The Future Configuration of NHS Occupational Health Services

This report was commissioned by NHS Plus from

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Introduction

The 452 statutory NHS organisations in England are currently served by 175 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. The purpose of this paper is to draw upon the available evidence and identify options for the future configuration of services.

NHS Plus commissioned this work in summer 2010 to contribute to the debate about service configuration. It is based upon a range of evidence, although worldwide published literature on the configuration of occupational health services is disappointingly limited.

Context

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 health 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.

¹ Future directions for occupational health care in the UK. A strategic overview FOM January 2010
"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). 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 the latest research commissioned by NHS North West.

**Fragmented services**

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.

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.

For junior doctors and healthcare students (eg nurses) services are usually hosted by a single provider that may be a very considerable distance from their workplace and who may have very limited expertise in dealing with the complexities of healthcare exposures and issues (eg infection prevention and control, serious psychological issues, and professional conduct).

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).

The current configuration makes little sense. 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.

The purpose of this paper is to describe potential service models that might be used by to lead service improvements that are:

- cost-efficient;
- effectively achieving challenging objectives;
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- offering a quality service to customers;
- oriented towards effective mechanisms for improving health; and,
- configured to meet future needs.

Configuring NHS occupational health services

A large volume of occupational health service activity is invested in preparing staff for work at the start of employment (e.g., screening and immunisation) and also in supporting sickness absence management.

Many of these tasks are straightforward requiring either no or very limited specialist expertise. However, some aspects of these tasks are complex and require specialist occupational health skills and a deep understanding of the NHS workplaces. The spectrum of needs has a very broad range and the skills mix of the occupational health team should reflect this.

For example, routine immunisations (e.g., HBV) can be undertaken by Technicians and Healthcare Assistants, more complex immunisation and screening needs (e.g., TB) may need to be delivered by general or specialist nurses, and the assessment of fitness for tasks of a HIV positive physician is likely to need support from a specialist in occupational medicine. Effective and efficient occupational health support for NHS staff will be reflected in a team with a broad mix of skills.

At present OH service design is mainly characterised by a local demand based approach. The NHS is divided into individual Trusts and each of these either provides an occupational health service for its own staff or commissions it from another provider (most commonly another local NHS Trust). This approach results in a large number of relatively small service providers of differing structures. Few are of sufficient size to make affordable a comprehensive and desirable skills mix.

This approach fits the occupational health service to the size of the local demand. Compromises are essential to keep the service affordable especially in relation to more costly and scarce specialist expertise.

This approach can be contrasted with an approach based on the structure of a desirable service, a resource-capability based approach. Taking this approach the service is built up around the best utilisation of the most costly and scarce resource. In occupational health services the most costly and scarce resource are consultants in occupational medicine. There are many reasons why we might wish consultants to work in teams: This has been a common theme in many reports (e.g., Carter Review of Pathology) and is, for example, an important driver in the current review of paediatric cardiac surgery. A common theme has been the espoused advantages of having at least three consultants in every team.

There has been no detailed recent work to examine the appropriate ratio of consultants in occupational medicine to NHS staff where a contemporary model of OH service is in place. However, a limited review of some of the larger NHS OH units with a comprehensive skills mix and with specialist nurses proficiently managing their own case load suggests the ratio may be in the order of 15-20000 NHS staff per consultant in occupational medicine. This ratio would be substantially lower in units without a broad skills mix or without specialist nurses managing their own cases. It might even be higher with greater specialisation in very large teams with nurse consultants.

Where NHS units also support non-NHS organisations the ration will change. For example the demand for consultant support from local authority work is much lower.
An occupational health service based on a minimum of at least three consultants might need to support a large NHS staff population in the order of 50-100,000 for there to be sufficient demand.

**Current provision**

Most Trusts, including almost all PCTs, already commission occupational health support from another organisation. However, the great majority do so to NHS providers who are by their nature immersed in the culture and practices of the NHS. About 5% of services are delivered by commercial providers. However, outsourcing to commercial providers has not been so successful with few commercial contracts being renewed (eg Greater Manchester West MH FT, Christie Hospital NHS FT).

In 2007 a network of six Cheshire NHS Trusts formally market tested occupational health announcing a formal tender process, accepting bids, hearing presentations, and meeting bidders. Despite considerable interest none of the bidders were able to convincingly demonstrate a capacity to deliver Cheshire’s current and future needs. The tender process provided persuasive evidence of the need for a Cheshire NHS OH Shared Service that supported the health and wellbeing of the NHS and reached out to other local employers.

**Case example: The challenge of commissioning suitable support**

The threats to the NHS of expansion of commercial provision are manifold. For example:

- Loss of support for specialist training leading to no sustainable specialist workforce
- Loss of expertise in the most complex cases through lack of consultant focus on NHS workplaces
- Loss of expertise for the most serious health issues in senior clinicians with serious impact on their ability to continue to practise.
- Loss of strategic direction for occupational health (as few contracts allow time for anything other than specified tasks).

At present the contribution to strategic activities, national and regional projects, and training programmes is predominantly from the larger NHS OH providers. These activities are essential if the NHS is to have a sustainable OH workforce capable of providing the most effective support for staff health and wellbeing. Many Trusts rely on the contribution of relatively few larger OH units to provide the specialist people and expertise for these activities. This reliance on larger OH units to sustain the specialty will continue in any future model of NHS provision.

**Commissioning needs to become more sophisticated to address strategic needs such as support for regional and national activities.**

**Critical Mass and Multi-disciplinary teams**

The NHS in England employs about 1.2 million staff in several hundred organisations. There are 176 different occupational health provider units supporting about 6000 staff on average. The North West is typical with 31 separate providers for a total NHS workforce of 186000.

There are very few examples of provider units that employ more than one consultant in occupational medicine to deliver the local NHS service (and these are all very large city hospital Trusts). There

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2 NHS Plus data
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are less than ninety\(^3\) NHS consultants in occupational medicine and many of these are either part-time, or devoting significant time to external non-NHS work, or both.

It is interesting to note that the current children’s heart surgery review has stated “At the moment we have 31 surgeons working in 11 centres. The surgeons are spread too thinly.”

Thirty three paediatric surgeons “spread too thinly” in eleven centres contrasts with <90 occupational physicians in ~180 centres.

There are many theoretical advantages of bigger units (Edwards 2002, Carter Garside Black 2003, Carter 2006):

- Improved continuity of good quality care
- Improved continuity of clinical responsibility
- Improved communication and knowledge sharing between team members
- An effective skills mix
- Improved succession planning
- Effective clinical supervision and appraisal/revalidation
- Better education and training
- Continuity of OH care as NHS staff move through local/regional posts
- Less professional isolation
- Enables work on strategic goals which require collaborative effort
- A vibrant environment for debate and developing new ideas
- Improved peer support

Some of these benefits are particularly important in occupational health. Patients need to feel confident in the decisions made by OH specialists that potentially have a considerable impact on their employment and income. Similarly patients will sometimes feel unhappy with the opinions given by their OH specialists. At these times OH specialists can be exposed to criticism and peer support is invaluable.

“When patients know that they are being looked after by a team they get a sense of confidence similar to that from having a second opinion, reducing the fear that their treatment is based on the knowledge of just one clinician.”

Carter, Garside and Black 2003

The largest NHS OH provider in the North West supports seven NHS trusts. It is already offering more than half of all the specialty training posts in the region. The unit has now established a Lead Nurse role to support the development of specialist nursing practice and to establish models for measuring and monitoring the quality of occupational health nursing practice.

Case example: Sub-specialisation enabled in a large team

The 2009 NHS Plus Workforce Survey showed the very wide variation in the size and skills mix in OH teams.

\(^3\) 2010 estimate base on 2006 Clinical Excellence Award role data
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In building larger multi-disciplinary teams it is important to manage the potential pitfalls that include:
• Loss of responsiveness to local variations
• Loss of focus on the OH needs.
• Loss of ownership with less clarity of service leadership
• Loss of agility as local and regional priorities change
• Loss of dependability as customer relationships are more distant
• Loss of proximity as services are centralised

“Optimally, occupational health services are provided by a multidisciplinary team”

Jorma Rantanen 2005
President of ICOH

<table>
<thead>
<tr>
<th>Consultants in occupational medicine(^4)</th>
<th>Other associate and junior doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses with specialist OH qualifications and registration</td>
<td>Nurses with other relevant training</td>
</tr>
<tr>
<td>General nurses</td>
<td>Technicians./Assistants</td>
</tr>
<tr>
<td>CBT therapists (counsellors)</td>
<td>Physical therapists</td>
</tr>
<tr>
<td>Administrators</td>
<td>Service managers</td>
</tr>
</tbody>
</table>

Table 1: The OH multi-disciplinary team (after Rantanen 2005)

The 2009 NHS Plus Workforce Survey found evidence of a wide range of professions employed in and supporting the delivery of OH services including physiotherapists, psychologists, ergonomists, complementary therapists and occupational hygienists.

Models: Lessons from the international literature

There is an extensive literature on models of service delivery. However, this is almost exclusively descriptive with little evaluation of the benefits.

A search of databases identified a large number of reports (Appendix C). In addition a number of international researchers were directly contacted during the preparation of this report. However, no further reports were identified.

A systematic review of evaluation of OH services found limited evidence that examined specific aspects of services but no evidence to suggest one model might be advantageous (Hulshof et al 1999). The only paper to report outcomes from different models was published in 1997 (Rasanen et al). This report was from a triennial survey of OH services in Finland. The report showed:
• More employees were supported per physician and per nurse in large multidisciplinary centres
• Internal services did more workplace visits than external providers
• Commercial services allocated more work to doctors (that was done elsewhere by nurses).

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This failure of commercial service arrangements to deliver efficient and effective care was also noted in Holland (Hulshof & Frings-Dresen 2010). In a 2006 study De Valk et al found significant variety in quality. The ability of OH care to improve health was highest when services were more integrated into the organisations they supported, offered a broader range of more comprehensive services, and were directed more towards preventive measures and had a broader scope of operation. In these Dutch organisations they found in-house OH services “were best suited to improve the health of the organizations they worked for and were thus better in terms of efficacy.”

In 2001 a large European review found no studies of cost effectiveness existed in most countries (Hämäläinen et al 2001).

A review for the Health and Safety Executive (HSE 2005) of 40 projects from around the world concluded: “Much of the information provided about the models lacked key elements of quantified data with no mention of cost-benefit or cost-effectiveness evaluation. Generally, where quantitative information was provided, it was in terms of outputs such as the number of people trained and not in terms of outcomes such as the positive effects on OH.”

In the UK there have been three reports describing (but not evaluating) NHS OH service provision. A 2003 report identified service variability and suggested that in the future there may be “a need for improved collaboration and changes in patterns of service delivery.”

Other studies of service model are currently underway in a number of WHO collaborating centres (Programme AA5:1). Some progress has been made in Japan (Higashi 2010) but none of the projects have yet reported any results.

The most relevant research has recently been reported by Ford, Kirk and Denman (2010) for NHS North West. In a comprehensive review the team surveyed all Trusts and NHS OH providers in the region and interviewed all the Heads of OH units. The data were analysed together with information on CQC ratings, sickness absence rates, and the NHS staff survey.

The authors found some smaller provider units supplying occupational health services to a single NHS trust were not fit for purpose. Larger OH provider units, supporting multiple Trusts, were significantly more likely to:

- Comply with service accreditation standards (SEQOHS)
- Employ specialist occupational health clinical staff
- Provide access to physiotherapy
- Provide access to effective counselling services
- Make more use of information technology

Ford, Kirk and Denman concluded:

“NHS occupational health provision should be reconfigured into a smaller number of larger providers offering a high standard of multi-disciplinary care with a full range of core services.”

They recommended units comply with national standards and engage stakeholders effectively. 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
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- 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

In summary the literature evaluating models of OH service is limited but the literature which is available on OH and other clinical services provides overwhelming evidence that economies of scale and improved quality of care is consistent with provision by large multi-disciplinary teams that meet accreditation standards and are enabled by information and communications technology.

Effective Commissioning

Occupational health has some characteristics that mirror regional/national specialised services.

Although the planning population for OH is relatively small in terms of NHS staff considered in the context of the wider population supported by those staff it is very large and covers a large catchment area that cuts across geographical boundaries. OH services do not usually require either repeated investment of significant capital or expensive technology but they share, with specialised services, a dependency on small numbers of specialists.

Finally the diseases identified and managed by NHS consultants in occupational medicine are either very uncommon (e.g., nosocomial HIV/HBV) or uniquely complicated due to the work setting (e.g., staff with infections).

Sir David Carter’s Review of Commissioning Arrangements for Specialised Services provides guidance that is high relevant to the commissioning of occupational health services (Table 2):

“[commissioning] success will depend upon commissioners having the necessary authority, credibility and expertise.”

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5 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.

6 See the NHS Plus Occupational Health Specification
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**Authority**

<table>
<thead>
<tr>
<th>Powers</th>
<th>Commissioners should have the power to designate providers for a period of up to 5 years, in accordance with a transparent process and criteria. Commissioners should be able to refuse to fund activity outside contract. Within a contract, commissioners should be able to set out specific reporting requirements from each provider for each service which measure performance against agreed criteria. (These criteria could include service standards, referral criteria, treatment thresholds, services given, discharge criteria, adherence to the patient pathways, clinical and patient outcomes.)</th>
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<tr>
<td>Sanctions</td>
<td>Commissioners should be able to apply sanctions and to withdraw funds, refuse to pay or fine providers if they fail to honour aspects of the contract or designation.</td>
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<tr>
<td>Choices</td>
<td>Commissioners should be able to choose to de-designate providers. Commissioners should be able to choose how many providers to … maintain sufficient critical mass in each provider to ensure clinical safety, quality and value for money.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Commissioners should be able to test value for money and relative value annually.</td>
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<tr>
<td>Incentives</td>
<td>Commissioners should be able to provide incentives to improve provision.</td>
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**Credibility**

| Access | Commissioners should have access to data on their population |
| Skills | Commissioning teams should contain senior professionals in health, finance, information, commissioning and analysis. |
| Experience | Commissioning expertise should be of a level to inspire trust. |
| Independence | Commissioners should be able to use challenging initiatives to exert influence. |

**Expertise**

| Analysis and audit | Commissioners should be able to independently audit and analyse provider data. |
| Standards | Commissioners should be able to monitor and appraise services against nationally agreed service and clinical standards. |
| Comparisons | Commissioners should be able to benchmark, compare and contrast services to lever service improvement and greater cost effectiveness. |
| Effectiveness | Commissioners should be able to develop nationally agreed clinical outcomes. |

**Table 2: Characteristics of effective commissioning of specialised services (Carter 2006)**

Further lessons are available from Lord Carter’s review of NHS Pathology Services. Since the publication of the Second Report of the Review of NHS Pathology Services many are currently considering re-configuration.

The Review recommended that networks for commissioning should be developed. Each consolidated commissioning network should have

- a single integrated management structure.
- a clinical director responsible for quality and clinical governance
- a commercial director with responsibility for contractual and other commercial arrangements.

The Report noted:

“Consolidation enhances quality by creating critical mass and by delivering better value for money through economies of scale. It creates the scope for increasing investment in order to improve service quality and provide more responsive services.

“The key issue is how to deliver consolidation. The historical command and control model of the NHS (if it ever existed) is no more. The strongly competitive ethos of the foundation trusts (and those organisations that seek to move towards that status), together with the nascent authority of commissioners, make this a difficult time to deliver change. However, a large number of
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practitioners have told us that they want consolidation, and already there are excellent and commendable examples of collaborative ways of working which are delivering improved quality and patient safety and better value.

“We have considered whether there is an optimum number of consolidated networks. Overall, we would expect that the number would not exceed three networks per SHA; indeed, a single network might cover one or more SHAs.”

<table>
<thead>
<tr>
<th>Clinically excellent</th>
<th>Responsive</th>
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<tbody>
<tr>
<td>- based on evidence of impact</td>
<td>- convenient</td>
</tr>
<tr>
<td>- underpinned by a mandatory accreditation system</td>
<td>- accessible</td>
</tr>
<tr>
<td>- optimised to the care pathway</td>
<td>- equitable</td>
</tr>
<tr>
<td>- swift to adopt innovation</td>
<td>- personalised</td>
</tr>
<tr>
<td>- operated by qualified/trained staff</td>
<td>- effective</td>
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<table>
<thead>
<tr>
<th>Cost-effective</th>
<th>Integrated</th>
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</thead>
<tbody>
<tr>
<td>- consolidated into reconfigured commissioning networks</td>
<td>- delivering choice and contestability</td>
</tr>
<tr>
<td>- managed end to end</td>
<td>- promoting world-class commissioning</td>
</tr>
<tr>
<td>- based on full IT connectivity</td>
<td>- enhancing other clinical services</td>
</tr>
<tr>
<td>- operated by effectively deployed staff</td>
<td>- contributing to disease prevention</td>
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</table>

Table 3: The vision for (pathology) services (Carter 2008)

In summary the evidence suggests that networks for commissioning should be developed.

Outsourcing

About 5% of services are outsourced to commercial providers. This has not been wholly successful with few commercial contracts being renewed (eg Greater Manchester West MH FT, Christie Hospital NHS FT). Although it has undoubtedly been used in attempts to solve problems with services outsourcing does not address concerns about lack of service quality and lack of critical mass it merely changes the provider of a service.

Although commercial providers have the potential to offer appropriate OH services to NHS staff the same problems will inevitably persist unless commissioning networks are formed to procure services for larger groups of Trusts.

Should services be outsourced it will be important to procure all the components of service needed for sustainable support to NHS staff including:

- Clinical leadership offering strategic direction
- Training posts for specialist doctors nurses
- Support for professional activities (eg deanery work)
- Expert support for complex cases (eg HIV infected clinicians)
- Expert support for senior clinicians in difficulties
- Developing expertise on staff health risks in healthcare

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- Contribution to regional and national projects
- Flexibility to extend NHS OH services to the wider community

In future commissioning will need to consider the sustainability of the OH support to NHS staff. Current commissioning arrangements tend not to address these types of issues.

Potential Models of Configuration

Common themes

A number of themes emerge 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: Too often OH service users (including staff representatives) are not involved in developing OH services. Successful services engage stakeholders. [Staff involvement is included in the SEQOHS standards that were accepted as a Boorman recommendation.]

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

Option A: No change (Informal Networks)

NHS Plus has operated as an informal network of OH units for many years. The network has been instrumental in influencing policy, developing and raising standards, increasing collaboration, and improving capacity.

Other local and regional networks provide peer support for activities such as audit and research and provide mechanisms for sharing knowledge (eg Table 4).

Informal networks reduce professional isolation, enable information sharing, provide a common voice or relevant topics, and provide a vehicle for professional development. The peer and service support enabled by informal networks are invaluable. However, their informality means they provide only a mechanism to overcome the shortcomings of the existing configuration of services.

Informal networks are important but they do not provide the necessary mechanism for a step change in service delivery through reconfiguration.

<table>
<thead>
<tr>
<th>London Confederation of OH Practitioners (LCOHP) – Objectives</th>
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<tbody>
<tr>
<td>Promote the highest standards of practice</td>
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<tr>
<td>Promote clinical audit</td>
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<tr>
<td>Encourage and facilitate teaching and training</td>
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<tr>
<td>Enhance understanding of OH within the health economy</td>
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<tr>
<td>Share practices and experiences</td>
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<tr>
<td>Promote fellowship</td>
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Table 4: An informal network
Option B: 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 (Greene et al 2009) to improve the quality of care (without the need for additional resources). Improvements were enabled by effective information systems.

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).

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). The authors noted:

“Complex organisational changes take time to develop and improvements are likely to be slow and incremental.”

- 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

Table 5: Benefits of managed clinical networks (from Wall and Boggust 2003)

NHS Scotland has published detailed a guide to implementation of MCNs.8 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

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- 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.

These theoretical arguments for network forms have only been tested by empirical work very recently. 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. Ferlie et al (2010) have advised MCNs need to develop in different forms with some local freedoms to encourage innovation.

“Network forms …needed skilled and well resourced management to be effective.”

Ferlie et al (2009) found a number of correlates of high performance (Table 6)

- 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

Table 6: Correlates of high performance in MCNs (Ferlie et al 2009)

Although this is a proven model for health services provision there are no current examples of Managed Clinical Networks in occupational health. There are many examples of other clinical services provided through MCNs. Detailed case examples have been described by Ferlie et al (2009) and in Lord Carter’s Review of Pathology Services (see below).

The Kent & Medway Pathology Managed Clinical Network is led by a Board made up of senior managers and executives from across Kent and Medway NHS organisations. It oversees the delivery, development and modernisation of local NHS pathology services in line with national direction. The Clinical Network:

- Comprises five Acute Trusts and ten laboratories
- Employs >700 staff and a budget of around £49m
- Carries out approx 17 million tests per year
- Covers an area of over 3,500 Sq Miles
- Serves a population of 1.7 Million

The Clinical Network aims to provide a modern, patient/customer focused service, which supplies fast, accurate, evidence based testing, by:

- working across traditional trust boundaries
- re-designing services
- reducing inappropriate variation through audit standardisation of operating processes and protocols, along with the use of evidence-based practice
- making effective use of information technology
- ensuring patients have access to the best services at the right time and in the right place
- planning and delivering services in the most efficient and cost-effective way.

The Clinical Network has a budget of about £49m. All the Trusts contribute to a budget for the management of the Clinical Network.

Each year the Trusts sign the Network Accountability Agreement which details the terms of engagement and defines the objectives of their relationship with each other.
Option C: Area (Collaborative) Services

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 have been 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.

Following publication of his Report on the Review of Pathology Services Lord Carter described a hosted collaborative service as:

“closest to the ideal model of pathology services of the future”.9

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Cheshire Occupational Health Service (COHS)

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 12500 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.

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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 25000 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.
Path Links is a single service operating across Lincolnshire. Formed in 2001 from the amalgamation of NHS pathology services in Boston, Grantham, Grimsby, Lincoln, and Scunthorpe, Path Links is hosted as a Clinical Division of the Northern Lincolnshire and Goole Hospitals NHS Foundation Trust.

Path Links provides a wide range of diagnostic investigations and clinical services to both Northern Lincolnshire and Goole Hospitals NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust, as well as to a total of 186 GP practices.

Serving a population of approximately 1 million, Path Links processes 4.5 million specimens, performs 20 million tests and generates 5 million test reports every year. All laboratories are extremely well equipped with modern ‘state of the art’ analysers linked to a central computer system. Equipment and operating procedures are common to all laboratories ensuring that Path Links provides a standardised and seamless service to all service users irrespective of which laboratory they use.

All Path Links laboratories work to national accreditation quality standards. Regular assessments by external auditors assess compliance with the published standards and ensure that the service provided meets the needs and requirements of service users.

“closest to the ideal model of pathology services of the future” – Lord Carter of Coles

A form of hosted collaborative/partnership service has evolved in Scotland. NHS Scotland employs about 160000 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

Option D: National Services

NHS Wales is considering a national service for its 90000 staff. This is an employee population similar to one of smaller English SHA regions. The recommendation that there should be a single NHS occupational health service for Wales was accepted by the Welsh Assembly Minister for Health and Social Services last year.

A team led by Professor Sir Mansel Aylward is likely to present a proposal for a national service for Wales in about November 2010. They are exploring a ‘hub and spoke’ type model with a central call centre (available to all service users). It is hoped that an improved skills mix will free up the limited numbers of OH practitioners to deal with specialist and appropriate cases whilst avoiding duplication. The ‘spokes’ would be local services based possibly in the health boards that would continue to provide local operational services (immunisation, health surveillance etc), with specialist practitioners operating across a number of units in sub-regional areas. Key issues being debated include governance, corporate structure, and IT.

Whilst the need to reconfigure services in Wales has been accepted the model has not yet been determined or evaluated.

Conclusions & Recommendations

This paper has reviewed the current evidence and set it in the context of the current arrangements in the NHS. It is immediately clear that if we are to progress towards a comprehensive health and wellbeing service for staff, with all the benefits to them, their families and the NHS itself, the current arrangements cannot continue.

Many departments are too small to contain all the expertise necessary for a comprehensive service and lack the critical mass to develop quality systems. There is a deficit of specialist practitioners (both medical & nursing) and in at least one department there is no specialist practitioner at all.
The Future Configuration of NHS Occupational Health Services

We need larger, geographically based departments that provide services to a number of NHS employers. These need not follow current administrative boundaries and would be better based on local geography and travel patterns. The services should be large enough to ensure that the full range of expertise is available while ensuring that tasks are undertaken who are competent to perform them. There is no justification for expensive, highly trained and experienced staff to undertake tasks that more junior members of the team can do.

This will require considerable change for occupational health staff as well as Trusts. Change of existing cherished systems tends to be anathema to the NHS, even in those who profess their desire for improvement. This will require tremendous engagement with all stakeholders, not least of whom are OH staff themselves.

Clinical work will need to be reorganised and a more active approach, involving getting out into the workplace will be required; again often spoken of as the bedrock of OH practice but rarely practiced!

New services and a central role in coordination rather than simply delivery will be the order of the day. New relationships will be needed and we must make more use of technology if this is to be sustained.

An exciting future!
The Future Configuration of NHS Occupational Health Services

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Appendix A - Configuring NHS OH Services: Strengths and Weaknesses

Opportunities and Threats – these external factors have been assumed to be the same for all models. The ability of a service to seize these opportunities and manage the threats will differ between the models.

<table>
<thead>
<tr>
<th>Model</th>
<th>Strengths (internal)</th>
<th>Weaknesses (internal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change (informal)</td>
<td>Excellent peer support</td>
<td>No formal direction so relatively slow to change</td>
</tr>
<tr>
<td></td>
<td>No formal direction so relatively slow to change</td>
<td>No formal bindings agreement</td>
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<tr>
<td>Managed Clinical Network</td>
<td>Enables a reputation for excellent quality service</td>
<td>Complex management structure may make it difficult to manage performance (and may be slow to change)</td>
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<td></td>
<td>Opportunity for developing expertise</td>
<td>Dependent on enthusiastic individuals</td>
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<td></td>
<td>Consistent services and prices</td>
<td>Lack of common IT amongst network members</td>
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<tr>
<td></td>
<td>Sharing learning across multi-disciplinary team</td>
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<td></td>
<td>Continuity of OH care as NHS staff move around regional Trusts (eg trainees)</td>
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<td></td>
<td>Enables work on strategic goals which require collaborative effort</td>
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<tr>
<td>Area Service</td>
<td>Can be matched to area commissioning networks</td>
<td>Ownership is dependent on excellent stakeholder engagement</td>
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<td></td>
<td>Enable a reputation for excellent quality service</td>
<td>OH staff and patients risk feeling separate to partner Trusts</td>
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<td></td>
<td>Simple management structure</td>
<td>Geographical area might be very large to provide critical mass in rural areas</td>
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<tr>
<td></td>
<td>Common IT (once in place) and good internal communications</td>
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<tr>
<td></td>
<td>Consistent services and prices over a large geographical area</td>
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<td></td>
<td>Easy to offer and agree new service lines with commissioners</td>
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<td></td>
<td>Enables an effective skills mix and subspecialisation</td>
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<td></td>
<td>Continuity of OH care as NHS staff move around regional Trusts (eg trainees)</td>
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<td></td>
<td>Enables work on strategic goals which require collaborative effort</td>
<td></td>
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<tr>
<td>National Service</td>
<td>Consistent services and prices nationally</td>
<td>Difficult to design a financial model that matches local service prices to local cost differences</td>
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<tr>
<td></td>
<td>Easy to offer and agree new service lines with commissioners</td>
<td>Likely to need an organisational structure that is divided into regions to be manageable</td>
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<tr>
<td></td>
<td>Enables the most effective skills mix and subspecialisation</td>
<td>Ownership is dependent on excellent stakeholder engagement</td>
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<tr>
<td></td>
<td>Continuity of OH care for all NHS staff as they move around posts in England</td>
<td>OH staff and patients risk feeling separate to partner Trusts</td>
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<td></td>
<td>Enables work on strategic goals which require collaborative effort</td>
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<tr>
<td></td>
<td>A single IT and communications system nationally (once in place)</td>
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<td></td>
<td>Managed career structure for specialist staff</td>
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Appendix B – Configuring NHS OH Services: FAQs

Why reconfigure OH services?
- There is a growing body of evidence that staff health and wellbeing is supported most effectively by large multi-disciplinary teams that serve many Trusts. [See especially Sections ‘Background’ and ‘Critical Mass and Multi-disciplinary teams’.]

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.

Who should lead the reconfiguration and future service?
- Reconfiguring 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 [See especially Section ‘Potential Models’ and sub-section ‘Managed Clinical Networks’.]

What should I do first?
- It is important to develop commissioning networks to procure the larger services that are needed to deliver effective occupational health services. A sensible first step is to establish links with neighbouring Trusts that might become the commissioning network. [See especially Section ‘Effective commissioning’.]

How can I commission appropriate OH service?
- The best way is to form or use an existing commissioning network. [See especially Section ‘Effective commissioning’.]

What configuration is the best?
- There is no single occupational health service that has been shown to be most effective. Both hosted collaborative services and managed clinical networks have attractive features. [See especially Sections ‘Models: Lessons from the international literature’ and ‘Potential Models’.]

How big should OH units be?
- Research conducted for NHS North West showed that larger units serving more than four Trusts were significantly more effective. However, there are likely to be advantages in even bigger services but there were no such current services to investigate. Evidence from other sources suggests that creating much larger providers is likely to be beneficial. [See especially Sections ‘Models: Lessons from the international literature’ and ‘Effective commissioning’.]

What is the correct skills mix?
- The OH team should comprise at least consultants in occupational medicine; nurses with specialist OH qualifications and registration; other doctors and nurses; CBT and physical therapists; and others [See especially Section “Critical Mass and Multi-disciplinary teams’.]

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 re-configuration 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.
Appendix C – Configuring Occupational Health Services: Bibliography (Models)


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