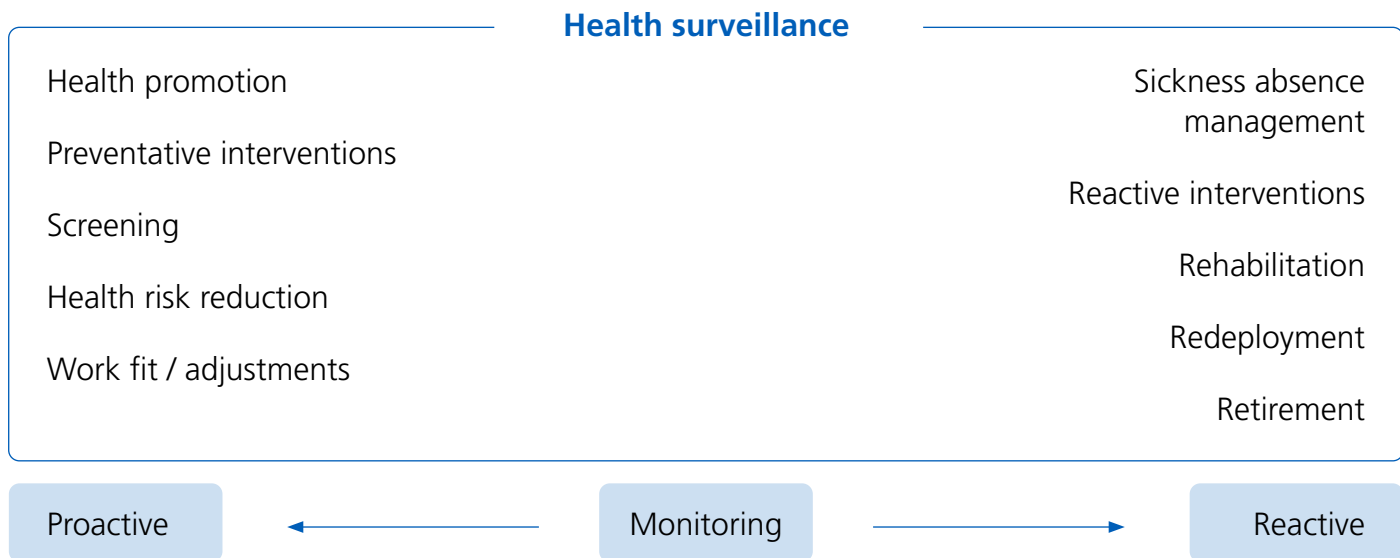
Throughout the pandemic, teams have drawn heavily on their own personal resilience and commitment to maintain exceptional patient care. In turn, the NHS has made supportive interventions more available for staff experiencing difficulties. This has partly involved reinforcing the reactive care that OH provides, but it has also included providing access to apps, helplines, and other resources to promote self- diagnosis and care.

This approach was right in the short term, but as a 'downstream' approach reacting to existing problems, it has contrasted with the NHS's strategic plan. Before the pandemic, the NHS recognised that 'prevention is better than cure' (as set out in '[prevention is better than cure](#)') and that service improvement was needed to enable a focus on upstream care, to build health.

Many large employers have recognised that a different approach to OH can reduce reliance on reactive, 'breakdown' measures. This has a positive return on investment not just in financial terms but in compliance with statute, moral duties and, particularly, staff recruitment and retention.

As Figure 2 shows, doing this requires the organisation to focus on developing approaches (shown on the left) as opposed to the dominant historic and current priorities (shown on the right).

Figure 2: Developing (proactive) approaches versus dominant (reactive) priorities



To be completely accurate, the OH service may provide advice about sickness absence management, to inform managers' actions and decisions.

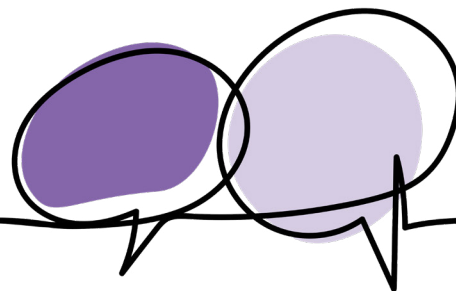
Beyond the workplace

The factors that influence people's health and wellbeing extend beyond the workplace, with social and external influences significantly impacting on people's ability cope. These might include family and carer responsibilities, social relationships, security, financial and other concerns. For this reason, it is important to consider how to support staff in these wider needs – for example, through provision such as financial awareness programmes and bereavement or relationship support.

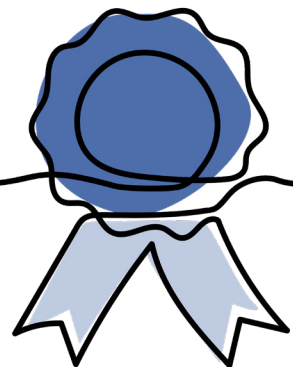
The return on investment for occupational health and wellbeing is well evidenced. For example, the Society of Occupational Medicine (SOM) has published a document called [Occupational Health; the Value Proposition](#). This provides a good basis to establish a business case, as do the resources referenced in the NHS Staff HWB Framework. A further, more recent, SOM Review also outlines the clear evidence base for good quality OH provision. Both reports are freely and easily available.

Part two

The evidence: key lines of enquiry



We each have
**a voice that
counts**



We are **recognised**
and **rewarded**

3. Putting OH at the heart of the NHS

This section explores a range of areas in which OH can move from the margins of the NHS to the centre. It looks at how OH colleagues can be integrated with other colleagues and the need to develop OH health leaders. It considers the benefits of existing networks and how to maximise their impact and how OH integrates into the broader context of wellbeing in the NHS.

OH services have often been seen as bolt-on 'corporate functions', often sitting as a subset of human resources teams. Many are physically housed away from the main operational elements of the organisation. Some OH services are also commissioned in, rather than delivered 'in house'. To ensure progress, we need to consider how we reposition these services both physically (addressed mainly in this section) and strategically (addressed mainly in Section 3) as essential to clinical delivery. This means integrating the service into the organisation they support and acknowledging them as core components of good care.

Ultimately, for OH to be acknowledged as an essential part of a successful organisation, it needs to be integrated into core operations rather than seen as a peripheral service. In other words, it needs to move from Figure 3 to Figure 4. Successful health and wellbeing workplace cultures are about establishing good OH as 'the way we do things round here'. So, this transition is an important one to consider and requires culture change.

Figure 3: NHS trusts and services with OH on the outside

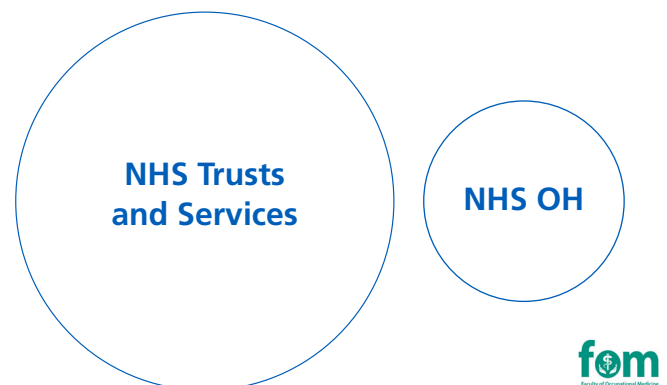
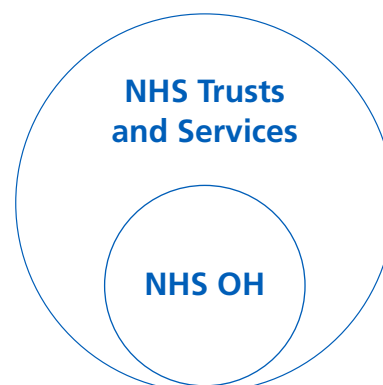


Figure 4: NHS trusts and services with OH on the inside



Integrating OH with other colleagues

The traditional reporting line for OH units is via the HR function. If this is the model of choice, it is important to strengthen links between those units and the clinical operational directorates (for example, formalising relationships with medical and nursing directors). However, it is also important to identify other key players, including [Wellbeing Guardians](#), [Freedom to Speak Up Guardians](#) and key development programme leaders, and to build relationships with them.

In-house and commissioned-in OH services

OH service delivery models vary across all our healthcare organisations. Many larger organisations employ their own dedicated OH functions, often providing services to neighbouring smaller organisations. Some medium-sized organisations have hybrid models that comprise a core team of OH professionals who commission in specific services from the private sector and other OH providers. Smaller organisations are more likely to commission in their OH services either from a neighbouring large NHS organisation or from the private sector.

So, we need to consider how a variety of delivery models can co-exist and meet the needs of our diversity of healthcare organisations.

Growing the specialist OH workforce

Today there are 98 specialist occupational physicians working in England's NHS hospital and community health services, compared with 172 in September 2009, a drop of nearly 50%. During that same period, the number of occupational medicine consultants has fallen by 34%. And in 2020 the Faculty of Occupational Medicine reported a fall of almost 30% in its number of registered specialist occupational physicians – from 710 to 510 in just five years.

These figures illustrate the trends in the specialist OH workforce in the NHS and beyond. These are due partly to demographic challenges, with older, more experienced workers retiring and insufficient investment in attracting and recruiting the staff needed to enable training. Meanwhile, the historic focus on cost control and reacting to need has reduced opportunities for NHS OH leaders to gain experience and expertise.

Exemplar organisations invest in training the next generation of care providers. Accredited specialists in the NHS are critical to delivering training and to the future of occupational medicine. But occupational medicine and nursing training remains a major challenge, with inadequate numbers coming through to meet future demand.

Current numbers of occupational medicine trainees are:

- in **England** approximately 42 specialist registrar/training posts, 32 NHS, 10 other organisations
- in **Scotland** numbers are smaller, 7 of 5 are in the NHS and 2 in other organisations
- in **defence services** 17–20.

OH, nursing training numbers are difficult to ascertain but about 1,000 NHS OH nurses are in organisations belonging to the NHS Health at Work Network, most having relied on their trusts to invest in their training.

Developing OH leaders

Traditionally, OH units have been led and managed by doctors (not always specialist consultants). However, this is not essential. There are many good examples of services that are well led and managed by people with nursing or other backgrounds. Where the service leader is not a specialist OH consultant, experienced NHS doctors in OH should be actively engaged in the leadership team and used to provide clinical governance and inform practice development.

Low-investment in training has led to an inability to effectively recruit across all disciplines working in OH. In other sectors, most service leaders are supported in getting broad OH experience and basic training requirements but are also invested in with significant leadership training (often to international MBA standards). This enables them to operate at a strategic level and to develop the trust and confidence of key operational leaders.

At present, this is rare in the NHS. If NHS organisations aspire to high-quality services, they need to recognise the value of investing in this area, including formally reviewing the training and education needs of staff beyond simple Continued Professional Development (CPD) requirements.

Several experienced OH leaders from the private sector are members of the NHS England and Improvement Health and Wellbeing Expert Advisory Board on a pro-bono basis and the NHS itself has examples of strong, experienced OH leaders, including the immediate past president of the Faculty of Occupational Medicine. But the NHS is not consistent or proactive in promoting the training and development of OH leadership.

NHS OH is a complex and difficult area and good leadership is essential to improve standards, so it may be helpful to engage with the Faculty of Medical Leadership and Management or other leadership support bodies including the Leadership and Lifelong Learning function within NHS England and Improvement to promote this area of work.

Given the scale, complexity and scope of the NHS (and the high cost and impact of employee ill health) it is perhaps surprising there is no national chief occupational health officer accountable for NHS staff OH support and care. This could be an OH specialist responsible for directly informing policy, direction and standards and help challenge local providers and drive strategic improvement.

By its very nature, the operation of the NHS enables (and in fact, needs) variation in local delivery. This is sharply polarised in the way OH is provided. One organisation that helps bring local providers together is the NHS Health at Work Network (originally known as NHS Plus).

The NHS Health at Work Network

This network was set up to establish common good practice and promote standards to support good OH practice – for example, through opportunities for mentoring and collaboration to lead service improvements. Membership includes about 100 NHS OH services. Some of these are often those within large, university teaching hospitals are excellent, with strong expert leadership: led by proactive, highly visible role models focusing on service quality and breadth of support to staff. Many have limited access to specialist support and operate in challenging clinical environments. [Find out more.](#)

Incorporating OH with health and wellbeing strategies

OH training does incorporate health promotion and wellbeing, but many OH practitioners lack experience in developing wellbeing programmes. Where other functions are involved, this area of work is often managed in silos. A strong programme must be systematic and joined up, with delivery from OH alongside colleagues from functions such as learning and development, human resources, organisational development and health and safety, as well as specialist providers, such as financial advice and employee assistance programmes.

Wellbeing programmes require a clear and agreed plan with clear evaluation frameworks – for example, Newcastle's Flourish programme and the system-wide enhanced HWB pilot currently funded and supported through a national programme coordinated by NHS England and Improvement.

It is important to be clear about desired outcomes, too whether health improvement, behaviour measures or staff engagement outcomes. If the different functions do not share this data with each other, it is hard to get a clear picture of need and then act before problems arise.

This is worth doing as well-structured health and wellbeing programmes tend to be widely communicated and staff regard them as a significant personal benefit and reinforcing the message that the employer cares and prioritises staff health and wellbeing.

Involving staff

Health and wellbeing programmes are rarely successful without strong staff involvement. So, it is important to adopt a systematic approach to using staff champion networks to establish and share priorities and learning, and to consider the service reputation carefully. This is an area that would benefit from communications expertise, with an openness to embrace innovation and technology.

Although app-based interventions are a useful start, they are not a panacea. However, technology can be used in other ways to widen staff access to timely, quality support - often difficult to manage in organisations with 24/7 operations. Equality demands that whatever shift or wherever in the organisation you work access to HWB support should be similar and timely to needs.

The NHS Staff HWB Framework

One important focus for wellbeing in the NHS has been the [NHS Staff HWB Framework](#) and its associated [diagnostic tool](#). The framework provides the basis for an ambitious, preventive strategy on HWB. Its 2021/22 planning guidance sets out the following three strategic priorities for HWB as shared earlier in the report:

- making sure organisations have a senior leader providing sponsorship and challenge for the work (in large organisations, fulfilled by a Wellbeing Guardian – typically a non-executive director)
- using Health and Wellbeing Conversations as a vehicle to help ensure that regular, supportive, conversations are held to check in and respond to issues of concern
- making sure staff have ready access to support, mainly by ensuring rapid access to mental health support and by integrating OH in a preventive HWB framework or management system. The framework is currently being refreshed through co-design with NHS health and wellbeing experts and stakeholders and is planned to be released in 2021.

The health and wellbeing of the people who work in the NHS, and care for others, has quite rightly been prioritised in a new way during the pandemic. We now need to maintain that focus and build on the good work and innovation that has taken place in response to the needs of our NHS people. This requires OH to be at the heart of the NHS, not at the periphery: driving this agenda forward and developing and embedding a more outward-looking, preventive approach as a strategic theme for organisations, linked to the engagement and retention of our people.

4. OH as an integrated strategic partner

This section considers how to better integrate OH as a strategic and integrated organisational partner. It looks at the potential for strategic OH and a business partnering model. It then talks about maximising the visibility and influence of OH at board level, supporting the role of the Wellbeing Guardian and developing leaders. It addresses the potential of OH as part of integrated system working and in influencing regulatory bodies

Before the pandemic, structured higher-level strategic engagement was relatively rare in NHS OH. However, during the COVID-19 crisis many NHS OH units have been required to step up and contribute actively to strategic debate and direction. There is a risk that these links will subside once the crisis abates. Nevertheless, the [NHS People Plan](#) for 2029/21 identifies staff health and wellbeing as a key priority – not least, through championing the Wellbeing Guardian role, which anchors this agenda at board level within organisations. OH has a key role to play at a strategic level to help maintain this focus.

OH as business partners

The HR profession has faced some of the difficulties experienced by OH. In response, they developed the HR business partner model, to encourage more proactive involvement working alongside operational colleagues. A similar role for OH could ensure that OH is better integrated within management and leadership, to enable strategic contribution.

This model is rare in NHS OH but would benefit from exploration as it moves OH professionals beyond traditional reporting lines and provides a potential vehicle for developing a stronger relationship with users and commissioners.

This role should not be limited to OH managers or consultants but should be available and contributed to by the whole OH teams. More complex or board-level engagement requires experienced staff, but less complex areas can serve as development opportunities for less experienced staff. If system-wide OH appointments are favoured it is important that linkages are formalised with the local OH business partners to enable two-way communication and intelligence.

Using the Wellbeing Guardian role

The development of the Wellbeing Guardian role enables a clear route for strategic engagement between OH and key leaders outside the traditional HR reporting line. This could play an important role in positioning OH as a critical part of organisational operations. For example, when teams are planning or building a new NHS service or facility, OH is rarely considered, yet good workplace design and organisation is critical to maintain staff health and wellbeing and it is usually far more expensive to retro-fit.

Showing Guardians what they could expect to see from a proactive, preventive OH service may help reinforce the role and profile of the service. OH could become an important lead indicator of health and wellbeing performance, rather than a service that helps organisations deal with lag indicators (typically sickness absence).

Incorporating OH in leadership training

Although it has recently been included in the General Medical Council medical training undergraduate requirements, OH and personal health and wellbeing is not mandated in basic training of other healthcare workers. Understanding the relationship between health and work is important to quality of care but also to personal protection.

OH and health and wellbeing are included in leadership and management training in many leading corporate organisations such as British Telecom (BT), British Petroleum (BP) and Royal Mail, where OH teams have worked with Learning and Development (L&D) colleagues to incorporate these elements in the core training.

In the NHS, leaders and managers already receive health and safety training. But usually this is focused on safety compliance and does not actively promote the competencies they need to support to their teams – which seems an area for intervention bearing in mind the high value as an NHS resource.

Leading by example

Research consistently confirms that line manager behaviour is a crucial factor in staff perception of care for their needs. Highly visible role modelling of positive and supportive behaviours by leaders and managers is essential in establishing a health-promoting culture.

In one example, the medical director at a hospital trust bravely shared their experience of needing immunosuppressive therapy and having to isolate during the first wave of COVID-19. This required new ways of working, including careful risk assessment and developing a very close relationship with her local occupational health unit. They speak positively about how the experience changed their understanding of the role of good OH. This is one example of how our leaders can support and 'role model' positive engagement with OH services. However, we need to consider how this can become 'the norm' rather than the exception.

OH visibility at board level

NHS OH provision is usually not regularly monitored or reported at board level. This means organisations are missing an opportunity to identify key staff health trends and prioritise resources or actions to address emerging needs. The pandemic has encouraged higher visibility of issues related to COVID-19, but we need to engage senior leadership with data and recommendations to continue to improve. The development of the wellbeing dashboard in Model Health System is an important step in providing a standard way to track performance at organisational level, including leading indicators.

Catering for integrated systems

The NHS is increasingly working in collaborative, integrated care systems (ICSs) and this will be formalised from April 2022 in line with the white paper. Systems working creates an opportunity to address disparities between how OH and other support services are provided at organisational level, and to create more sustainable models of provision. For example, some systems would likely benefit from services organised on a hub-and-spoke model, with regional specialist expertise supporting localised OH provision.

The development of ICSs also provides an opportunity to improve access to OH (particularly, for example, in primary care), with potential for services collaborating across an ICS, including improving provision into social care and partner organisations.

Influencing regulatory bodies

It is important to influence key regulatory bodies to ensure that all NHS people training includes occupational health and wellbeing. There already are good links with other bodies, such as the Faculty of Occupational Medicine and Society of Occupational Medicine, and organisations such as the British Medical Association, the Royal College of Nursing and the Council for Work and Health.

These could be strengthened and actively used to understand NHS staff needs and make sure that colleagues developing national OH policy and standards are working in partnership with regulators and relevant professional bodies to recognise the value that OH expertise brings to the NHS. This should also actively include the Health and Safety Executive, which is currently updating its [Health and Work Strategy](#).

OH colleagues should nurture these links as mutually beneficial two-way relationships with national policymakers in which each party supports the other. These activities will require dedicated time to release staff to do this work. This should be seen as an investment that will pay back many times over. (See also the NHS Health at Work Network, in Section 3).

The way health and wellbeing is measured and reported at board level, integrated into training, and aligned with requirements of regulators and professional bodies, needs to be reviewed and improved. This is key if health and wellbeing is to be established as an integral part of organisational strategy and performance.

5. Measurement, quality and performance

This section highlights the importance of measuring quality and performance to demonstrate the impact of the service by using data. It considers what to measure, record management systems, quality improvement standards, compliance and reporting to the board.

OH is a complex and poorly understood area and in some cases historical practices have left organisations accepting average or even poor standards, without good understanding of the benefits of excellence. This has sometimes contributed to the slow pace at which OH teams have changed and embraced new practice, with many departments largely unchanged over long periods. Improving performance requires good data and clear standards.

Using data

Data is important for three main purposes:

- to understand performance
- to analyse needs
- to enable improvement.

Traditionally, OH performance data has focused on easily measured activity data: for example, waiting times, or the number of appointments delivered or cases. However, this data can be hard to interpret and does not document value added or trends. Also, aggregation can hide small clusters of new issues that require action. It can be tempting to simply benchmark raw data of this nature between organisations. However, this can be misleading as local variations can underpin expected differences. What is more, driving target rates across different systems can promote adverse behaviours, such as increasing presenteeism.

For example, the new Wellbeing dashboard, available through the [Model Health System online analytics platform](#), sets out a balanced set of metrics to understand wellbeing more fully and could be better utilised, or expanded upon to consider an OH data set.

What to measure

A formal regular reporting methodology could include reporting on return on investment for key OH programmes, such as vaccination, health promotion and interventions. This type of reporting is often presented without giving clear sight of its impact. However, in this case it would be important to include impact measures that can be readily understood and communicated.

Examples might include 'The new approach to case management and return-to-work support enabled 100 nurses to return to work safely two weeks faster than previous benchmarks.' or 'The new early access physiotherapy service for our healthcare workers is saving between £2.50 and £5 for every £1 we invested in it.'

As NHS OH has had little coordination in how it is structured or what it consists of, the focus has been on 'having an OH intervention' rather than the quality or specifics of the intervention. Outcome measurement is inconsistent, and where participation rates are measured, they do not necessarily document how much of the need is being met or satisfied. So, quality standards should seek to do this.

Recording systems

It is usual practice for OH to use its own record systems and data recording, many using the bespoke OH platforms, such as eOPAS or Cohort. These platforms have often been designed around case scheduling and clinical record management and it takes time and expertise to use them for trend analysis or edge case reporting, to identify emerging clinical needs. They are also not always easy to integrate with other NHS data systems, such as the Electronic Staff Record (ESR).

So, it is important that OH has access to recording systems that enable analysis and understanding of the needs of the workforce and are not limited to activity recording. Delivering 500 appointments of a certain type can be useful for some areas to monitor success (if, for example, this relates 500 vaccination appointments or health surveillance activities out of a required 650). But knowing that 500 reports were generated does not tell us about how efficiently these were delivered or indeed whether they were necessary, added value or delivered a positive outcome.

Quality standards

Currently, nationally opinion suggests that, despite some gaps, the [Safe Effective Quality Occupational Health Services](#) (SEQOHS) is the best available.

More than 10 years ago, the NHS Health at Work Network (then NHS Plus) strengthened the standards for NHS providers with an additional NHS focused domain. Despite calls and agreement for many years (including in the [2009 Boorman review](#)) that all NHS OH providers have SEQOHS quality accreditation, this has not been mandated or enforced. So, internal and external providers can still deliver NHS OH without them, and many organisations have been 'in the process of applying' for prolonged periods.

Now is the time to ensure this is driven forwards as the SEQOHS process ensures review and documentation of processes and governance. Currently 100 or more NHS OH units are still 'working towards' SEQOHS.

If accreditation were mandated, any OH service struggling with the evidence requirements may need to project management support to speed up or complete their application.

In the People Plan, NHS England and Improvement recommended using the SEQOHS standards, but this has not been progressed during the pandemic and the proposal is under consideration for updating. This is a good opportunity for wider involvement across the NHS. At present, the standards cover process but do not determine the scope and nature of the service or its outcomes.

There are no clear, universal standards exist setting out what comprises a 'good' service, and further work is required in this area to fully understand and define what quality NHS OH services are.

Compliance

After appropriate standards have been agreed, the measurement framework used to demonstrate OH performance needs to check compliance levels with audit thresholds. An example of this is the 'handrail' standards for OH written reports, developed by North West Regional OH Partnership. Although they vary from one trust to the next, these standards have clearly established the organisational need for OH reports and monitor their consistent delivery.

Contracts and work plans will also encourage appropriately protected data sharing, to give organisations and teams a clear picture of good practice.

Reporting to the board

OH leaders could also prepare a lengthier annual 'state of the nation' report for the board. Reporting could relate not only to number of referrals but also opinion and evidence of outcomes, highlighting preventative measures taken.

Understandably, much focus has traditionally been devoted to measuring the downside of health and wellbeing, such as sickness absence or staff turnover attributed to ill health. NHS England and Improvement has been working already on improved leading indicators for example, in the Wellbeing Dashboard on Model Health System and learning may be taken from safety in documenting preventative actions and learning from 'near misses'.

Things to measure might include:

- Monitoring staff survey and pulse data to identify the number of staff reporting that they have had a wellbeing conversation
- contributions recorded to organisational policy improvement.

A balanced dashboard includes measures of staff HWB, engagement, satisfaction and perception of care is desirable to achieve. Measurements could be interrogated to ascertain whether they are measuring the desired outcomes (in other words, upstream preventive activity). This helps avoid too much attention being paid to sickness absence, which can drive targets that have undesirable consequences, such as presenteeism or plan to conceal adverse rates.

During the pandemic, some OH units have invested in specialist data-management staff to ensure reliable and efficient delivery. Many units would benefit from continuing this approach.

Good quality, timely and comparable data is needed before we can understand and improve OH provision and performance. The recent introduction of the Wellbeing Dashboard is a significant step in providing a more comprehensive and balanced HWB service across every NHS trust. Ideally, this data should be complemented by more detailed and consistent data on the range of services OH provides, including scale, responsiveness, and outcomes. Boards should consider this as key performance indicators (KPIs), alongside quality, operational and financial indicators.

6. Enabling a positive identity for OH

This section focuses on the importance of developing a positive look for OH services so that all our NHS people, including managers and leaders, recognise and value OH as a positive and proactive enabler of a health and wellbeing culture. It looks at ways of demonstrating and communicating success, working closely with colleagues in communications teams.

Reputation and trust are key issues for service users, commissioners and OH staff, and this needs to be explored in further detail as part of this programme of work. Anecdotally, over an extended period NHS OH has been perceived as a 'distressed purchase' or 'breakdown service', used when staff have become ill or are already underperforming in some respect.

We need to recognise that in many cases, concerns about the impact of OH support on career prospects have led to negative perceptions of being 'sent to OH' and mistrust as part of potential adverse consequence. For users, much contact has been restricted to periods of absence or poor performance. This has fuelled a perception of referral to OH as negative and a belief that OH is best avoided or, even, not to be trusted.

Meanwhile, commissioners have often viewed OH as an overhead cost and an easy target for cost reduction. During multiple efficiency-savings exercises and investment, OH has been eroded. This has had an impact on OH staff, who in many cases feel undervalued, under-resourced and forced to deliver transactional, reactive service.

So, increasing visibility of the value and positive impacts of good OH support is essential: to promote trust and confidence in OH and to improve staff recruitment and retention.

Refreshing the look of OH

For many NHS OH staff, the recent years have been hard and demoralising and many have become deskilled. Taking a tired OH workforce on the cultural change journey to reposition services will require a careful balance so that these scarce practitioners are re-engaged and motivated, as opposed to being labelled as 'the problem'. There may be some resistance or cynicism towards proposed changes so a clear and credible vision of the opportunity needs to be established to enable staff to progress along the traditional change curve.

Attracting talent to NHS OH is important and the opportunity for a new approach presents an opportunity to make working in NHS OH a career of choice for a wider group of multidisciplinary professionals than has often been the case. This is especially crucial in attracting and retaining the future OH leadership talent needed to deliver a refocused model.

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Communications and managing profile are a vital part of managing such a service improvement. Examples of innovation include [Newcastle's Flourish programme](#) and the [Oh, hello](#) approach being promoted in Cambridge trusts.

Effective communication is also valuable in establishing user trust and confidence and reducing the previous stigma of 'being sent to OH'. This also needs to be reflected in the experience offered to

NHS staff attending a good OH department. Investing in a clear vision of ambition for leading OH services and ambition for OH as a positive asset is key.

At the same time, any communications work can be used to highlight a genuinely stronger offer, otherwise it could come across as marketing without substance. The examples above encompass a wider and stronger proposition, delivered proactively supported by investment and sponsorship of the board and chief executive officer. However, we equally need to seek out and learn from similar case studies as part of this programme of work.

Demonstrating and communicating success

Often, information about OH has a focus on negative consequence (for example, sickness absence or harm). It is important that OH leaders make good links with communication and learning leaders. Successful communication requires repetition and reinforcement, using clear language and positive framing / narratives, focusing on key themes of prevention and care (while avoiding the implication that working in the NHS may be hazardous or high risk).

New ways of working

A new aspiration to have leading OH services requires embracing wider multi-disciplinary working and greater partnership working. It also requires local providers to agree clear route maps towards excellence, with clear milestones along the way.

Most corporate OH providers have documented and reviewed annual business plans. Among NHS providers, this is not the norm. However, the process of creating an annual plan requires stakeholder engagement on priorities and resources – valuable in its own right.

There is an opportunity to undertake careful needs analysis to consider what future OH services should be expected to provide.

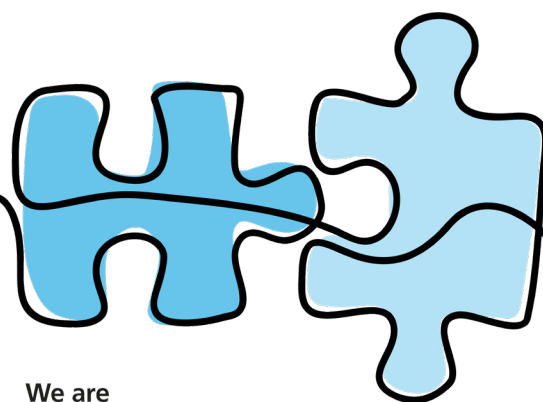
Raising awareness of OH

High quality services actively promote their profile internally but also externally. High profile conference contributions, application for awards, case studies published in OH and HR trade press and media inputs reinforce and raise profile both for existing employees and for the wider communities. This is important for attraction of new talent both in OH and the wider staff pipeline.

In summary, we need to explore ways to enhance the profile of OH to create a positive, preventative, and proactive image with which our people as service users, managers, leaders, and wider partners seek to engage in a constructive way.

Part three

Next steps



We are
a team

7. Adopting, innovating and improving service models

This section looks at ways of innovating and embracing new OH service models that release capacity and improve capability of services, maximising the use of technology. It highlights the importance of creating a long-term programme of change that enables rapid change on 'quick wins' while developing longer-term service and culture change.

The COVID-19 pandemic has changed the landscape for OH and required rapid adaptation to meet changing demand. At times, OH has been slow to embrace change, but COVID-19 has shown what OH is capable of, with rapid development to grow capacity, enable remote working and be more flexible in delivery. It is important not to let this new approach slip back to 'the old ways'.

OH colleagues will need to focus on the following areas to ensure that the learning is embedded, and momentum maintained with regard to new ways of working and delivering OH support and services:

- improved triage and consistent routing of OH casework
- developing audited casework pathways to document quality and ensure consistent compliance
- widening scope – for example, in actively encompassing diversity and inclusion and extending to key social determinants of ill health, such as relationship support and financial health
- remote consultation and advice – prioritising need and delivering remote support in the way that Babylon did for clinical systems
- adopting leading digital practices (for example, in health and wellbeing areas such as nutrition, mental health support and physical activity) to provide and engage users with rapid, flexible access to high quality information
- data mining and mapping to help identify emerging needs and publish best practice
- developing partnerships with leading technical organisations so that the NHS participates as a testbed, rather than following trends
- encouraging NHS OH practitioners to research and evaluate innovations and supporting them to publish in professional publications and major conference events – providing benefits to profile and reputation, but also making sure NHS is a leader in developing best practice rather than lagging behind the others

- reviewing opening hours so that staff working 24/7 can access OH support without changing normal shift patterns. This is challenging but has been possible in some NHS OH units during the crisis, such as the collaborative OH working partnership in the North West
- developing a more consultative model of OH delivery using a business-partner approach.

NHS OH needs to actively seek to innovate across all aspects of service delivery and should be encouraged to adopt an active continuous improvement methodology, with progress documented and reported – perhaps promoted by the NHS Health and Wellbeing Network.

Corporate organisations with outsourced OH provision often build this into the contract specification – either rewarding innovation financially or penalising poor progress. Internal organisations could be asked to include this within their agreed annual business plan.

Our improvement model

This review offers many suggestions for service improvement. Further consultation and discussion is needed at all levels – especially within OH itself, before leadership and management prioritise activity. Developing a long-term approach to support staff OH and health and wellbeing that is sustained over time and connects with a wider strategy, requires a sound foundation.

Healthy debate on priorities is a good opportunity to promote inclusion.

Each of these phases is described below.

1. Fix

6 - 12 months

This stage involves a two-fold approach:

- Making immediate fixes and taking advantage of 'quick-wins'. An evaluation strategy could be associated with this to learn from the impact of these areas of improvement.
- Undertaking a gap analysis in partnership with OH stakeholders to consider future models of service delivery versus the current state, and how to get there as part of a longer-term programme of service improvement. This could be achieved through co-design, considering best practice, opportunities and barriers to success.

2. Focus 1 - 2 years

- This stage could develop a medium to long-term plan for focused investment in growing OH services, based on findings from the previous stage.
- A programme of work and associated service improvement projects could be developed.
- Projects could be delivered in partnership with the OH community and stakeholders through co-design.
- An evaluation strategy could underpin this work, to demonstrate impact of this investment.

3. Grow 2 - 5 years

- The NHS has developed expertise in service transformation for patient care services. This methodology could also be used to transform OH services over a longer-term period of investment.
- This phase would continue scaling, spreading and sustaining learning from the previous phase, as well as seeking to grow all OH services to meet the needs of our evolving healthcare workforce.

Areas needing action

Based on discussions so far, we have identified some areas needing action. These are divided into two groups:

- Easy fixes. These are the changes that most stakeholders we have spoken to so far believe to be essential and needed urgently. To avoid delays and demonstrate our commitment to change, we are starting work on these areas during the first year of our programme.
- Ideas to develop and grow. These are some of the other areas that we're looking at doing, depending on what emerges from our consultation.

Easy fixes include:

- launching the Growing OH programme
- starting engagement and co-design work with our OH community and wider stakeholders, to further shape the Growing OH programme vision and areas for improvement and investment
- identifying, supporting and learning from pockets of service improvement in OH
- developing the leadership capability of our OH community, through a suite of development programmes
- starting to identify and share evidence-based practice in OH, to further shape the programme of work.

Ideas to discover and develop through co-design with stakeholders include:

- designing a blueprint for future-facing OH services and delivery models
- quality standards, including SEQOHS
- growing our OH workforce
- using technology more effectively
- measuring OH service outcomes and impact
- creating a trusted OH profile
- making OH a strategic and integrated organisational partner, with board-level influence
- determining the role of OH in proactively preventing ill health and creating a wellbeing culture for the future, balanced against supporting pandemic intervention and recovery today.

8. What next: help us shape the Growing OH programme

The NHS has recognised the primary importance of 'looking after our people', set out in the People Plan and the Planning Guidance for 2021/22. OH needs to be at the heart of this change, as a source of expertise and leadership in embedding a culture of health and wellbeing within every NHS organisation and system.

So the stage is set, and the time is right, for OH to move out of the shadows and change the common perception that it is a breakdown service, an overhead, or a backroom function. Instead, it can play a vital and proactive role in maintaining staff HWB, preventing problems from arising, and helping organisations identify and plan around staff need.

OH has lacked the visibility within the NHS to be involved in developing staff HWB management strategy. This has reduced its opportunity to be more proactive in preventing staff health issues and in challenging leaders to build a health-promoting working culture.

As we move towards the next phase of the pandemic, many NHS staff will be reflecting and making important decisions about where they want to work and what work they want to do. A key factor in those decisions is likely to be a workload and rhythm that feels sustainable, and a workforce that feels safe and where they feel their employer cares for their health and wellbeing.

Part of the NHS remit, as a healthcare provider, is to care. However, this has not always been the experience of staff in the past – as evidenced by the annual NHS Staff Survey. The People Plan highlights the need to change the work culture so that NHS organisations become good places for its own people, as well as for its patients. The People Promise encapsulates this in the phase '**We are safe and healthy**'.

Consistent, high quality OH services play a vital role in making this a reality. A first step is to recognise the value of OH services and to improve their quality where needed.

This discussion document reveals a picture of OH services that have often been inconsistent and reactive in nature. This document proposes areas for discussion about how to improve and strengthen OH provision. What we do know is that good OH services are key to making the NHS the best place to work. For this to happen, we need far-reaching culture change, including structural changes and corresponding communications work, so that people across the NHS can start to see the real potential of this valuable service.

Figure 5 suggests the starting point of the vision for the Growing OH programme, and ten potential areas for service improvement based on the learning within this discussion document.

Figure 5: Proposed drivers for improvement for discussion and co-design with stakeholders

Proposed Vision

...supporting the health and wellbeing of our NHS people by growing and developing NHS Occupational Health services and our OH people to reach their full potential as strategic, integrated, and proactive organisational partners.

Proposed actions for discussion

...Grow a strategic and trusted OH voice

...enable OH to be a trusted, strategic, and integrated organisational partner

...Grow our OH services

...support system wide service innovation and improvement in OH?

...enable equality of access to services that meet the needs of all our diverse NHS people

...increase the focus on proactive and preventative care?

...design and embrace future models of multi-disciplinary service delivery

...enhance service standards, quality, measurement, and consistency?

...better use technology effectively, to support service delivery

...Grow our OH people

...empower OH leadership, service improvement and innovation

...increase OH workforce capacity and capability?

...Grow from the pandemic

...empower OH to both strategically and operationally support recovery from the pandemic?

... enable a co-design, service improvement, and learning-focused approach?

...and what are we missing?

The Growing OH programme is underpinned by the principle of co-design and the fundamental belief that our colleagues in OH and beyond need to be empowered to create and flexibly realise positive change that will make a difference to their services and, ultimately, the wellbeing of people across the NHS.

For this reason, the initial phase of this ambitious programme is to engage our OH community and wider stakeholders to help us shape our ambitions, to ask how the 10 drivers for change could become a reality, if there are any areas we are missing and how we might include these in the programme, and how we can shape and deliver this overall vision for Growing OH collaboratively and in partnership.

NHS England and Improvement have developed a series of engagement mechanisms, including engagement events and surveys, to support this co-design phase. More information is available at: www.nhshealthatwork.co.uk/growingoh.asp

NHS England and Improvement are committed to shaping this programme of work together. Having benefitted from this initial engagement and co-design phase, the Growing OH programme plan will be finalised and work will begin in delivering the programme and its ambitions, in partnership with our OH community and stakeholders.

Appendix 1: People who shaped this discussion document

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People Promise

