The implications of the Francis report for occupational health in the NHS

The report by Robert Francis QC into serious failings and poor standards of care at Mid Staffordshire National Health Service (NHS) Foundation Trust has become a rallying cry for assurance of standards in health care [1]. Publication of the report in 2013 was a pivotal moment for the NHS, a point against which patient care and governance will be measured in future.

Francis made 290 recommendations for action, accepted in the government’s response [2] but neither publication mentioned occupational health (OH). This omission may reflect the history of OH provision; it certainly prompts questions for the future. Can OH services contribute to good corporate governance in health care, as an integrated part of an improved infrastructure to support and nurture good practice? Can they assist in the identification and monitoring of areas within NHS trusts where the culture of bullying and intimidation so graphically described by Robert Francis are present? Can they bring direct benefits to patients? The answers must be ‘yes’—but obstacles include history, current focus and financial uncertainties around occupational health in the UK.

The origins of OH services lie in manufacturing industry and philanthropy of enlightened employers. Their focus was on the identification and prevention of diseases linked to occupations and workplaces. When the NHS was established in 1948, free at point of use, occupational medicine was not included. Provision of specialist work-related health care continued to be the responsibility of the employer, only available to a minority of the population. OH services developed for NHS staff during the late 1970s but did not have robust funding arrangements. Their early successes, helped by an effective vaccine against hepatitis B, included increased protection of staff from infectious diseases and reduced risks of transmission to patients. Workplace visits identified hazards and risks of health care including exposure to radiation, anaesthetic gases and respiratory sensitizers, particularly glutaraldehyde. Health surveillance programmes followed. Identification of links between manual handling and musculoskeletal problems seen in NHS OH departments had a major influence on the approach to physical loads in health care. Psychological risks were also recognized, but an audit of 36 NHS trusts showed that activities related to stress at work were more likely to be reactive than preventative [3]. In 1994, NHS executive guidelines required OH services for NHS staff to be accessible and encouraged self-referral [4]. They emphasized the importance of systems for managing health and safety at work, compliance with legislation and the need to ensure that staff are fit for, and placed in, appropriate work.

As disease patterns changed, with fewer occupational diseases, there has been a gradual shift in emphasis, sometimes controversial, towards encouraging work retention despite health issues or disability [5]. An emerging evidence base has encouraged a proactive approach to management of sickness absence. In 2006, Waddell and Burton [6] showed that work is generally good for physical and mental health. In 2008, the Black [7] review highlighted the health risks of worklessness for individuals and society. In 2009, Boorman [8] reviewed the health and well-being of NHS staff and championed active rehabilitation. Survey data from four NHS trusts made explicit the correlation between high health and well-being scores in staff and quality measures of good patient care. At the same time, shocking events unfolded in Mid Staffordshire culminating in the Francis report, which declared the first priority for the NHS to be delivery of a high standard of care to all patients [1]. Occupational health’s first priority must be the 1.3 million NHS staff employed to care for patients.

A high standard of OH practice involves good governance and compliance with quality standards, evidence based wherever possible. Standards for accreditation as a ‘Safe Effective Occupational Health Service’ (SEQOHS) relate to business probity, information governance, competency and supervision of OH staff, facilities and equipment, relationships with purchasers and workers. For NHS services, six additional standards include some measures of clinical quality; prevention, timely intervention and access to early treatment for the main causes of absence in the NHS, rehabilitation, health assessments for work, promotion of health and well-being, and teaching and training for service users and future OH professionals. Approximately half of all NHS OH services (72) have achieved SEQOHS accreditation; a further 79 are working towards it [9].

The UK working population is more diverse and this is reflected in the health profile and associated risks found in new entrants to the NHS. Particular strengths of NHS OH services include infection control expertise and links with colleagues in microbiology, communicable disease control and infectious
diseases. Links can also be forged with musculoskeletal and mental health services to facilitate timely intervention for staff. OH services in the NHS should be engaged with the goals and aims of their organizations and involved in their governance. Francis identified immature and ineffective early warning systems in Mid Staffordshire. OH is uniquely placed at the interface between staff and managers to be part of effective early warning systems, which can alert managers if staff are in difficulties and if they believe a blame and bullying culture pervades.

Francis challenged the NHS to improve multidisciplinary audit for all clinical services. The Health and Work Development Unit of the Royal College of Physicians pioneered national audits of OH practice in the NHS [10] but continuing widespread participation is threatened by financial pressures. Other challenges for occupational health include improved use of information technology, metrics to monitor staff health and well-being, greater use of telephone consultations and assistance to other clinical disciplines to optimize management of long-term conditions, including implications for work.

Francis also recommended development of links between NHS trusts to enhance their ability to deliver up to date and high standards of service provision and professional leadership. Many NHS OH services are too small to deliver the full range of activities, to provide access to relevant specialists or to increase the scope of the OH team to include other professionals, particularly physiotherapists and psychologists. The NHS Health at Work Network which represents the majority of NHS OH teams in England encourages collaborative working and facilitates sharing of best practice to improve clinical quality and service delivery [11].

Anecdotal reports of redundancies among NHS consultant OH physicians alongside failure to appoint to vacancies elsewhere (personal communications) are cause for concern. Availability of specialist health assessments for senior health-care professionals supports responsible officers and the revalidation process. Assessment and monitoring of health-care staff infected with blood-borne viruses also requires consultant OH physicians to meet Department of Health standards and ensure protection of patients. The majority of specialist training posts in occupational medicine are now in the NHS; any decline in consultant trainers will have a significant impact upon the future OH workforce.

NHS employers issued updated guidance in December 2013, to remind NHS organizations, post Francis, of the evidence that access to good OH support improves staff engagement and can contribute to cultural change. ‘Ensuring that your OH service is working well for your trust will enable staff to deliver safe, effective, and efficient patient care’ [12]. OH services working well for the NHS must be responsive to new situations and opportunities, alongside their traditional role. Reports from three network services provide examples; occupational asthma and rhinitis linked to use of detergent enzymes in cleaning medical instruments [13]; evaluation of a case management approach to sickness absence referrals demonstrated benefits to staff and their employing trust [14]; an outreach clinic can provide effective work-related health advice in primary care [15].

NHS reorganization including the development of commissioning and establishment of NHS England will impact upon OH services in the NHS and may provide new opportunities. Despite concern that the proposed Health and Work service of the Department of Work and Pensions is narrowly focussed on sickness absence, it could be a first step towards extending OH to the wider population. The long-term goal must surely be to mainstream OH practice, incorporating it into health care provision for the whole population. NHS occupational health services could play a major role in this transformation, which would raise the standard of care to all patients.

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References

9. Faculty of Occupational Medicine, Royal College of Physicians. SEQOHS Accreditation Scheme for OH Services. www.seqohs.org (2 June 2014, date last accessed).


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**OCCUPATIONAL MEDICINE CALENDAR**

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