Improving occupational health systems and practices to ensure a better recruitment experience.

As part of the streamlining programme in the North East, a workstream looking specifically at improving occupational health processes across the region has resulted in an improved recruitment experience for staff as well as time and cost savings.

Background

The North East has around 74,000 staff spread between 11 foundation trusts; eight acute trusts, two mental health trusts and one ambulance service. All 11 trusts agreed to participate in the occupational health workstream. Each signed a memorandum of understanding on behalf of their organisations agreeing to fully co-operate in terms of decisions made by the programme for wider regional adoption.

A vision and four objectives (appendix 1 – vision and objectives) were agreed for the workstream together with terms of reference (appendix 2 – terms of reference). The workstream met monthly and reported progress, challenges or items for decision or escalation to the programme board on a monthly dashboard (appendix 3 – template dashboard). The objectives were to

- design, develop and implement a portable vaccination record
- design, develop and implement a standardised approach to pre-employment health questionnaires
- ensure records are fully transferrable between organisations
- agree and adopt a regional Key Performance Indicator (KPI) for new starter health clearance.

Challenges

Different provisions

Each organisation had different occupational health provisions, for example, staff numbers varied along with access to electronic clinical systems. Members of the workstream were mostly from a clinical background, few had managerial or project management experience so the initial meetings were a challenge. However, the group has since developed a supportive positive culture that enables them to agree documentation and processes supported by their region’s physicians.
Private provider
One of the trusts had a contract with a private sector provider. Concerns were expressed by some parties, with assurances sought that there would be no discussion about sensitive data which may be perceived as potentially placing the private provider at a competitive advantage.

Third-party systems
Some trusts did not have access to an electronic occupational health system, others use COHORT or eOPAS. With COHORT there is no standard or comparable version in use, either regionally or nationally this is due to trusts not choosing to purchase system upgrades. Product familiarisation was limited to the version being used and departments had also chosen to adapt their COHORT packages to their preference. This resulted in the data stored at trust level being held in different fields, with different names and was not easy to transfer between one organisation and another.

Learning from other regions or countries
The region found little opportunity to learn from the experiences of other regions. Whilst Wales had progressed with COHORT’s connectivity with the Electronic Staff Record (ESR) it was not clear what, if any, other options other regions had explored.

Reporting lines and engaging physicians
Other workstreams, such as recruitment and mandatory and statutory training, reported to the director of HR (or equivalent) who had formally signed up to the regions streamlining programme. Whereas the managerial responsibility for occupational health (OH) varied, some reported to medical directors, others to their director of estates. It was also important to ensure that the OH workstream effectively engaged with the region’s occupational health physicians to ensure that any decisions made included their participation and endorsement.

Skill mix
Occupational health workstream leads are clinically strong but some have limited managerial experience. Whilst clear about their profession’s concerns they needed a managerial ‘voice’ to rebuff the expectations that they should deliver nationally despite their concerns.

Medical consent
Releasing health information from one organisation to another requires explicit consent from the individual to do so. Also, the Inter-Authority Transfer functionality within ESR in its current form automatically retrieves occupational health data. This has raised concerns among clinicians about not being able to correctly evidence medical consent. This issue of medical consent is being explored with ESR.
Progress against objectives

Objective: To design, develop and implement a portable vaccination record

The first stage was to address the variation in how vaccination details were recorded. This took some time before reaching a point in which all parties were satisfied and that their systems would be amended accordingly. A paper version (appendix 4 – recording vaccinations) was developed to mirror that used for electronic systems.

Occupational health colleagues advised that due to delays in evidencing immunisation and vaccination details, common practice had been to invite candidates for a blood test to verify immunity. Costs and timescales varied but it was recognised as an inconvenience for the candidate, negatively impacting on their welcome to a new organisation and job role.

With no effective interface between third party systems and ESR, the two options available were:

1. to follow a mass upload with the support of their regional ESR colleagues
2. for occupational health departments to manually enter individual information both into ESR as well as any other systems.

This dual entry method was not welcomed. Phased methods were discussed for new starters or by staff groups. Department capacity was a significant factor, as were concerns about medical consent and how the information would be retrieved from ESR.

Whilst not the desired ESR methodology, the region agreed to share vaccination records via secure nhs.net accounts. Following a successful four-week pilot process-testing period, this method was adopted for use for any relevant appointments within the region. Over the four-week period, it was calculated;

- For 60 individuals, health clearance time improved by an average of 4.5 days per candidate by receiving vaccination details directly and not waiting on blood tests.
- Collective savings of two days nurse appointment and assessment time.
- Six hours of admin time saved.
- Almost £2,000 of blood tests no longer required.

Objective: To design, develop and implement a standardised approach to pre-employment health questionnaires

Baseline data was collected from across the region, this showed that there was variation in approaches. After much debate and risk assessment, a regional minimum data set was agreed (appendix 5 – work health assessment template). Two trusts that required additional information specific to either height (for ambulance purposes) or BMI added these to the assessment.
Providers using third-party systems had to upload the questionnaire into their system. One provider identified a cost for doing this, but a regional price was secured as the information was identical.

**Objective:** To ensure records are fully transferrable between organisations

The possibility of a regional electronic solution was explored with third party system providers, but there was no solution that was viable.

Standard operating procedures were developed and used for both clinical and non-clinical appointments.

In terms of a regional ‘perfect occupational health process’, working within the systems and parameters available, a two-working day Key Performance Indicator (KPI) to respond to regional requests for immunisation and vaccination details was agreed.

**Addressing the challenges and key successes**

**Third-party systems.** Concerns relating to the third-party provider’s involvement proved to be unfounded and they are a key member of the workstream freely providing information, support, advice and guidance to colleagues as all other participants.

The region is yet to confirm whether it will progress with the option of a collective third-party clinical system provider. The current regional information-sharing solution is feasible between small numbers of organisations, but it is limited to the North East. Any decision would require clear financial and procedural impact evidence.

**Memorandum of Understanding.** Each HR director signed a regional Memorandum of Understanding on behalf of their organisation, this helped to address managerial accountability. The MoR also helped to ensure that any trust-based queries were diverted to their HR director colleagues.

**Involving physicians.** Key to achieving the agreed outcomes was ensuring that physicians were kept informed and had the ability to contribute. Equally, when professional concerns were raised about clinical consent their programme board was supportive and recognized the impact both regionally and nationally.

**Membership.** The membership of the workstream was key to its success - a mix of clinical and managerial, which allowed the group to have the relevant impact and credibility. A supportive board was also a key benefit as they acknowledged and dealt with any concerns raised, escalating to a national level as appropriate.

**Next steps**

**Regional**
The North-East streamlining programme board is considering the following objectives for 2018/19:
• agreeing regional responses to both clinical occupational health procedures and campaigns
• influencing the creation of national occupational health standards
• implementing the agreed outcomes from the doctors in training pilot for August 2018.

**National**

The North-East streamlining programme is drafting a paper for a future commission specific to achieving a national occupational health clinical consistency standard. This would include:

• a set of fully endorsed national vaccinations and immunisation processes
• a defined and endorsed minimum data set to enable occupational health clearance.

The parameters of this work are being explored on a national basis for it to be supported by the Faculty of Occupational Health.

HR directors in the North East considered the achievements of the programme up to December 2017 and in recognising the benefits of continuity, agreed to commit to and part-fund a further phase; April 2018 to March 2019.

Since commencement, the North-East programme has also welcomed the lead employer Trust as well as another NHS provider in the region who have each recognised the benefits of participating in the programme.

**Contact**

Sarah Kilner, North East Streamlining Programme Manager