

**REVIEW OF OCCUPATIONAL
HEALTH SERVICES IN THE HPSS**

**SUPPORTING A HEALTHY
WORKFORCE**

MARCH 2004

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HPSS

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CONTENTS

	Page
Executive Summary	1 – 3
1. Introduction	5 – 8
2. Context for the Review	9 – 21
3. Rationale for Change	23 – 27
4. Vision for the Future	29 – 30
5. Range of Services	31 – 34
6. Standards for Service Delivery	35
7. Primary care	37 – 38
8. Options for Service Management	39 – 46
9. The Case for Investment	47 – 53
10. Equality	55 – 58
11. Recommendations	59
12. References/Bibliography	61 – 62
Appendices	
Appendix A: Membership of the Working Group	63
Appendix B: Action Plan	65 – 67
Appendix C: List of respondents to Consultation	69 – 70

EXECUTIVE SUMMARY

This Report seeks to bring about improvements in the health of all those working in the Health and Personal Social Services (HPSS) in Northern Ireland. It recognises that there is a link between the health of the HPSS workforce and the quality of care delivered to patients. The Report considers the complexity of issues involved in improving the health of the workforce. Practical urgencies for improvement in Occupational Health provision and advice are also noted.

The resources currently utilised in the delivery of Occupational Health Services (OHS) in the HPSS in terms of finance and people are described, and benchmarks used to identify areas for development. The Working Group undertook a range of initiatives to complete the terms of reference. It was quickly realised that little comparative information existed on Occupational Health Services both within and outside of Northern Ireland. A major survey of provision was undertaken across all HSS organisations and Occupational Health departments in Northern Ireland. Appropriate summarised information is included in Section Two and is used as a baseline for recommendations.

The Report describes a vision for OHS in the future, with a change in emphasis from the management of illness to health protection. A range of services and standards are specified. The specification takes into account emerging needs, new developments in the workplace and best practice. The specification also includes standards for service provision in the future.

The needs of Primary Care are also briefly explored and acknowledgement given that Occupational Health provision should be extended to General Medical Practitioners and their staff. Further work needs to be undertaken in this area.

Models are explored for the provision of services in the future, which range from a rationalised number of local services to a wholly central service. The following models were considered:

- A. Status Quo
- B. Rationalised locally delivered OH Services (2 or 3)
- C. Singular Service: Central management and local delivery
- D. Specialist Central Service/Rationalised local Occupational Health Services (medically led at all levels)
- E. Specialist Central Service/Rationalised local Occupational Health Services (nurse led at local level)

The advantages and disadvantages of each model are identified. The view of the working group is that Model B best meets the needs of the HPSS over the next 2-10 years.

The Report concludes with the following recommendations:

- The Vision set out at Section 4 should be adopted to guide the future direction of Occupational Health Services within the HPSS.
- A core range of services and standards should be agreed for the effective management of Occupational Health Services (Sections 5 & 6).
- Additional resource should be targeted on the management of absence both through designated staff and specific initiatives (Section 5.5).
- Further discussion should take place with Primary Care representatives to enable development of a phased implementation plan (Section 7).
- Model B, that is, two or three locally managed Occupational Health Services, supported by a Regional Steering Group should be adopted as the preferred model for Occupational Health Services delivery (Section 8).
- The numbers of Occupational Health physicians, therapists and nurses should be increased in line with new developments, and roles developed appropriately (Section 9).
- Access to other specialists should be formally defined and resourced (Section 9).
- The importance of rehabilitation should be recognised by managers, staff and occupational health providers, and evidenced by appropriate service provision and take-up (Sections 3.7 & 5).
- An information strategy should be developed along with a costed plan for implementation (Section 9).
- Additional resources should be made available to fund developments (Section 9). An initial investment of £1 million recurrently is needed to progress service developments.

The Group is keen that the development of ideas and recommendations are fully informed by the many stakeholders in the process. A Workshop was held in April 2002 to gather preliminary ideas and views of managers, staff and staff representatives across the HPSS. This Report will facilitate the next stage in the consultation. The Report identified a number of drivers for investment in

the future development of an Occupational Health Service for the HPSS. A detailed business case is contained in the main body of the report.

The Department has recently secured additional resources to implement the recommendations contained in the report. A total of £900,000 over a three year period has been identified and will be allocated as follows;

Year	Expenditure
2004/05	•£150,000 to improve capacity within the HPSS allocated on the basis of bids from Trusts; •£150,000 available for development of Primary Care OHS
2005/06	£300,000 To improve capacity through investment in absence control management and investment in Occupational Health Nursing.
2006/07	£300,000 To support realignment of OH Services including potential appointment of an additional Occupational Health Consultant.

Summary of Benefits

In the longer term investment will produce cost benefits in the following forms:

- reduction in sickness absence,
- reduction in injury related compensation and pensions,
- fewer ill health retirements,
- reduction in staff cover for those off work.

The ultimate benefits however, will be to the quality of service available to patients and service users, and a healthier and happier workforce.

1. INTRODUCTION

1.1 Background

This Report seeks to bring about improvements in the health of all those working in the Health and Personal Social Services (HPSS) in Northern Ireland. It recognises that there is a link between the health of the HPSS workforce and the quality of care delivered to patients. The HPSS directly employs almost 60,000 staff; that is, approximately 8.5% of the total workforce of Northern Ireland. As the largest employer in the local economy, there is both a responsibility and a commitment to be an exemplar employer with regard to the health of our staff. The recently published strategy for managing and developing people in the HPSS ‘*The Employer of Choice*’¹, stresses the importance of promoting good health in the workplace, and the role of effective Occupational Health provision in achieving that aim.

The World Health Organisation states that “*every citizen of the world has a right to healthy and safe work and to a work environment that enables him or her to live a socially and economically productive life*”². That commitment further underpins this report.

The Report considers the complexity of issues involved in improving the health of the workforce. Occupational Health Services, Health and Safety responsibilities and the role of Health Promotion are integral aspects of any strategy for improvement. This Report concentrates largely on the contribution of Occupational Health and the complementary role and responsibilities played out along side employers, line managers and individual staff.

The Report also recognises practical urgencies for improvement in Occupational Health Provision and advice. Sickness levels within the HPSS are higher than comparable staff groups in the Health Services in England, Wales and Scotland. Employers need greater support and advice in the management of attendance. Improvement in Occupational Health provision may not of itself reduce absence levels. It will however, provide the necessary support for staff and managers. Occupational Health specialists do not see attendance management as their responsibility, although there is a clear role to provide advice to those who are charged with managing absence. The primary responsibility for the management of sickness absence remains with line managers. Therefore, this Report considers other alternatives, which may need to be progressed alongside developments in Occupational Health provision. These include investment in Human Resources

¹ May 2002, *The Employer of Choice*, DHSSPS

² *Global Strategy on Occupational Health for All*, World Health Organisation, 1994

departments to provide support and training to managers in their attendance management role. Investment in designated staff to drive attendance management locally, and the piloting of a number of attendance management initiatives are other potential options.

Much work has been undertaken in the last five to ten years to develop an evidence base supporting management action on attendance management. The Report by the Nuffield Trust “*Improving the health of the NHS Workforce*” described ten actions for organisations to incorporate into “comprehensive and integrated staff health and improvement plans”³.

In addition the Group noted the Cabinet Office Report “*Working Well Together – Managing Attendance in the Public Sector*”⁴. As an outcome of the Cabinet Office Report, performance targets were set for the reduction of sickness absence in the Public Sector. A Resource Pack was developed to help all public sector bodies to manage attendance in a fair, consistent and supportive way. The Resource Pack has been issued to all HSS Trusts and the Working Group would commend its application within HPSS organisations.

The number of staff retiring early from the Service on grounds of ill health continues to give cause for concern. At the same time as losing these scarce skills, the Service is experiencing difficulties in recruiting and retaining staff across key groups, such as nursing. The steady rise in permanent injury benefits is yet another indicator of a less than healthy workforce. Other costs include those arising from accidents at work.

A further important factor influencing provision in the near future will be the implementation of recommendations relating to healthcare workers and serious communicable diseases, in particular, blood borne viruses. It is likely that new guidelines will come into place in Northern Ireland relating to health clearance arrangements for all healthcare workers new to the HPSS. These will include a check for TB disease/immunity and offers of Hepatitis B immunisation, and testing for Hepatitis C and HIV. In addition, there will be compulsory health clearance for Hepatitis B, Hepatitis C and HIV for healthcare workers engaging in exposure prone procedures. The new measures will bring additional workload/capacity issues for already stretched Occupational Health Departments, and additional costs associated with immunisation and tests.

This Report proposes that it is both timely and necessary to invest in the health of our workforce. Modernised provision will have a cost. In the

³ Improving the Health of the NHS Workforce, Report by Nuffield Trust, March 1998

⁴ ‘Working Well Together, Managing Attendance in the Public Sector, Cabinet Office, 1998

longer term that cost will be recognised as a prudent investment, with returns realised in a healthier, better motivated workforce, reduced levels of sickness, a general reduction in the costs associated with work-related illness and injury, and ultimately a better provision of service for patients and service users.

The Report also takes into account the needs of primary care staff. Primary care covers a wide range of services provided by a number of different health and social care professionals. Many of these staff are outside the automatic provision of HPSS Occupational Health Services as they are independent contractors or employees of independent contractors. General Medical Practitioners and the staff whom they employ are a key group without access to Occupational Health services. This Report has taken the view that improved provision should include an extension of cover to this group. The nature, phasing and funding of that provision will require further work.

The Report aims to set out the background to developments and make recommendations for change aimed at bringing about tangible improvements for staff, employers and HPSS service users.

1.2 Review of Occupational Health Provision

In January 2002 the Department of Health Social Services and Public Safety established a Working Group to undertake a review of Occupational Health provision and make recommendations for the future. The Group was chaired by Mr David Bingham, Director of Human Resources, DHSSPS, and included members drawn from HPSS employers, Occupational Health professionals, general practice and an external advisor. Members of the group are listed at **Appendix A**.

1.3 Terms of Reference

The terms of reference for the Review were to:

- Identify the resources currently utilised in the delivery of Occupational Health Services in the HPSS in terms of finance, skill mix, policies and practices.
- Develop a specification for an Occupational Health Service to meet the needs of the HPSS over the next 2-7 years. The specification should take into account emerging needs, new developments in the workplace and best practice. The specification should also include standards for service provision in the future.

- Consider the needs of Primary Care, and set out the case for extending Occupational Health provision to General Medical Practitioners.
- Develop a model(s) for the future delivery of Occupational Health Services for the HPSS and Primary Care, and prepare a business case identifying the need for investment in additional services, infrastructure, skills, training and workforce planning.

1.4 Process

The Working Group undertook a range of initiatives to complete the terms of reference. It was quickly realised that little comparative information existed on Occupational Health Services both within and outside of Northern Ireland. A major survey of provision was undertaken across all HPSS organisations and HPSS Occupational Health departments in Northern Ireland. In addition, the broad outline information provided by the Survey was supplemented by a Case Study commissioned within Craigavon Hospital Trust, which explored the nature, frequency and cost of work-related ill health and injury within an HPSS setting. Other work was undertaken to consider the causes of early retirement on grounds of ill health within the Northern Health & Social Services Board area. Each piece of work has provided the Group with useful information to inform the decision making process. Appropriate summarised information is included in Section Two and is used as a baseline for recommendations.

The Group has involved stakeholders in the consultation process, and this report takes into account a wide range of responses from individuals and organisations (See **Appendix C**).

2. CONTEXT FOR THE REVIEW

2.1 The Health & Personal Social Services Workforce

2.1.1 Workforce Statistics

The HPSS directly employs almost 60,000 staff. Nursing and Midwifery is the largest staff grouping. Each group of staff have general and particular needs associated with their employment. Figure One shows the workforce distribution.

Figure One:

NI HPSS STAFF IN POST BY OCCUPATIONAL GROUP March 2002 <i>* Figures rounded to nearest 100</i>	Head Count*
Administrative and Clerical	10700
Works and Maintenance	600
Ancillary and General	7100
Nursing and Midwifery	17600
Social Services	4000
Professional and Technical	5100
Medical and Dental	2900
Ambulance	800
Home Help	7000
Bank staff	4000
TOTAL HEAD COUNT	59800

In addition to those directly employed by the HPSS, health and personal social care is delivered by many who are independent contractors. In March 2002 there were almost 1000 General Medical Practitioners working in Primary Care. Whilst the HPSS directly employs many of the staff working in the primary care sector, General Practitioners also directly employ a number of staff (estimated over 2000). This group of staff cannot currently access the Occupational Health Service provided for directly employed staff.

2.1.2 Ill Health Retirements

Figure Two sets out information based on HPSS Superannuation data, on the numbers of staff retiring on grounds of ill health from 1992/93 to 1999/2000. The information shows that in any year more than a third of those retiring from the HPSS are retiring on the grounds of ill health.

Readers should note that the information is based only upon staff that are members of the HPSS Superannuation Scheme.

Figure Two: HPSS Superannuation – Ill Health Retirements

Year	All Retirements	Ill Health Retirements	Ill Health as % of all retirements	Active Membership	Ill Health as % of Total Membership
1992/1993	1,223	410	33.5	33,711	1.2
1993/1994	1,362	471	34.6	33,664	1.4
1994/1995	1,515	511	33.7	34,648	1.5
1995/1996	1,460	534	36.6	35,677	1.5
1996/1997	1,312	488	37.1	36,515	1.3
1997/1998	1,310	425	32.4	38,076	1.12
1998/1999	1,030	376	36.5	40,255	0.93
1999/2000	1,006	358	35.6	42,308	0.85
2000/2001	1,180	367	31.1	43,974	0.84

The importance of this information is further underlined by consideration of the average age of those ill health retirees. *Figure Three* provides information for three periods over the last decade.

Figure Three: HPSS Superannuation – Average Age by Pension Type

	Incapacity Pension	Average Age	Injury Pension	Average Age
1990/1991	284	53	1	56
1995/1996	520	50	22	42
2000/2001	362	51	2	46

The information confirms that the HPSS loses the contribution of a high number of essential experienced staff who health permitting could have contributed to the Service for a further five to ten years.

Preliminary findings from work currently being undertaken in Scotland shows that many ill health retirees find alternative employment subsequent to leaving their healthcare occupation. When we consider that over 40% of staff (See Figure 4) are leaving due to musculoskeletal conditions, it is not surprising that workers may find a less physically demanding occupation. However, there may be potential for exploring greater use of redeployment, as an alternative to ill health retirement.

If we are to influence the numbers of ill health retirements, we need to consider new strategies for maintaining the health of employees. These strategies will require the introduction of new rehabilitation measures to support return to work. Occupational Health staff can also work with

professionals in eliminating work induced problems. Those staff who are clearly unable to continue to work should be encouraged to make earlier application for ill health retirement.

An audit of early retirement in a Community Trust and an Acute Trust⁵ for the two-year period April-March 1999-2000 and 2000-2001 established useful information on reasons for ill health retirement within the HPSS. The audit considered 82 individuals who had retired on grounds of ill health over that period. The reasons identified for ill health retirement in the group are noted in *Figure Four*.

Figure Four: Reasons for Ill Health Retirements, Independent Survey

Reason for ill Health Retirement	% of Total ill Health Retirees in the Period
Musculoskeletal	48%
Mental Health	26%
General Medical	8%
Cancer	4%
Neurological	4%
Circulation	4%
Immobility	4%
Unknown	6%

Musculoskeletal conditions account for almost half of all reasons for ill health retirement. Musculoskeletal conditions were further broken down into back (28%), generalised pain (3%), lower limb (4%), hip (5%), arm (2%), neck (4%) and shoulder (2%). The second major cause of ill health retirement was identified as Mental Health. This includes depression, anxiety, stress, psychosis and bi-polar disorders.

40% of those in the study were nurses, including 6% who were auxiliary nursing staff. The next highest group was ancillary and general staff (21%), followed by social work (18%). Administration and Clerical staff represented 10% of the figures, with the remainder made up of professional and technical staff (4%), estates staff (4%) and medical staff (3%).

Whilst exercising caution about the small data set being used, the trends identified are supported by other research.

⁵ Audit of Early Retirement on Medical Grounds, NHSSB OH Department, 2002, Unpublished

In 1995 a household survey⁶ carried out in GB on behalf of the Health and Safety Executive established that musculoskeletal conditions and work related stress were the highest causes of ill health arising from the workplace.

In a discussion document presented by the Occupational Health Forum for Northern Ireland⁷ the following study was also referenced:

*'Within the European Union, it has been estimated that during the period 1998-1999, almost 8 million people in work or having been in work were suffering from health disorders. Of all the people reported, 53% involved musculoskeletal disorders, which were most frequent in the construction, transport and health and social work sectors, while stress related illness accounted for 18% of cases.'*⁸

The Working Group also considered the position of staff on long term sickness. The majority of staff applying for ill health retirement are absent for the twelve months prior to retirement. Staff usually take their full allowable occupational sick pay, that is, six months full pay and six months half pay. Pensions are based on the best year in the last three years of employment, and also relate to the number of years service. This is an area worthy of further exploration and guidance for employers and employees.

A further discussion point raised by the study was the identification of health problems at pre-employment stage and the possible link with conditions identified as the reason for early retirement. The fact that health problems may be identified at pre-employment stage emphasises the importance of competent, objective and fair Occupational Health advice in declaring fitness for employment. As Occupational Health had only been in place for 10 years in the organisations covered, many of those retiring had not been seen for a pre-employment assessment. Only 18 cases contained pre-employment information. Of the 18 assessed, 7 noted pre-employment conditions. Of the 7 noted, 6 identified similar conditions at ill-health retirement. As a general point it is clear that entry to the Service is a key threshold for the application of consistent principles to determine suitability of applicants. Panels must be clear about the application of Disability Discrimination requirements. This should not be confused with the identification of poor attendance records, which should influence appointment decisions. This may be an area where managers require further guidance.

⁶ Self-reported working related illness in 1995. HSE Books, 1998

⁷ Developing an Occupational Health Strategy for Northern Ireland, Discussion Document, April 2002

⁸ Source: Eurostat – Statistics in Focus

Investment in Occupational Health Services would facilitate access to expertise to assess the impact of work on health and help employers to design jobs that minimise risk and promote health in the workplace.

2.1.3 Cost of Injury

The cost of work - related injury is much more than a financial figure. The effect on individuals and families is potentially far reaching. The cost for the HPSS includes lost skills and experience. There is also a direct financial penalty on the Service resulting from work-related injury.

A Health and Safety Executive Study showed that the cost of accidents to a hospital amounted to 5% of the annual running costs⁹. Furthermore, in 1997, the National Audit Office estimated that the immediate costs of accidents in NHS hospitals in England was approximately £12 million.

Figure Five shows the total monies paid out to HPSS Superannuation members, in respect of Injury Allowances between 1998/1999 and 2000/2001.

Figure Five: Total Monies paid out in Injury Allowances

Year	Permanent Injury Pension (Sect 44) £	Permanent Injury Lump Sum £	Temporary Injury Allowance (Sect 66) £
1998/1999	483,430	70,357	80,942
1999/2000	500,298	40,173	67,140
2000/2001	513,273	1,030	66,631

From April 2001 management of temporary injury claims passed from the HPSS Superannuation Department to employing bodies, that is, primarily HSS Trusts. The employing bodies also meet the cost of the pensions/allowances arising from Permanent and Temporary Injury. An individual who has retired early from their work, and can demonstrate that their illness was caused by their work, may be awarded Permanent Injury Benefit. That benefit (pension) may be up to 85% of their salary per annum, and is paid by the employer for the lifetime of the former member of staff. Employers are concerned that the cost pressures created will continue to build and directly impact on the ability of the Service to fulfil its primary purpose, that is, providing care to

⁹ HS(G)96 (1996) The Costs of Accidents at Work, Health and Safety Executive

patients/service users. Occupational Health has a key role to play in risk assessment and the promotion of health in the workplace. That role complements those of health and safety/risk managers and health promotion specialists. There is an economic argument for a more proactive approach to Occupational Health within the HPSS, maximising its contribution to health and safety and health promotion, in order to support reduction in work-related ill health and injury.

2.1.4 Absence Management

Absence levels in the HPSS are approximately 20-25% above the average Health Service levels in England, Scotland and Wales. The factors contributing to absence are varied. Sickness absence has a myriad of causes. The effective management of absence is one of the highest priorities for managers across the HPSS. A reduction in absence levels would increase the availability of resources to invest elsewhere, to reduce pressure on other staff and to allow investment in monies saved to improve the quality of service to service users. If we were able to reduce absence levels to those of comparable services in England, Wales and Scotland, there would be a saving of £10 million on Occupational Sick Pay alone. The benefit to service users and staff would be in the increased capacity of the workforce.

Absence levels for the HPSS averaged 6.5% for 2001/2002. This compares to a figure of 4.5% for NHS Trusts. However, there is little information available to determine the percentage of absence that is related to work. The Working Group commissioned a study of the volume and cost of work-related illness and injury within an Acute Hospital Trust in Northern Ireland. The study covered a 12-month period (1 February 2001- 31 January 2002). 484 appointments were made with the Occupational Health Department during the period. Of these 248 were management referrals and a further 9 were self-referrals. 14% of referrals were for work-related reasons. *Figure Six* provides a breakdown of those work-related referrals.

Figure Six: Breakdown of Work-Related Referrals, Acute Trust Case Study, 2001/2002

Work Attributed Conditions	Number of referrals	% of total work related referrals	Number of days related absence	Cost of work-related absence
Work-related Injury: musculoskeletal and low back pain	13	19%	529	£22,974
Work –related Illness: Skin conditions	3	4.4%	32	£ 2,232
Other Work Related categories: Psychological, Industrial Relations	20	29%	688	£43,514
Accidents/ Incidents at Work	Not resulting in referral	N/A	137	£ 7,638
		Totals	1386	£76,358

Costs were based on the average hourly rate for various disciplines of staff. They are based only on the cost of hours lost by those absent from work. They do not take into account the cost of covering the absence. Consequently, the true cost of the work related absence could be as high as £150,000 in the year, excluding the costs of any employer liability claims which may have been instigated.

It is also interesting to note that that 42.5% of staff who attended Occupational Health and were coded under the Other Work-Related categories had no associated absence.

The Report for the Cabinet Office “Working Well Together – Managing Attendance in the Public Sector” provides a valuable analysis of data on sickness absence in the public and private sector. It examines:

- why some parts of the public sector are much better at achieving higher attendance than others, taking account of structural influences such as workforce profile, and
- why levels of sickness are higher in the public than private sector.

Whilst the Report was published in 1998 its recommendations and analysis continue to have value today. Within the HPSS there continues to be wide variation in absence rates (range 5% - 10%), and the Northern Ireland public sector average continues to be higher than the Northern Ireland private sector average.

In attempting to identify factors which might offer some explanation for the higher rates, eight key factors were identified, namely:

- Working hours
- Caring/social responsibilities
- Motivation
- Changes in working practices
- Absence culture
- Safety, health and welfare services
- Short-term self certification
- Long-term sick pay

Other useful comparative information is available from the Confederation of British Industry's Annual Absence and Labour Turnover Survey.

Figure Seven

CBI Report: Absence Levels by Sector

"Pulling Together: 2001 Absence and labour turnover survey"

Sector	Number of working days lost (all employees 2000)	As % of available days
Public sector	10.2	4.5
Transport & Communication	9.4	4.2
Construction	8.7	3.9
IT/hi-tech services	7.2	3.2
Energy/water	7.1	3.1
Banking, finance & insurance	7.0	3.1
Manufacturing	6.9	3.1
Other services	6.2	2.7
Retailing	5.8	2.6
Professional services (lawyers, medical etc.)	4.5	2

2.2 Current Occupational Health Provision

2.2.1 The Providers of Occupational Health Services

All HPSS employing authorities and Trusts are required *'to ensure that their staff have access to confidential Occupational Health Services, either provided by them or obtainable from another provider.'*¹⁰ Occupational Health Services for the HPSS are delivered by a range of providers. The larger in-service providers are Westcare, the Royal Group Hospitals OHS, the Belfast City Hospital OHS and the Northern Health and Social Services Board (NHSSB) Occupational Health Service. All but the NHSSB directly employ a Consultant Occupational Health Physician and provide services to a range of HPSS authorities and Trusts on the basis of Service Level agreements. In addition a number of Trusts directly employ their own Occupational Health nurses and, by contractual arrangement, access specialist advice/service from a Consultant physician. Usually, that specialist advice is provided by one of the three Physicians already employed by the larger Services. On some occasions an independent Occupational Health Physician provides the advice/service.

2.2.2 Cost of Occupational Health Services Provision

Figure Eight provides summary cost information for the provision of Occupational Health Services to HPSS staff across Northern Ireland. The information is based on a survey of HPSS employers and Occupational Health Departments¹¹. For convenience the costs are based on the four Health Board areas. This does not necessarily reflect the cost of a particular Occupational Health Service. For example, the Eastern Health and Social Services area is covered by two larger Occupational Health Services, and a number of smaller Trust - based services. In addition, some providers may provide an extended range of services. However, the figures do provide an overall picture of expenditure and allow a breakdown of costs by number of staff covered.

¹⁰ HSS(GEN1) 2/95 Occupational Health; Services for HPSS staff

¹¹ Review of Occupational Health Services for HPSS Staff, completed May 2002, unpublished

Figure Eight: Expenditure by Health and Social Services Board, 2001/2002

Area	Expenditure £	Staff Covered	Cost per Head £
Northern	292,856	11,550	25.35
Western	313,063	9,467	33.06
Southern	329,042	8,830	37.26
Eastern	1,047,370	29,424	35.59
NI HPSS	1,982,331	59,271	33.44

Thus, between 1 April 2000 and 31 March 2001 the total cost of provision was just under £2 million. This averaged out at £33.44 per member of staff.

2.2.3 Occupational Health Services Staffing

Figure Nine: Staff Numbers and Groups at May 2002

Staff Group	Numbers	
Medical	3	Consultant Occupational Health Physicians*
	2	Specialist Registrars
	13	Medical Officer sessions per week
	22	General Practitioner sessions per week
	40	Total medical staff
Nursing	1	D Grade
	12.5	E Grades
	6.4	F Grades
	10.1	G Grades
	3	H Grades
	3	I Grades
	35	Total nursing staff
Admin & Clerical Staff	21.3	staff

*A further 4-5 sessions per week are provided by an external provider.

It is worth noting that it is becoming increasingly difficult to recruit General Medical Practitioners (GPs) for Occupational Health sessions. The rates payable to GPs under the new contract are set and proving unattractive to practitioners. It is unlikely that the service can continue to rely so heavily on the availability of GPs to provide Occupational Health sessions. This supports the view that Occupational Health services should be adequately staffed by a body of Occupational Health physicians (See paragraph 9.5).

2.2.4 Related Services

In addition to the core services provided by Occupational Health, employers indicated that their services were supplemented by access to related specialist services. These included Physiotherapy, Clinical Psychology, Counselling, Dermatology, Respiratory Medicine, Occupational Hygiene, Aromatherapy, Audiology and Optometry. This access is usually based on informal agreements.

2.2.5 Integration with Health and Safety and/or Health Promotion.

It was also evident in the Review of Services that there was a varying degree of integration with Health and Safety and/or Health Promotion functions. The majority of Trusts employ or designate a Health and Safety Officer(s), Fire Officer(s), Health Promotion Officer(s), and a Back Care/Manual handling Trainer(s). A few Trusts also have Resuscitation Training Officers.

2.3 Expenditure Benchmarks

It is extremely difficult to secure useful benchmarks for Occupational Health Provision. With regard to cost *Figure Eight* has already identified the range of expenditure per head of staff across the four Board areas. It is difficult with other benchmarks to establish that we are comparing like with like. However, the following are useful benchmarks for expenditure:

A sample of English Trusts	£42 per member of staff
Scotland for Occupational Health and Safety	£80 per member of staff
Scotland (excluding Health & Safety function)	£50 per member of staff
NI HPSS	£33 per member of staff

It is clear from the few available benchmarks that expenditure on Occupational Health Services for HPSS staff lags significantly behind investment elsewhere. Later in the Report a case will be made to increase expenditure to £50 per member of staff over the next three years to provide an effective service capable of proactively addressing the range of issues facing the HPSS. This will ultimately require an additional recurring expenditure of £1 million. These additional costs have been based on additional staff costs.

2.4 Staffing Benchmarks

The Association of NHS Occupational Physicians (ANHOPS) has published Guidelines for staffing in 1999¹². These considered the minimum workforce requirements for an NHS service and then qualified the final requirements by reference to a range of influencing factors.

Figure Nine compares the ANHOPS Guidelines as a comparator with the current position.

Figure Ten: ANHOPs Guidelines for Staffing

Guideline	HPSS Requirement	Actual HPSS Position
1 clinical session per 1000 employees	60 Clinical sessions/ 6 WTE OH Physicians	30 Sessions/ 3 WTE OH Physicians
1 Occupational Health Nurse per 1000 employees	60 OH Nurses	35 OH Nurses

In considering the appropriate workforce levels and skill mix it is important to remember that current provision is supported by a significant number of GP and medical officer sessions. Also, whilst 30 Occupational Health Physician sessions are noted as currently available these are not all available for clinical work. Physicians are significantly involved in the additional activities noted at Section 2.5.

The core requirements for a small NHS Trust (750 employees) per week, are set out in *Figure Eleven*

**Figure Eleven:
Core Requirements for a small NHS Trust per week (750 employees)**

Post Title	Core Manpower Levels	Additional Requirements
Occupational Physician	Clinical Activities 1.00 session Policy/Strategy input 0.5 session	For every additional 100 employees: Clinical Work 1.00 session Policy/Strategy input 0.25 session
Occupational Health Nurse Adviser	1.00 – 1.25 WTE	For every 1000 employees: 0.75 – 1.00 WTE
Administrative Staff	1.25 – 1.50 WTE	For every 1000 employees: 0.25 – 0.5 WTE

¹² ANHOPS Guidelines, Assessing the Occupational Health Manpower levels for NHS Trusts (2), 1999

2.5 Factors Influencing Staffing Levels

ANHOPS Guidelines recognise a range of factors influencing the figures set out in the tables above. These include:

- The requirement to undertake the management duties of the Service.
- Degree of management of rehabilitation programmes/support.
- Degree of management/co-ordination of risk management, health and safety, fire, physiotherapy etc.
- Number and location of provider sites.
- Amount of income generation activities undertaken.
- Amount of training and advisory services provided e.g. first aid, induction, risk management, sickness absence etc.
- Amount of health promotion activities undertaken.
- Requirement for OH Nurses to undertake counselling services.
- The administration requirements of recall procedures e.g. for hepatitis B.
- Contribution to undergraduate training.

Since the figures were first identified, Occupational Health Departments have taken on a range of additional activities. Clinical Governance, in particular, has added a new dimension to the Occupational Health role. Proposals regarding future staffing levels must be based on the future needs of the organisation, the core range of services specified, the standards set for performance and the skill mix required in delivering the service. The extended role of competent Occupational Health Nurses raises particular skill mix opportunities.

The vision for modernised Occupational Health Services in the HPSS requires significant change in focus and range of activities, supported by appropriately skilled and resourced staff.

3. RATIONALE FOR CHANGE - PRESSURES

The Group identified a range of pressures underpinning the rationale for change. Some of these have already emerged through discussion of the current situation. They are now summarised together:

3.1 Loss of Scarce Skills

The loss of scarce skills and experience through ill health retirements, and the impact of the associated financial costs. There are increasing financial pressures from permanent injury benefits, the cost of employer's liability claims and the cost of replacing skilled staff. Generally high sickness levels also necessitate alternative strategies for the effective management of absence. Overall, there is a direct impact on the capacity and capability of the HPSS to deliver a quality service to patients and service users.

3.2 Workplace Pressures

Underlying the effects of ill health on staff and the service there is recognition of the pressures that staff face in their workplaces. There have been significant changes in the way the HPSS operates over the last ten to fifteen years. Organisations have introduced new management arrangements and sought out more effective ways of working. New technologies have revolutionised clinical and general working practices. Public expectations have risen and an emphasis on patient/user centred care predominates. Whilst change has enabled increases in levels of activity, it has also coincided with a view that individual workloads have increased and a perceived rise in levels of stress. A further pressure is the rise in violence against staff. A publicity campaign on violence to staff was launched in March 2004 to raise awareness and echo the Government's zero tolerance policy. The HPSS is committed to becoming the Employer of Choice within the NI economy. It is essential that if we are to achieve that position we must develop strategies to improve and protect the health and safety of our staff. The importance of good mental health on general staff morale and individual staff motivation has to be recognised.

3.3 Limitations of the Status Quo

It is timely to describe a new vision for improved Occupational Health Services for HPSS Staff. There is a need to move from an emphasis on

the management of ill health to the development of a culture of Health protection. The *status quo* does not adequately meet the needs of Occupational Health providers nor the employers commissioning the services. Funding does not enable development of the service to meet the aspirations of the stakeholders. There are examples of good practice across different Occupational Health Services, but these are not consistent.

3.4 Disability

Employers need increased support and advice to enable greater numbers of disabled persons to find appropriate employment within the HPSS. Advice is also required when individuals encounter circumstances where disability changes their ability to continue in their particular job. Again the Service works from the perspective of complying with legislation rather than supporting more imaginative approaches to adjustment and redeployment.

3.5 Needs of Primary Care

At present General Medical Practitioners and their staff are currently unable to access the Occupational Health expertise within the Service they contribute to (See also Section 8). There is also recognition that doctors have particular needs, which need to be taken into account when developing appropriate services for the future.

3.6 Communication and Lack of Common Purpose

Communication and relationship issues are still identified by managers and by Occupational Health staff as a difficulty. There are at least three sets of expectations for Occupational Health Services. Occupational Health staff often feel that managers have unrealistic expectations of the service, particularly where absence management is concerned. Managers feel that Occupational Health is not always sufficiently responsive in areas such as completing pre-employment assessments, and also seek more assistance with regard to perceived abusers of absence policies. Service users are confused by the role of Occupational Health – is it an extension of the disciplinary arm of the organisation and/or how does it match with my GPs management of my health? There is a need for clear communication and understanding of the role, range of services provided and standards to be met. A common understanding of purpose should replace the different sets of

expectations. The re-branding of Occupational Health Services may assist in developing a changed service.

3.7 Rehabilitation

Rehabilitation has been undervalued by HPSS organisations. There is a need to invest in rehabilitation initiatives. Informal access to specialists is insufficient and demonstrates restricted access to services. These should be replaced by formal professional arrangements for specialist input in the important areas of staff mental health, musculoskeletal and skin problems. Rehabilitation programmes have the potential to return staff to full health and a full role as quickly as possible. Whilst consultation noted significant support in this area, there was also caution from a probity and equity perspective. This may be best summed up by an excerpt from the Cabinet Office Report, which noted that:

“Public sector organisations will be conscious of concerns that taxpayers money should not be used to provide benefits in kind to public sector staff; and sensitive about using occupational health and welfare support to duplicate or replace NHS provision”.

This issue will require further consideration.

3.8 Integration with Health Promotion and Health and Safety

The Group also identified the need for greater integration with health promotion and health and safety. This is not to say that these functions have to be met within a single organisational arrangement. However, there need to be clear links between the areas to ensure that the full potential of the complementary parts is achieved. All employers have duties and responsibilities under the Health and Safety at Work (Northern Ireland) Order 1978 and subsidiary regulations. These require employers to maintain a safe and healthy working environment for their staff, and cover employers’ responsibilities for the health, safety and welfare of employees at all work sites. The Cabinet Office Report found that:

“many employers including those in the public sector, have focused on the safety end of the spectrum, aiming to prevent injuries at work. Reducing occupational injuries and illness has an important part to play in reducing total sickness absence. Improved attention to health at work issues, especially assessment and prevention measures, would be likely to make a significant contribution to reducing sickness absence”.

3.9 An Occupational Health Strategy for Northern Ireland

The timely development of an Occupational Health Strategy for Northern Ireland¹³ provides a reinforcement of many of the themes addressed in this report. It is noted that the discussion document Developing an Occupational Health strategy for Northern Ireland proposes that Occupational Health Support Teams would provide support for all small medium sized firms in that particular Health Board area for which it held responsibility. The document also notes that the Health Service may require additional resources in order to play its part in the areas of rehabilitation and provision of professional occupational health services. Whilst the group welcomes the intent behind these proposals, it is equally clear that the first priority for modernisation will be to realise the level and quality of service required first for our own staff, before the Service could move on to extend its role to a wider workforce group.

3.10 Lack of Performance Measures

A further issue requiring development is the lack of any agreed performance measures for Occupational Health. We need to be able to benchmark the performance of the Service(s) in the future against agreed indicators of effectiveness (some quantitative and some qualitative).

3.11 Capacity and Skill Mix

The capacity and skill mix of Occupational Health services also requires consideration. There are insufficient Consultant Occupational Health Physicians providing the Service. Services are also reporting increasing difficulty in recruiting qualified medical staff. Non-consultant, career grade posts such as staff grade may form a useful part of workforce plans for the future. There is a need to further increase the numbers and develop the roles of qualified Occupational Health nurses in line with the future needs of the HPSS.

3.12 Contribution to Policy Development

¹³ Developing an Occupational Health Strategy for Northern Ireland, Discussion Document, April 2002, The Occupational Health Forum for Northern Ireland

The contribution of Occupational Health to the development of consistent employment practices and policies needs to be confirmed within the Occupational Health brief.

3.13 European Community Developments

Developments in the European Community have demonstrated a greater potential contribution of Occupation Health to the effective running of organisations. That contribution should be fully realised within the HPSS sector. Whilst we may not be recommending moving towards models such as in Finland, where Occupational Health Physicians deliver primary care in the workplace, we are looking for greater innovation in securing the well being of staff at work.

4. VISION FOR THE FUTURE

4.1 From Management of Illness to Health Protection

The vision for modern Occupational Health provision is of a service focused on enhancing the working capacity of the HPSS workforce; where health protection is a valued goal above the management of illness. A proactive service will develop and implement strategies to protect and promote good health in the workplace. There will be investment in innovative approaches to health protection and an effective contribution to the design of work and the modification of jobs. Occupational Health will lead the development of relevant HPSS policies and best practice guidance for staff and managers. Research and development will be valued as essential to supporting an innovative service. Multi-disciplinary approaches will be valued and the role of Occupational Health staff developed in line with changing needs. Services providing beyond basic statutory requirements. The HPSS will be an exemplar employer in its provision of Occupational Health Services for staff. There will be equal access to a comprehensive service for all HPSS staff.

4.2 Clarity of Role, Purpose and Standards

There will be a common understanding of the role and purpose of Occupational Health. HPSS staff will have a clear route to both core Occupational Health services and to specialist medical advice and support. Routes to services, which will improve the possibility of early return to work, will be clearly understood, such as referral to physiotherapy or clinical psychology. There will be evidence of a range of rehabilitation programmes. Occupational Health Services will have agreed standards and indicators for effective performance. There will be minimum service delivery standards set across the range of services provided.

4.3 Structured to Deliver

The management of the Occupational Health Service will be appropriate to the delivery of objectives. Currently, little common information exists to identify trends in activity or the impact of particular initiatives. An information infrastructure will support effective decision-making and minimum data sets will provide a framework for information gathering.

Opportunities to use Information Technology to increase the efficiency of the Service will be explored, such as, the use of Smart Cards for Junior Doctor rotational appointments.

4.4 Resourced Appropriately

Occupational Health Services will be appropriately resourced for the agreed range and level of performance. Services will demonstrate value for money.

4.5 Confidentiality

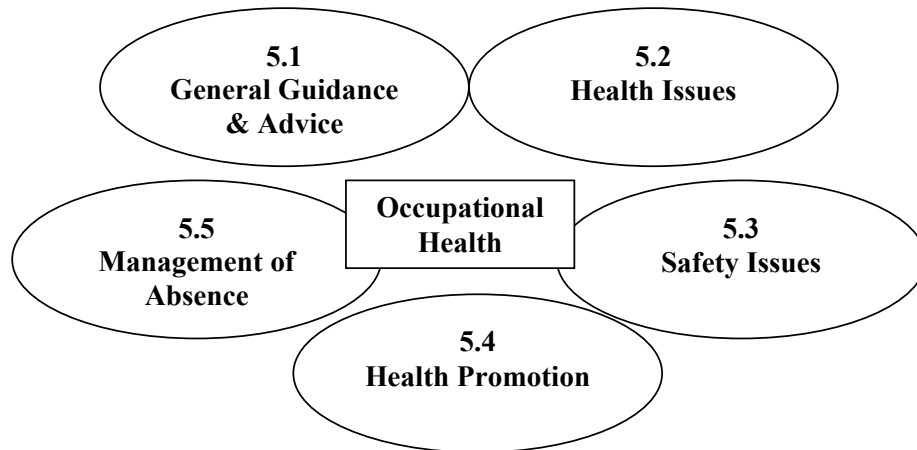
Confidentiality will continue to be a core value of Occupational Health. The parameters of confidentiality will be clarified in a HPSS policy document and disseminated clearly to staff, employers and Occupational Health providers.

4.6 Achieving the Vision

In conclusion, the Group recognises that the vision is far reaching, affecting the role and purpose of Occupational Health Services in the HPSS, the range and standard of services available, the philosophy underpinning Occupational Health and the associated change in behaviours and culture. Achievement of the vision will take time and require significant investment. Implementation will not be achieved over night. The vision will shape the direction of change over the next 2-10 years.

5. RANGE OF SERVICES

In this section the Group has set out a core range of services which should be available under the various roles of Occupational Health. The lists are not exhaustive, but provide general indicators in each area. The functional roles covered are:



5.1 General Guidance and Advice

- Development of Occupational Health guidance, policies and standards.
- Monitoring the health of employees.
- Hazard identification, risk assessment, elimination or control of risk followed by audit of effectiveness.
- Implications of legislation and guidance e.g. the Disability Discrimination Act, Working Time Directive, Clothier Report.
- Health requirements under the Working Time Directive.

5.2 Health Issues

- Immediate access to advice and treatment for biological hazard exposures.
- Pre-employment health assessment – should not be constrained by resources – improved pre-employment screening.
- Health assessment in employment usually following absence – A triage system where staff are quickly seen by an Occupational Health Nurse able to refer on to an Occupational Health Physician or other specialist, may ensure optimum use of resources and enable staff to return to work faster. (facility for self-referral and management

referral). Alternately, written referrals would be examined by a nurse and doctor, and it would be decided whether it was appropriate for the nurse or doctor to initially see the person. If a nurse was to see the person first, then they could refer on to the occupational physician.

- Advice on the provision of rehabilitation after a period of sickness or the appropriateness of return to work.
- Managerial advice on the management of absence.
- Provision of a comprehensive occupational immunisation programme.
- Appropriate screening, advice and support.
- Access to a confidential counselling service.
- Developing health surveillance strategies to meet statutory obligations.

5.3 Safety Issues

- Assessment and reduction of risk.
- Assistance with job design.
- Production of comprehensive workplace assessments.
- Monitoring of ill-health and accident statistics.
- Training and good practice in the usage and disposal of needles and sharps.
- Advice and training on the correct aids for use in manual handling.

5.4 Health Promotion

- Education of staff in, and promotion of adherence to, health and safety legislation in association with other parties.
- Health promotion and education in the workplace.

5.5 Management of Absence

Sickness absence is one of the major issues affecting general service delivery. Responsibility for the effective operation of sickness absence policies rests with line managers. However, there is also an important role to be played by Occupational Health. The Cabinet Office Report noted that, with regard to ‘Safety, Health and Welfare Services’:

“Improved attention to health at work issues, especially assessment and prevention measures, would be likely to make a significant contribution to reducing sickness absence”.

The Report also noted that there was a wide variation in the extent to which employers provided and used welfare and occupational health services:

“In general and when used well, occupational health services can provide assistance to both employees and managers in helping plan the return to work. However, where poorly managed, the use of occupational health facilities was seen to cause significant delay to the absence management process and hinder earlier more active steps by management to resolve cases”.

The roles and responsibilities of managers, human resource departments and occupational health staff require open discussion within HSS organisations. Line managers must continue to take responsibility for the management of sickness absence. Human resource departments must be at hand to give specialist advice and support. Occupational Health Departments must contribute effectively at key stages, such as, pre-employment health assessment. Advice on the development of attendance management and light duties policies, the design of rehabilitation programmes and referral to appropriate medical interventions are all roles that can be undertaken effectively by Occupational Health services. The role of Occupational Health Nurses should also be further explored with respect to their contribution to management of absence programmes. Occupational Health directly contributes to the ability of the Service to effectively manage absence.

“Working Well Together” recommended that all public sector organisations:

“Encourage staff to make full and effective use of welfare and counselling services in order to minimise sickness absence.”

In providing greater support for Managers in the area of attendance management there is also a need for investment in Human Resource Departments to fund initiatives to address rising absence levels.

5.6 Income Generation

This area is further referred to at Section 9.7. The Working Group acknowledges that a number of HPSS Occupational Health services currently undertake income generation activities. In some instances those activities involve the provision of a range of Occupational Health Services to other HSS organisations. It is not possible for this Report to

identify whether that provision covers the full range of services available to host organisations, or whether a limited range of services is provided. The vision for the HPSS is that all employees will have the same access to a comprehensive range of Occupational Health Services.

Other income generation activities involve provision of services to other public sector organisations, and to some in the private and independent sector.

The primary purpose of the Service is to meet the needs of staff within the HPSS. On attaining this primary purpose, service providers could consider offering access to services and expertise to other organisations on an income generation basis (See also 9.7).

6. STANDARDS FOR SERVICE DELIVERY

6.1 General

The Working Group received a significant number of comments around the standards used in the Consultation Report. Having considered the comments received several themes emerge:

- The specification of standards is essential to ensure the fair provision of a high quality service.
- Standards are an essential part of auditing and governance processes.
- The identification of key standards requires further work. The Regional Advisory Group for Occupational Health Services will undertake that work.
- Service protocols are a further aspect of the standard development process.
- The areas initially identified for standard setting are not an exhaustive list, and the Regional Advisory Group will need to give further consideration to the following list:

Areas for Standard Setting

- Pre-employment
- In-service referral
- Immunisation
- Health Surveillance
- Ill Health retirement
- Health and safety

6.2 Pre-employment Health Assessment

One of the priority issues for the Regional Advisory Group will be the drafting of a standard relating to pre-employment health assessment. A number of organisations questioned the need for face-to-face health assessments. Accurate assessment at pre-employment stage is an essential pre-requisite for a healthy workforce. A qualified Occupational Health Nurse may carry out that assessment, with access to an Occupational Health Physician as required. The use of questionnaires alone is not considered sufficient.

Furthermore, it is clear that the Guidance currently being developed by the Regional Advisory Group on Communicable Diseases, particularly with respect to blood borne viruses, will require that all new employees meet with an Occupational Health Nurse at minimum, to check for TB disease/immunity.

7. PRIMARY CARE

Effective primary care is an essential and integral sector of the Health and Personal Social Services. Whilst staff directly employed by HSS Trusts have access to Occupational Health Services no such provision is currently available for General Medical Practitioners. Staff employed directly by these groups are also outside of HPSS provision. The situation relates to the independent contractor status of practitioners.

However, the Working Group considers that the same arguments can be made for access to a comprehensive range of Occupational Health Services, and that such access will directly benefit Patients and Service Users. Research studies have been undertaken elsewhere which demonstrate the needs of this Group.

The Working Group has also considered a proposal endorsed by the Royal College of General Practitioners and General Medical Services Committee, and published in 1997, which advocated the need to establish a properly funded provision¹⁴. In addition, the DOH announced in the NHS Plan that Occupational Health services would be extended to General Medical Practitioners and their staff from 1 April 2001. Further Guidance was subsequently published detailing what Health Authorities should commission, funded through additional allocations to their budgets¹⁵.

Similar commitments have been made in Scotland and Wales. It is too early to assess the success of the implementation roll out. In 1997, the Employment Medical Advisory Service of the then Department of Employment, Trade and Investment set up a Working Group with the aim of addressing general practitioners Occupational Health needs. This Group reported to the Health and Safety Executive Northern Ireland (HSENI) in April 2000. A Working Group was then established to consider the implications of the Report, inform stakeholders and make recommendations. The conclusion of that work is not yet available. Consequently, the Steering Group is keen to consider the recommendations with a view to possible incorporation into the overall development of Occupational Health Provision for the wider family of HPSS Service providers.

Guidance on serious communicable diseases will impact on all primary care practitioners. That impact will be taken into account in further discussions.

¹⁴ Occupational Health Services for GPs – a national model, RCGP & GMSC, 1997

¹⁵ The Provision of Occupational Health and Safety services for General Medical Practitioners and their staff, Department of Health, May 2001

General Medical Practitioner representatives were late invitees to the Working Group. Nevertheless, there is agreement that HPSS Occupational Health Services need expanded and developed to meet the need of general practice. Further consultation was carried out seeking views on this and a separate report entitled 'Review of Occupational Health Services for General Medical Practitioners and their staff' is available detailing outcomes. In the first instance the work will cover General Medical Practitioners and their staff. A subsequent phase will explore other primary care practitioners, for example, General Dental Practitioners.

8. OPTIONS FOR SERVICE MANAGEMENT

8.1 General

Models explored for the provision of services in the future range from a rationalised number of local services to a wholly central service. If centralisation were to work, it would require the development of systems and approaches to reduce remoteness. A local service on the other hand, could lose the efficiencies of a centralised service and lack access to specialist expertise. Therefore, local services would require to be complimented by access to specialist Occupational Health Physician advice, and access to physiotherapy and mental health sessions, for example. Five possible models are described in Section 8.4. The working group believes that any recommendation on the future form of Occupational Health Services should await clarification of the wider reorganisation of HSS organisations.

The model should align with future organisational arrangements and support achievement of the objectives set for Occupational Health Services in the future. The models are retained in the Report to assist future debate.

8.2 Criteria

Each model was considered against a number of criteria, to determine the extent to which each delivered an improved service to the HPSS, its managers, and staff. The criteria used were:

- Cost - effective and optimises expertise.
- Responsive to the needs of the HPSS.
- Acceptability – the degree to which the objectives of the Occupational Health team and service commissioners are compatible.
- Equity – ensuring a fair share of the service is available according to need.
- Accessibility of core and specialist services.
- Accountability of the service to employers.
- Security – that is, the robustness of the service, risk of interruption to provision.
- Extent to which model facilitates professional development opportunities.
- Data intelligence – Performance Monitoring.
- Profile and influence – ability to influence decision-makers.
- Robustness and sustainability.

- Supports Occupational Health service development.
- Enhances the quality of service from a clinical perspective.

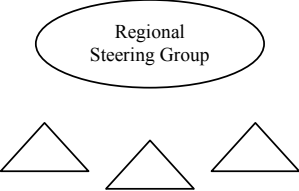
8.3.1 Models

The following models were considered:

- A. Status Quo**
- B. Rationalised locally delivered Occupational Health Services (2 or 3)**
- C. Singular Service: Central management and local delivery**
- D. Specialist Central Service/Rationalised local Occupational Health Services (medically led at all levels)**
- E. Specialist Central Service/Rationalised local Occupational Health Services (nurse led at local level)**

Figure Twelve sets out the advantages and disadvantages of the broad models

Figure Twelve: Advantages and Disadvantages of Service Management and Provision Models

Type of Model	Description	Advantages	Disadvantages
<p>A. Status Quo</p>	<p>Existing services range from locally delivered with directly employed medical and nursing staff to wholly 'bought in' services.</p>	<p>Established relationships are an advantage of the status quo. Relationships between Occupational Health staff and local managers are generally good. Range of services owned by individual and groups of Trusts. There is accountability to the service commissioners. There are examples of excellent and good practice across different services. The service is cheap relative to other Occupational Health Services.</p>	<p>Not delivering what is required. The status quo is inequitable and incapable of meeting the future needs of the HPSS and Occupational Health staff. Whilst there are pockets of excellence in Occupational Health, this is not consistent. The service does not have sufficient capacity or flexibility to respond to the needs of staff or managers. There is little opportunity for professional development within the current structure and resources are limited. Initiative is stifled. The lack of common information inhibits effective decision-making, and prevents any consistent approach to performance management.</p>
<p>B. Rationalised Locally Delivered Occupational Health Services (2 or 3)</p> 	<p>Two or three discrete Occupational Health units covering geographic health economies. Autonomous units of management, directly employing own staff. Services provided to employers on the basis of service level agreements. A regional steering group would provide a strategic overview for the direction & development of services, making bids for additional resources, monitoring information and setting common standards, protocols and policies.</p>	<p>The model would be highly responsive to the needs of the HPSS, and ensure equity of access for each of the geographic areas. Trusts would identify with their local unit. The units are of sufficient size to ensure some economy of scale, whilst also supporting access to a range of specialist services. The model is sufficiently robust to support the future needs of the service and facilitate professional development. The Steering Group would ensure consistency of service, standards, policies etc.</p>	<p>There may still be problems with consistency as the rationalised units are managerially autonomous. May cost more than having specialist services grouped under a single body. Relies on networking across the three units to optimise collaboration and sharing of best practice. The units are accountable to different organisations.</p>

FigureTwelve : Advantages and Disadvantages of Service Management and Provision Models (Continued)

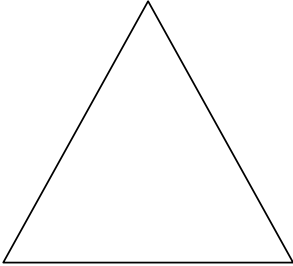
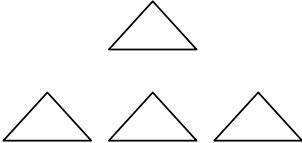
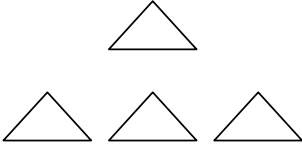
Type of Model	Description	Advantages	Disadvantages
<p data-bbox="264 309 577 384">C. Singular Service: Central Management & Local Delivery</p> 	<p data-bbox="660 309 1034 472">A single occupational health unit providing a service to all of the HPSS. The Unit directly employs and manages all staff and resources. Staff are based both at the centre and at outposts.</p>	<p data-bbox="1057 309 1449 751">There is potential for cost efficiencies in management and the control of resources. Expertise is optimised and ensures equal access to services across clients. Common standards, protocols and policies are facilitated. There is consistent identification of training needs and increased opportunities for professional development. The gathering of consistent information is facilitated and performance monitoring easily implemented. The model can support the development of highly specialist services in a central team.</p>	<p data-bbox="1471 309 1897 667">A centrally managed service may be seen as remote and slow to respond to local need. Local stakeholders may perceive that the service is not accountable to them. Accountability is to the centre. It may be difficult to integrate with local Health and safety functions and responsibilities. The model may be less acceptable to Trusts, as the management of the occupational health service moves away from them.</p>
<p data-bbox="264 761 638 868">D. Specialist Central Service / Rationalised Local OH Services (Medically led at all levels)</p> 	<p data-bbox="660 761 1034 979">A regional unit directly employs specialist medical and other staff. Other medical and nursing staff are directly employed within local occupational health units. All units (regional and local) are autonomous. All units are medically led.</p>	<p data-bbox="1057 761 1449 1203">The model allows a split of core and non-core services. Local ownership is maintained whilst facilitating a higher level of specialisation. The good practice role is given priority by the central service, which also has a lead role in standard setting, monitoring absence levels, trends in accidents etc. There is cost-effective provision of specialist services: including specialist risk assessment, specialist medical referrals, temporary Injury benefit service and potentially a service for general practitioners.</p>	<p data-bbox="1471 761 1897 951">Specialist services less accessible in certain areas. There is potential for unclear relationships between the centre and the local services. The model shifts specialist expertise to the centre with a corresponding loss of presence at local level.</p>

Figure Twelve: Advantages and Disadvantages of Service Management and Provision Models (Continued)

Type of Model	Description	Advantages	Disadvantages
<p>E. Specialist Central Service / Rationalised Local OH Services (Nurse led at local level)</p> 	<p>A regional unit directly employs specialist medical and other staff. Only nursing staff are directly employed within local occupational health units, and those units are nurse led. All units (regional and local) are autonomous.</p>	<p>This model also allows a split of core and non-core services. Local ownership is still maintained, and the model raises the profile and facilitates an extended role for Occupational Health nurses. A high level of specialisation is maintained within the central unit. The good practice role is given priority by the central service, which also has a lead role in standard setting, monitoring absence levels, trends in accidents etc. There is cost-effective provision of specialist services: including specialist risk assessment, specialist medical referrals, temporary Injury benefit service and potentially a service for general practitioners.</p>	<p>Medical staff are employed only by the central organisation – this may be unacceptable to Trusts with the perceived loss of medical expertise, support and influence at local level. The service may not be as responsive to staff and managers if medical staff are not as easily accessible at local level. Specialist services less accessible in certain areas. There is potential for unclear relationships between the centre and the local services</p>

Note: The rationalisation referred to within Models B, D and E could be based on the new integrated health and social care systems. The specialised central service in Models D & E (and within C) could include Occupational Hygiene, Occupational Psychology & Audiology; standardised recording & data analysis; research & training; leadership & direction in terms of standardised policies and protocols; an income generation/NHS plus role; & Occupational health provision for General Medical Practitioners and their staff.

8.3.2 Preferred Model

Model B scored highest against the evaluation matrix used by the Working Group and therefore was identified as the preferred model.

Model B consists of a rationalised number of Occupational Health Units, serving all of the HPSS, including primary care. The number of Units and the staff populations covered should be revisited following agreement on structures arising out of ‘Developing Better Services’. Each Unit would directly employ all of the Occupational Health staff in their geographic area. Each Unit would operate from its own central base, but staff may be based in key locations across the Unit. Each Unit would be autonomous in managing staff and resources, but account to HSS organisations through Service Level Agreements. Highly specialist staff may be employed by any Unit and shared with other Units, again on a Service Level Agreement basis.

All Units would provide a common core of services and operate to common standards and protocols. There would be common information systems and minimum data sets would facilitate information gathering and monitoring.

A Regional Steering Group would be formed to guide the overall development of Occupational Health services, the steering of the implementation plan for change, the co-ordination of bids for additional resources, oversight of common policies and standards, and review of monitoring information.

Consultation responses varied in their support for different organisational models. However, there was strong support for the following:

- Acceptance that the *status quo* is not able to deliver the changes required.
- Support for a Regional Advisory Group with a remit to set direction and policy, develop protocols and standards, oversee investment of new monies, identify a minimum data set, monitor and analyse information, and make recommendations for best practice.

8.4 A Way Forward on Structure

As noted at the outset of this section, any decision on the future form of Occupational Health Services should await clarification of the wider reorganisation of HSS organisations. The model should align with

future organisational arrangements and support achievement of the objectives set for Occupational Health Services in the future.

Irrespective of which model is chosen there is a clear and immediate role for a Regional Advisory Group. The Working Group recommends that a Regional Advisory Group be established.

Management arrangements for the provision of services to General Practitioners and their staff require further consideration. The role of the Primary Care Sub-Group will be to specify the service required and develop a supporting Business Case.

9 THE CASE FOR INVESTMENT

9.1 Drivers for Investment

In making the case for investment in the management of the health of the HPSS workforce, it is useful to restate that a number of imperatives are driving change and impacting on the ability of Occupational Health Services to deliver both now and in the future. These can be summarised as:

- Policy commitment to extend Occupational Health provision to general practitioners and the staff whom they employ – already underway in England, Scotland and Wales. (Approximately 1100 GPs, plus an estimated 3000 directly employed staff).
- New duties of HSS employers in relation to communicable diseases particularly blood borne viruses.
- Unacceptably high levels of sickness absence across the HPSS (6.5%), and the associated costs of that absence.
- Fulfilment of statutory duties under health and safety legislation. The focus of management action to date has been on the safety side.
- Employers have responsibilities for the health of their workforce.

“Investing in Health”, the Public Health Strategy for Northern Ireland makes the case for a proactive approach to the management of the health of the population. The HPSS is the largest employer within Northern Ireland, and in the role of an exemplary employer has the potential to influence the health of a sizeable proportion of the population. This is further backed by an ethical responsibility. ‘*The Employer of Choice*’¹⁶, stresses the importance of promoting good health in the workplace, and the role of effective Occupational Health provision in achieving that aim.

9.2 The Cost of Work Related Ill Health and Injury

At 31 March 2002, the HPSS employed over 62,000 staff with an annual pay bill of £1,069 million. Just over half of these staff work part-time. The whole time equivalent (WTE) figure was over 44,000 staff.

A 6.5% absence rate is a direct cost of £70 million. Research studies show that the true cost of absence is likely to be significantly higher. Indirect costs include occupational health and welfare costs, lower productivity, reduced quality, missed targets, lower patient/user satisfaction, higher management costs, increased stress on colleagues

¹⁶ May 2002, The Employer of Choice, DHSSPS

attending work and increased accidents at work. These indirect costs arise regardless of whether staff cover is arranged. If overtime or agency staff are used there will not be the same effect on service delivery but costs will increase. The Cabinet Office Report concluded that:

“Our best estimate of total absence cost, taking account of under recording, poorer quality service etc. is that the damage caused through sickness absence is closer to twice the level indicated from direct costs alone.”

HPSS Pay Bill 2001-2002	£1,069 million
6.5% absence	£70 million
Cost of Agency staff*	£18 million

** Agency staff are largely, but not exclusively, used to cover sickness absence. The figure is used as an indicator of the cost of cover.*

Another cost indicator for work related ill health and injury is the cost to the HPSS of Temporary and Permanent Injury Benefit. Permanent Injury pensions paid between 1998 and 2001 are set out below:

<u>Permanent Injury pensions</u>	
1998–1999	£483,430
1999-2000	£500,298
2000-2001	£513,273

Whilst the HPSS average rate of sickness absence for 2001-2002 was 6.5%, rates varied widely across Trusts (from 4.5% to 10%). Similar variations in range were reported in the Cabinet Office Report (1998), and following exploration of reasons for variation that Report concluded that sickness absence levels had been and could be influenced by management actions. Consequently, targets were set for sickness absence and are reported on in the annual NHS Performance Indicators Report:

NHS Sickness Absence Rates

1999 - 2000	4.6%
2000 - 2001	4.5%

That is a national percentage improvement of 3%.

HPSS Sickness Absence Rates

2001-2002	6.5%
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The CBI annual absence and labour turnover survey, conducted in Jan-Feb 2002, reported on absence and labour turnover for 2001. The Report '*Counting the Costs*' states that average absence levels in 2001 were 25% lower than those recorded ten years ago. Ten-twelve years ago absence levels for the HPSS averaged 5.5%. The trend within the HPSS is opposite to that described.

There is significant potential to impact upon sickness absence rates across the Health and Personal Social Services. **Reduction of absence levels, from 6.5% to 6.2%, representing a reduction of 5%, could realise a cost benefit of £3.5 million.**

However, achievement of performance improvement requires an investment in Occupational Health, Human Resource Departments and line managers. The minimum investment required in staffing is set out at Section 9.5.

In addition, Human Resource Departments do not have sufficient resources to actively manage absence. Therefore, we recommend investing in a Pilot Scheme to evaluate the contribution of Attendance Management/Welfare Officers within Personnel Departments (Estimates at Section 9.5).

9.3 The cost of extending Occupational Health Provision to General Practitioners and their staff.

These costs are difficult to quantify as stand alone figures.

**Additional numbers to be covered:
1100 General Practitioners
3000 staff**

A full specification of service is currently being developed and costed. It is likely that full costs will be in the region of **£400,000.**

9.4 Cost of new duties of HPSS Employers

In the near future, HPSS employers will be required to change pre-employment health checks for all employees new to the HPSS. Health checks for all new employees will include:

- Check for TB disease/immunity
- Offer of hepatitis B immunisation
- Offer of testing for Hepatitis C and HIV

In addition, there will be

- Compulsory health clearance for Hepatitis B, Hepatitis C and HIV for healthcare workers engaging in exposure prone procedures.

The extra resource implications of this guidance will be significant. All new staff will require face-to-face Occupational Health contact. Whilst the take-up rate of optional offers is unknown, there is a direct cost associated with the compulsory elements.

This further supports the case for additional staff set out at Section 9.5.

9.5 Cost of Implementing Workforce Plans (Workforce Planning)

Achieving the vision for Occupational Health Services set out in Section Four requires a re-examination of the roles and skill-mix of those providing the service. Realising the full potential of the Occupational Health nurse will be a major contributing factor to future developments. The service is clearly delivered by a team, and effective team working will continue to be a key feature of the service.

One of the main pre-requisites for any development is adequate staffing levels. There are costs associated with delivering a service to meet the immediate requirements set out above. Achieving the fuller vision will be impossible without this minimum level of investment in posts. Having considered the benchmarks set in Section 2.3, the Working Group considers that the following is a realistic minimum plan for the development of the Service.

Figure Thirteen:

Additional Posts	Numbers	Cost £
Consultant Occupational Health physicians*	2-3	120,000-180,000
Occupational Health nurses	20	500,000
Occupational Health therapists**	3	50,000
Pilot Attendance management/welfare staff	6	150,000

* Maintain 2 Specialist Registrar posts.

** For example, occupational hygiene, ergonomics etc.

Access to specialist services such as physiotherapy and clinical psychology, should be defined by employers.

9.6 Cost of a modernised information system

A modern occupational health service requires appropriate management information systems to support delivery of the service, manage the business, and identify trends and optimise decision-making. Information and research are key to a developing service. Consequently, the Service(s) should be characterised by a research programme with priorities identified over successive years.

In addition, it is essential that data is consistently recorded and can be accessed in a way that gives comparative information across providers of service. There should be a Minimum Occupational Health Data Set agreed for the HPSS, which also allows the measurement of Key Performance Indicators. The information gathered should facilitate appropriate monitoring and audit.

New technologies should be explored such as the cost and benefit of introducing Occupational Health Smart Cards. The use of Smart Cards for junior doctors is currently being piloted in England, and the evaluation of the pilot will be of interest to the HPSS.

The development and implementation of appropriate information systems will require investment. **A specification of need should be developed to enable the resource requirement to be defined.**

9.7 Income Generation

The vision for a modern service is primarily about meeting the needs of staff within the HPSS and including those working independently in the primary care sector. On attaining this primary purpose the Service could consider offering access to services and expertise to the wider community, on an income generation basis. The Occupational Health Strategy for Northern Ireland is likely to propose access to services for Small Business Enterprises (SMEs). This would require additional capacity and investment.

9.8 Summary of Investment Required

Appendix C sets out the cost of actions to deliver on the Reports recommendations. In summary, these are grouped and noted below:

Figure Fourteen:

Action	Cost £
Enhanced Workforce (Phased)	880,000
Support for initiatives linked to attendance management performance improvement	100,000
Extension to Primary Care	400,000
Information infrastructure	Unknown
Known costs	1,380,000

Investment in additional resources has been referred to throughout the Report. The above investment will not achieve all that is set out in the vision for a future service. It will, however, make a significant input to the journey.

The Group have not advocated a simple proportional increase investment in existing services. The issues identified in the Report are not necessarily about increasing Occupational Health staff, although an appropriate resource investment will be essential.

The approach taken in Scotland has been to identify a number of implementation Groups steering allocation for funding to achieve tangible benefits in key areas. Specific projects have been designed to achieve change and these have been funded correspondingly. Consequently, the Regional Advisory Group would advocate the development of an Implementation Plan, with a number of component parts. These would include:

- Extending the OH workforce (Section 9.5).
- Education and Training.
- Implementing an Information Strategy & Systems (Section 9.6).
- Initiatives to improve the management of absence.
- Development of rehabilitation programmes.
- Extending service provision to primary care.
- Increasing the range of services available

9.9 Summary of Benefits

In the longer term, investment will produce cost benefits in the following forms:

- reduction in sickness absence.
- reduction in injury related compensation and pensions.
- fewer ill health retirements.
- reduction in replacement costs.

The ultimate benefit however, will be to the quality of service available to patients and service users, and a healthier and happier workforce.

10. EQUALITY

10.1 Introduction

Northern Ireland Act 1998

Section 75 of the Northern Ireland Act 1998 requires each Public Authority, in carrying out its functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity –

- Between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- Between men and women generally;
- Between persons with a disability and persons without; and
- Between persons with dependants and persons without.

In addition, without prejudice to the above obligation, each Public Authority must also have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

The Act also set out a detailed procedure for the enforcement of these duties, including a requirement for all public authorities to submit Equality Schemes to the Equality Commission.

The main vehicle through which the HPSS will fulfil its statutory obligations is through implementation of its Equality Schemes.

The HPSS is committed not only to comply with these statutory obligations, but also to be an exemplar employer with regard to equality of opportunity.

10.2 Background

The Department recognises the importance of good health in the workplace and accepts that the Occupational Health Service has a role to play in lowering levels of absenteeism, which continue to give cause for concern.

The World Health Organisation states that “every citizen of the world has a right to healthy and safe work and to a work environment that enables him or her to live a socially and economically productive life”¹⁷

The HPSS directly employs almost 60,000 staff; that is, approximately 8.5% of the total workforce of Northern Ireland. As the largest employer in the local economy, there is both a responsibility and a commitment to be an exemplar employer with regard to the health of HPSS staff.

The recently published strategy for managing and developing people in the HPSS “The Employer of Choice”¹⁸ stresses the importance of promoting good health in the workplace, and the role of effective Occupational Health provision in achieving that aim.

In January 2002 the Department of Health Social Services and Public Safety undertook to conduct a review of Occupation Health provision throughout the HPSS.

The overall consultation process realised 28 responses, which when analysed were favourable and the majority in agreement with the proposals. It was recognised that there was a need to conduct a parallel consultation exercise with General Medical Practitioners about the extension of an Occupational Health Service to primary care was realised and this was completed in October 2003.

10.3. Aims of the Review

To develop a strategy to improve the provision of Occupational Health Services to the Health and Personal Social Services, which will include Primary Care.

The overall aims of the Review of Occupation Health Service are to:

- To improve the health of the HSS workforce.
- To reduce the level of sick absences.
- Reduce the costs of sick absence and ill health retirement from the HPSS.

¹⁷ Global Strategy on Occupational Health for All, World Health Organisation, 1994

¹⁸ The Employer of Choice, DHSSPS May 2002

10.4 Persons affected by the Review

Implementation of the review should lead to improvements in the health of employees of the HPSS, HPSS employers, patients or service users who would be affected by the work activity of the HPSS.

In terms of the equality categories listed in Paragraph 10.1 it is not considered that the review will result in any group being adversely affected.

10.5 Consideration of Available Data/Research on Section 75 Categories

When considering the equality implications of the Review, account was taken of information provided by existing surveys and other research in relation to the 9 Section 75 Groups.

It may be worthy to note that 79 % of HPSS employees are female.¹⁹

NISRA has worked with all Departments to audit the extent and quality of coverage of Section 75 groups in key Departmental data sources. This audit has demonstrated that the data available in relation to the respective categories varies. Work is being taken forward to develop further the information base, which will be helpful to individual Ministers and Departments in considering the future direction of policy.

10.6 Assessment of Impact

The vision for modern Occupational Health provision is of a service focused on enhancing the working capacity of the HPSS workforce where health protection is a valued goal above the management of absence. There is a need to move from an emphasis on the management of ill health to the development of a culture of Health Protection.

There will be equal access to a comprehensive service for all HSS and Primary Care staff. There may be a positive impact in relation to gender groups and marital status due to the high percentage of female employees within the HPSS and Primary Care.

It is not envisaged that any of the nine Section 75 Groups will be adversely affected, and positively promotes equality of opportunity for all.

¹⁹ NI HPSS Workforce Survey September 2002

10.7 Monitoring of Impact

Action plans developed for the implementation of the policy will work towards the achievement of a range of specific targets that have been agreed and set out in the Action Plan at Appendix B.

These targets will be measured annually and will provide an opportunity to consider if there is any adverse impact on any particular group.

A Regional Advisory Group will be established who will carry out regular monitoring exercises as the policy is implemented.

11. RECOMMENDATIONS

The following recommendations are set out to facilitate consultation with all stakeholders.

The Working Group recommends that:

- The vision set out at Section 4 is adopted to guide the future direction of Occupational Health Services within the HPSS.
- A core range of services and standards is agreed for the effective management of Occupational Health Services (Sections 5 & 6).
- Additional resource is targeted on the management of absence both through designated staff and specific initiatives (Section 5.5).
- Further discussion takes place with Primary Care representatives to enable development of a phased implementation plan (Section 7).
- The model of service should align with future organisational arrangements and support achievement of the objectives set for Occupational Health Services in the future. (Section 8).
- Irrespective of which model is chosen there is a clear and immediate role for a Regional Advisory Group. The Working Group recommends that a Regional Advisory Group be established during 2004.
- The numbers of Occupational Health physicians, therapists and nurses are increased in line with new developments, and roles are developed appropriately (Section 9).
- Access to other specialists is formally defined and resourced (Section 9).
- The importance of rehabilitation is recognised by managers, staff and occupational health providers, and evidenced by appropriate service provision and take-up (Sections 3.7 & 5).
- An information strategy is developed along with a costed plan for implementation (Section 9).
- Additional resources are made available to fund developments (Section 9).

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Appendix A

REVIEW OF OCCUPATIONAL HEALTH SERVICES IN THE HPSS

MEMBERSHIP OF THE WORKING GROUP

Mr David Bingham, Director of Human Resources, DHSSPS (Chair)

Mr Raymond Donnelly, Newry and Mourne HSS Trust

Mrs Irene Hewitt, Beeches Management Centre (Facilitator)

Miss Therese McKernan, Director of Human Resources, Greenpark HSS Trust

Mrs Margaret Neely, Human Resources Manager, Westcare

Mrs Judith Orr, Director of Human Resources, United Hospitals HSS Trust

Mr Kevin O'Connor, Occupational Health Nurse, United Hospitals

Dr Lorna Rodgers, Consultant in Occupational Health Medicine, Belfast City Hospital

Dr Delia Skan, Health and Safety Executive, Northern Ireland

Dr A B Stevens, Consultant in Occupational Health Medicine, Royal Group Hospitals

Dr C Burgess, Consultant in Occupational Health Medicine, Westcare

Dr J Hunter, Royal College of General Practice

Dr B Patterson, British Medical Association

Ms Bernadette McGurk, Occupational Health Nurse, Greenpark

Dr E MacDonald, Department of Public Health, Salus Health Authority, Glasgow

**‘SUPPORTING A HEALTHY WORKFORCE’ REVIEW OF OCCUPATIONAL HEALTH SERVICES IN THE HPSS
ACTION PLAN FOLLOWING CONSULTATION**

	REPORT RECOMMENDATION	ACTION	RESOURCES (£000's)	TIMESCALE
1	Vision set out at Section 4 is adopted to guide the future direction of Occupational Health Services within the HPSS.	Prepare Final Report for submission to Management Board, DHSSPS, supported by a Business Case. Re-issue to Service as Strategic Direction.	NIL	December 2003 – March 2004
2	A core range of services and standards is agreed for the effective management of Occupational Health Services (Sections 5 & 6).	Establish a Regional Occupational Health Advisory Group . (Chaired by the Department, Heads of Occupational Health Services, Occupational Health Nurse, Chief Medical Officer Representative, external advisor). Role: Policy making body; develop protocols and standards; oversee investment of new monies; identify minimum Occupational Health data set for service monitoring; monitor, analyse trends and provide appropriate guidance for service. Revise minimum standard for pre-employment health assessments – face to face health assessment. (nurse with access to a consultant).	Secretariat provided by DHSSPS NIL	April 2004
2a		Establish Project Group to manage implementation programme and monitor spending.	300 300 300	2004 – 2005 2005 – 2006 2006 – 2007

	REPORT RECOMMENDATION	ACTION	RESOURCES (£000's)	TIMESCALE
3	Additional resource is targeted on the management of absence both through designated staff and specific initiatives (Section 5.5).	Seek bids from Trusts/Agencies for Attendance management initiatives linked to performance. Pilot concept of attendance management officers (6 sites). Reinforce Cabinet Office Guidelines. Monitor performance against targets.		2004-2005 2005-2006
4	Further discussion takes place with Primary Care representatives to enable development of a phased implementation plan (Section 7).	Work with Primary Care sub-group to develop a service specification for GPs and their staff. Implement in Phases over two year period.	Secretariat provided by DHSSPS Estimated 300	February 2004 – October 2004
5	Model B, that is, two or three locally managed Occupational Health Services, supported by a Regional Steering Group is adopted as the preferred model for Occupational Health Services delivery (Section 8).	Further consideration of management arrangements has led the Group to recommend that any structural changes happen in line with wider changes to the HPSS structure. General support for a Regional Advisory body allows this element of the model to proceed, strengthening standard approaches and monitoring performance of current services.	NIL	on-going
6	The numbers of Occupational Health physicians, therapists and nurses are increased in line with new developments, and roles are developed appropriately (Section 9).	Strengthen Occupational Health Physician capacity across the Service – fund 2/3 additional Occupational Health consultants. Services to bid for additional capacity. Strengthen Occupational Health Nursing capacity – extended roles plus additional numbers. Services to bid for additional capacity (Query matching funds by employers)	As determined by Project Plan	April 2004 – March 2007 Phased
7	Access to other specialists is formally defined and resourced (Section 9).	OH Services to consider cost-benefit of OH specialists, appropriate protocols and make bids to regional Advisory Group.	As determined by Project Plan.	April 2004 – March 2007

	REPORT RECOMMENDATION	ACTION	RESOURCES (£000's)	TIMESCALE
8	The importance of rehabilitation is recognised by managers, staff and occupational health providers, and evidenced by appropriate service provision and take-up (Sections 3.7 & 5).	Trusts to optimise approaches to rehabilitation.		October 2004
9	An information strategy is developed along with a costed plan for implementation (Section 9).	Regional Occupational Health Advisory Group to prepare an information strategy for Occupational Health; specify management information required and seek identify resource requirement to implement. Strengthen IT infrastructure to meet strategic needs. (Introduce Smart Cards for staff in training following NHS Pilot.)	To be confirmed following specification	2004-2007
10	Additional resources are made available to fund developments (Section 9).	Based on Business Case supporting overall Review, and individual Business Cases from trusts seeking funding of new initiatives.	As Project Plan	April 2004 – March 2007

Appendix C

RESPONSES TO CONSULTATION WERE RECEIVED FROM THE FOLLOWING:

- 1 Dental Adviser, DHSSPS
- 2 Director of Finance, DHSSPS
- 3 NICS Occupational Health Service
- 4 BCH, Consultant in Occupational Health Medicine
- 5 Multi professional Audit Group
- 6 Ulster Community and Hospitals Trust
- 7 NHSSB
- 8 NIPEC
- 9 Consultant in Occupational Health Medicine Westcare
- 10 Musgrave Park Hospital
- 11 RCN
- 12 Armagh and Dungannon HSS Trust
13. AHHRM
- 14 Altnagelvin HSS Trust
15. Down Lisburn Trust
- 16 Craigavon Area Hospital HSS Trust
- 17 WHSSB
- 18 Royal Hospitals HSS Trust
- 19 SHSSB
- 20 Chair of General Practitioners Committee
- 21 Homefirst HSS Trust

- 22 Chartered Society of Physiotherapy
- 23 Employment Medical Advisory Service
- 24 Belfast City Hospital HSS Trust
- 25 United Hospitals HSS Trust
- 26 Causeway HSS Trust
- 27 EHSSB
- 28 Royal Victoria Hospital

**Produced by: Department of Health, Social Services & Public Safety Castle Buildings,
Belfast BT4 3SJ**

Telephone: (028) 9052 2863

www.dhsspsni.gov.uk

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