Defining the value of accredited specialists in occupational medicine working in the National Health Service and exploring future opportunities for enhancing the provision of occupational health services in England.

A project commissioned by

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List of abbreviations

Covid-19	Coronavirus
GP	General Practitioner
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
ICS	Integrated Care System
IPC	Infection Prevention Control
IT	Information Technology
MDT	Multi-disciplinary team
NHS	National Health Service
OH	Occupational health
OM	Occupational medicine
PA	Programmed Activity
PPE	Personal protective equipment
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrence Regulations
SEQOHS	Safe Effective Quality Occupational Health Services
STP	Sustainability and Transformation Plans
WTE	Whole Time Equivalent

Executive summary

Background

This document reports on findings on a commissioned project exploring the attributes and role of accredited specialists in occupational medicine (OM) working in the National Health Service (NHS). This exploratory work focused on two interdependent themes. In theme 1, we explored the development and use of core attributes (such as skills, knowledge, experience, and relationships) of accredited specialists in OM before and during the Covid-19 pandemic. In theme 2, we then explored how these specialist attributes can be further harnessed and deployed to enhance occupational health (OH) provision for NHS staff and others in the future. In addition, we considered how these skills could be used to contribute to patient-centred care and integrated into primary and secondary care services.

Methods

The project comprised mixed methods for data collection purposes.

- In phase 1, we conducted a cross-sectional survey of OH departments. This comprised a 27-item survey to capture data on OH workforce demographic details, type of OH services (in-house and contracted) provided locally, including OH involvement at an NHS level during the Covid-19 pandemic period. The survey was piloted first then a link to the online questionnaire administered via the NHS Health at Work Network.
- In phase 2, we conducted a series of semi-structured (virtual) individual and focus group interviews with OH and non-OH representatives from other medical specialties and partner organisation from across the NHS in England.

Results

Response rate

In phase 1, 65/128 (51%) NHS OH departments completed the online survey. In phase 2, we invited 12 accredited specialists in OM to take part in individual interviews on the basis that they were in-house accredited specialists working in the NHS and represented different geographical regions in England, nine accredited specialists (five female and four male participants) agreed to take part. Sixteen (OH and non-OH) participants took part in the focus group sessions following a direct invitation to 41 individuals.

Key findings

Over half (58%) of respondents worked in a SEQOHS accredited OH service. There was a large variation in the trust-wide workforce size (range 2500-15000 staff). The majority (75%) of NHS OH providers were based in acute NHS Trusts, with others based in community/primary care, mental health trusts, and ambulance trusts. The majority of OH providers (87%) also provide contracted services to external organisations. While OH staffing groups and levels varied considerably across NHS organisations, in general, OH providers employ an average of 1.89 WTE doctors, (44% are accredited specialist consultants and 24% are specialist trainees/registrars). An average of 7.48 WTE nurses are employed, approximately 54% are OH-trained nurses. Each provider employs on average 3.78 WTE other clinical staff such as technicians/phlebotomists/healthcare assistants, 1.06 WTE physiotherapists/occupational therapists, and 1.83 WTE OH psychologists/counsellors. 5.75 WTE non-clinical staff were employed.

Over half (71%) of OH providers felt their trust senior management team have a good understanding of the role of OH, with a smaller proportion (61%) perceiving OH initiatives and activities to be backed by strong leadership and support either within the Trust or within their OH service.

During the Covid-19 pandemic period, over three-quarters of NHS OH providers had increased OH staffing levels to meet the rise in demand for OH services and advice. The majority of OH providers developed collaborative cross-specialty partnerships (infection control, microbiology, HR, etc.) to support the wider organisational response to the pandemic. The majority of OH providers were actively involved in specific high-level trust-wide strategic planning and coordination activities including Covid-19 risk assessment and management of NHS staff, Covid-19 outbreak management in the workplace, Covid-19 staff swab testing for symptomatic staff, and in-house Covid-19 track and trace. A smaller proportion (30%) contributed to the rollout of the national (patient/community) Covid-19 vaccination programme. In addition to their involvement in the high-level strategic response to the Covid-19 pandemic, many NHS OH providers contributed to sub-group committees focused on specific areas of interest such as infection control, staff testing, staff support, redeployment, and personal protective equipment (PPE), Covid-19 vaccine delivery and planning.

During Covid-19 many OH providers also expanded the range of services offered to meet specific emerging needs e.g., 24-hour telephone advice line, Covid -19 PCR testing for staff and their family/household members, antibody testing, Covid risk assessments, outbreak management rehabilitation programme for shielded NHS staff and those with Long Covid-19, mental health and wellbeing hubs for staff, and extended operating hours. A broad range of operational and logistical challenges was experienced by OH providers and was directly attributed to the pandemic e.g.,

workforce constraints, significant workload pressure, rapidly changing policy directives. Despite this, many OH providers reported positive outcomes, particularly a greater recognition and appreciation trust-wide of the role of OH, increased opportunities to collaborate with other clinical areas and departments, enhanced collaborative decision making, and adoption of new technologies to streamline services.

In phase 2, we identified two overarching themes and six sub-themes. The first overarching theme: '*Professional credibility has currency'* contains four sub-themes *'Establishing oneself as a medical specialist in occupational medicine', 'Developing and nurturing valued and trusted relationships', 'Harnessing strategic and clinical leadership capabilities to navigate a complex system'* and *'Showcasing clinical expertise in a Covid-19 world'.* In this theme we explore the attributes and skills development of accredited specialists in OM, the significance of professional collegial relationships across the NHS hierarchy and their unique role within the wider OH landscape, and how they use their clinical and leadership skills at an individual and strategic trust-wide level.

The second overarching theme: *'A visionary future: harnessing opportunities to revolutionise NHS OH services'* has two sub-themes '*Attracting and nurturing multi-disciplinary talent and investing in the next generation of clinical leaders'* and *'Widening the provision of OH services across the NHS'.* This theme explores several prominent issues relating to the future of NHS OH services in England, with a focus on opportunities to grow a sustainable OH workforce and the potential opportunities for expanding NHS OH practice.

Conclusion

The unique circumstances of the COVID pandemic, and its impact on the work of the NHS, demonstrated the diverse skills and clinical expertise of accredited specialists to all parts of the service and, particularly to other medical specialists and senior managers. This was evident from executive, strategic and clinical leadership, and demonstrates the benefits that accredited specialists in OM can bring to staff care and clinical practice. Finally, most respondents described an ambitious vision for the future of OH services across the NHS in England.

This work provides evidence to support our main recommendation that each of the 42 Integrated Care Services should now contain a group of in-house accredited specialists in OM to deliver strategic and specialist leadership to the multi-disciplinary teams charged with the care of the staff. Location within an ICS would encourage the establishment with multi agency partnerships in health, community and social care partners who are the backbone of ICS.

It is recommended that creating the role of National Chief Medical Officer in Occupational Health would allow co-ordination and consistency across the 42 ICS's and enable the development of patient as well as staff focused future Occupational health model. This would provide the national level strategic and political voice for the largest employer in the UK.

These recommendations support the new NHS England and Improvement 'Growing OH' improvement programme, which has the ultimate vision of empowering all OH services in the NHS to become strategic, systemic, integrated and proactive partners in supporting the wellbeing of our NHS people.

Guidance on embedding specialist occupational physicians with ICS is required and a rigorous impact evaluation will be part of the arrangements. We will produce a short video drawing on the lessons learned during this study.

In finalising this report, we have consulted with prominent stakeholders in peak-body OH-affiliated organisations regarding the project findings and they each provide strong support for the key recommendation as described below

Statements of support

In finalising this report, we have consulted with prominent stakeholders in peak-body OH-affiliated organisations regarding the project findings and they each provide strong support for the key recommendations. These recommendations support the new NHS England and Improvement 'Growing OH' improvement programme, which has the ultimate vision of empowering all OH services in the NHS to become strategic, systemic, integrated and proactive partners in supporting the wellbeing of our NHS people

"This is a timely and valuable piece of research, at a key crossroad for NHS Occupational Health development. The "Growing OH" programme, led by NHSEI, is seeking to give OH a strategic voice and to transform services to improve capacity and capability. This is recognised as crucial to delivering the promise of The People Plan and is an opportunity to consider how best to use our experienced senior OH specialists, to enable leading services and to prevent NHS staff remaining "cobblers children", with inconsistent and sometimes under resourced OH approaches. The success of operating at ICS level enables health inequalities to be addressed and OH specialists should be utilised to maximise impact across these systems. Siloed working duplicates inefficiently and reduces effectiveness of clinical governance in a complex specialty, that the pandemic has highlighted can deliver much potential to ensure NHS staff deservedly feel safe, protected and cared for in their crucial roles. I welcome this research and encourage NHS leaders to consider its implications in the context of strategy being developed by the "Growing OH" approach."

Dr Steve Boorman (Chair, Council for Work & Health)

"This is a really important piece of work which captures the key role that accredited specialists play in strategy and leadership. Most importantly, it highlights the vital need to provide universal access to occupational health services led by accredited specialists to improve the health and well-being of the working age population and reduce health inequalities."

Professor Steve Nimmo (President, Faculty of Occupational Medicine)

"SOM welcomes this important report. Health is the main reason why people fall out of work, impacting on the UK economic recovery and the Government's "levelling up" agenda. Occupational medicine consultants are key specialists who help improve people's ability to stay in work. Investment in occupational medicine is a cost-effective way of supporting this levelling up agenda but there are gaps in access to the unique skills that these consultants offer. SOM is encouraged to see the NHS England and Improvement "Growing OH" programme but agrees with the report's call for a National CMO in Occupational Health and that a comprehensive occupational health offer, using the infrastructure of the NHS, is put in place."

Ms Jayne Moore (President, Society of Occupational Medicine)

"The COVID-19 Pandemic has brought many challenges to NHS Occupational Health Services but also many opportunities for the future. This is due to the way in which many services responded rapidly and became a crucial strategic voice within their organisation. Having sufficient skill and expertise from Senior Managers in Occupational Health (Nurses, Administrative and accredited specialists) has proved invaluable to articulate the importance and value for staff protection and wellbeing. This piece of work demonstrates the importance of the accredited specialist in this field and the 'added value' that they bring to an organisation beyond the routine transactional OH activity. I hope that this study encourages leaders of NHS provider services to consider the important value that these roles can bring to their organisation and seek to invest for the health & wellbeing of their staff. As Chair of the NHS Health at Work Network, I am delighted to see this research which supports the direction of the NHSE/I 'Growing OH programme' and the impact that it can have in our Clinical Speciality."

Ms Hilary Winch (Chair, Heath at Work Network)

Background

In England, most OH departments in the National Health Service (NHS) are in-house services whose staff are directly employed by their NHS Trust. A minority of Trusts contract OH services from the private sector. NHS OH services are hosted within a range of settings, usually acute hospital trusts or community or ambulance trusts. The range of services offered by OH departments, and the extent to which these are readily available to NHS staff vary considerably, particularly for GPs and their staff working in primary care.

In addition to delivering services to local NHS staff, some OH services also have contracts with external organisations including neighbouring NHS Trusts, public and private sector organisations, and charities, thereby generating income that benefits their host Trust. This variability in service provision and external contract work is also reflected in the composition of OH staffing in NHS OH departments; some employ in-house OH consultants or physicians on a part or full-time basis who provide clinical leadership to their OH team of nurses, allied health professionals (physiotherapists, psychologists, technicians, and phlebotomists) and administrative staff. Other NHS OH departments are nurse-led and rely for medical cover on sessional locums or remote doctors.

The health and wellbeing of the NHS workforce is front and centre of the NHS People Plan and NHSE&I's operational planning priorities for 2021/22. (NHS England / NHS Improvement, 2021) This commitment requires high-quality, expert OH provision, drawing on the skills of OH professionals, with a critical role for accredited specialists in OM.

OH services in the NHS must be equipped to deal with the workforce health issues which are expected to affect staff emerging from, and after Covid-19 and to deal with future public health and emergencies. Covid-19 has demonstrated the importance of planning and adequate resourcing for the future.

This should include attention to service quality and an appropriate staffing profile within NHS OH services. Both have been the subject of guidance and reports over many years, in particular, the Boorman report of 2009 outlined a wide agenda of measures to support the health and well-being of NHS staff in which multidisciplinary OH services would have key roles. Boorman suggested the appointment of regional specialists in OM to ensure that all Trusts had access to such expertise. (Boorman, 2009)

The Boorman report was strongly supported by the Department of Health, which recognised that improved staff health in the NHS would lead to better care for patients (NHS England, 2011) and was followed by publication in 2011 of a national framework for NHS Health and Well-being Improvement (Department of Health, 2011).

The Faculty of Occupational Medicine (FOM) welcomed the Boorman recommendations (Faculty of Occupational Medicine, 2009) and in 2011 also recommended that consultants in OM should be included in Public Health Teams (Faculty of Occupational Medicine, 2011). The FOM, in consultation with major stakeholders in government, industry, the NHS, and OH professionals developed standards for OH services, to allow them to demonstrate and gain accreditation as Safe Effective Quality Occupational Health Services, (SEQOHS) (Faculty of Occupational Medicine, 2020). These standards, first published in 2012 and reviewed in 2015, are currently under review by The Faculty of Occupational Medicine who are consulting widely and expect to publish updated SEQOHS standards within the next 12 months.

The government's Joint Work & Health Unit at The Department of Health and Social Care and the Department for Work and Pensions has commissioned research to consider 'What are the objective measures of defining good Occupational Health'. This includes piloting outcome-linked metrics with OH providers and employers which could be used to support continual provider improvement and improve employer choice (DWP&DHSC, 2021).

In response to the 2021 People Plan, NHS England and Improvement launched the Growing OH Programme, to develop and empower NHS delivered OH services to become integrated, strategic, and proactive organisation partners. The first stage was a review of OH in the NHS, by Dr. Steve Boorman, commissioned by NHSE/I which has highlighted ten key areas for service improvement. NHSE/I has launched the Growing OH programme with a consultation inviting senior leaders and stakeholders and those working in OH services, to consider these 10 areas in focus group discussions (NHS Health at Work Network, 2021).

The NHS is experiencing a major restructure to form integrated care systems (ICSs) to replace Sustainability and Transformation Plans (STPs).

ICS are part of a fundamental shift in the way the health and care services are planned, paid for, and delivered, and are a key part of the future direction for the NHS as set out in the NHS Long term plan. Their primary aim is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and health and social care. Joining up of health and care services is essential as demonstrated during the Covid-19 pandemic as the response rested on different parts of the system working together to address the public health emergency. All parts of England are now covered by one of 42 ICSs. Currently, ICSs have no basis in legislation and therefore no accountability, but this will change in 2022.

After several decades during which the emphasis in the NHS was on organisational autonomy, competition, and the separation of commissioners and providers, ICSs depend instead on collaboration and focus on places and local populations as the driving forces for improvement. (King's Fund, 2021). This is an opportunity for OH services across an ICS to work together with

equitable provision for all trusts in the sector, including community services, primary care, and potentially health and social care. There is also the potential for provision of OH input into patient care across an ICS.

These changes and potential opportunities are set against a context of a reducing number of accredited specialists in OM in the NHS in England, in particular, the impending retirement of many experienced OH-consultants and OH-qualified physicians coupled with the lack of sustainable increase in the number of training posts available, although effects are now underway to improve this situation. This was highlighted in an all-party parliamentary report in 2017 and the situation remains unchanged (All Party Parliamentary Group on Occupational Safety and Health, 2016). Recruitment and retention of these accredited specialists in the NHS was problematic before the pandemic, and now more than ever their skills are needed to cope with a tsunami of complex Covid-19 related staff health issues, specifically relating to mental health and Long-Covid.

Furthermore, in recent years anecdotal reports from within the OM specialty and the wider NHS environment suggest that the future growth and evolution of NHS OH services is critical to the health and wellbeing of NHS staff and consequently patient care.

This research focuses on two interdependent themes. In theme 1 we explore the development and use of core attributes (such as skills, knowledge, experience, and relationships) of accredited specialists in OM before and during the Covid-19 pandemic. In theme 2 we then explore how these specialist attributes can be further harnessed and deployed to enhance OH provision for NHS staff. We also explore how these skills could be used to contribute to patient-centred care and integrated into primary and secondary care services.

The following sets out the project objectives and corresponding questions which fall under two broad themes.

Objectives

1. To explore, from the perspective of other clinicians and non-clinicians, the added value accredited specialists or consultants in OM bring in supporting the Trust and colleagues in other specialities at a clinical and strategic level before and during Covid-19 pandemic. *(theme 1)*
2. To explore opportunities for enhancing and expanding the provision of OH services, including the role of consultants in OM, across the wider NHS landscape (primary and secondary care). (*theme 2*)

3. To explore, from the perspective of OH colleagues (clinical (not medics) and non-clinical staff), the value which accredited specialists bring to an OH department, to clients (staff), managers, and their Trusts. To consider how the skills of an accredited specialist can be further used to enhance OH provision to the NHS for staff and patients. *(theme 1 & 2)*

These objectives formed the basis for two interdependent themes. In theme 1 we explored the core attributes (such as skills, knowledge, experience, and relationships) of accredited specialists in OM and how they used these attributes before and during the Covid-19 pandemic. In theme 2, we then explored how these specialist attributes can be further harnessed and deployed to enhance OH provision for NHS staff. We also explored how these skills could be used to contribute to patient-centred care and integrated into primary and secondary care services.

To meet the overarching objectives, the following series of questions were addressed:

THEME 1 ("Where have we come from before and during covid19 pandemic?")

1. What are the skills, knowledge, experience, and relationships which an in-house accredited specialist in OM can bring to an NHS OH service?
2. How were these attributes demonstrated during Covid-19 and how can they continue to add value in the future?

THEME 2 ("Where to from here-in the endemic Covid-19 era")

1. How can the attributes (skills, knowledge, experience, and relationships) of an accredited specialist in OM further promote an enhanced level of OH provisions for NHS staff in primary, secondary, and community services?
2. Could the role also sit within the ICS landscape to bring benefits to the wider NHS patient community?

3. How can we optimise and embed OM and health practice as a part of patient-centred primary and secondary healthcare? What would be the needs and expectations from different stakeholders?

Methods

We used the following mixed methods approach for data collection:

Phase 1 (Cross-sectional survey)

We developed, piloted, and administered an online survey comprising 27 questions to capture data on the local workforce profile and provision of OH services delivered across the NHS during the Covid-19 pandemic period. To invite respondents to complete the survey, an introductory email with a link to the online survey was sent, on behalf of the project lead, directly to the Heads of Service of NHS OH providers. The online survey was available for completion between 25 May 2021- 27 June 2021 and two follow-up email reminders were sent to optimise the response rate.

The survey questions can be found in the appendix.

Phase 2 (Interviews)

We conducted (virtual) semi-structured 1-2-1 interviews with qualified accredited specialists and consultants in OM from across different regions in the United Kingdom *(theme 1)*. In addition, we conducted a series of (virtual) semi-structured focus group interviews with representatives from other specialties and departments who work collaboratively with OH teams in the NHS e.g., rheumatology, physiotherapy and occupational therapy, infection prevention and control, NHS Employers, training (Deanery), Human Resources (HR) and Department for Work and Pensions *(theme 1 & theme 2 (objectives 1-2).* We separately facilitated a focus group interview targeting representatives (service managers, allied health professionals) from within the OH workforce *(theme 1 & theme 2 (objective 3).*

The purpose of these interviews was to elicit wider views and opinions from relevant stakeholders. Interviews lasted between 45-90 minutes and were recorded then transcribed verbatim. The interview schedules can be found in the appendix.

Analysis

Quantitative

Descriptive summary analysis was conducted on the quantitative data collected in the online survey and the results are presented as frequencies and proportions (percentage) of the total number of responses. No inferential statistical analysis was undertaken.

Qualitative

The project group agreed on the interview schedule to be used for the 1-2-1 interviews and three separate focus groups. The interviews were conducted by two members (VP and AG) of the

project team, with one member (VP) of the project team leading on the analysis. All audio interviews were transcribed verbatim. The method of analysis comprised reading through each of the interview transcripts to become familiarised with the text. We used inductive thematic analysis as a guide when analysing the qualitative data collected (Braun & Clarke, 2006) and our analysis was guided by our pre-defined objectives and areas of interest. The lead researcher conducting the analysis generated a series of proposed cross-cutting and overarching descriptive themes and sub-themes to describe common aspects identified in the data which were reviewed and discussed with the wider project group until consensus was reached. Verbatim quotes (statements) are provided to illustrate meaningful constructs in the data.

This project was registered as a service evaluation with the clinical audit team at Guy's and St Thomas NHS Foundation. Reference 12313

Results

Phase 1

The online survey was piloted on two separate occasions and corrections were made to ensure it was easy to follow and complete. An email invitation (with a link to the online survey) was sent to 128 Heads of NHS OH Services in May 2021 and from this we received 65 completed surveys from across all regions in England, equating to a response rate of 51%.

Representations across NHS organisations

Over half (n=38; 58%) were SEQOHS accredited and a smaller proportion (n= 10; 15%) were in the process of working toward their accreditation. Approximately a quarter (n=17; 26%) were not SEQOHS accredited. Over half (n=35; 55%) of respondents were from a nursing background, with smaller proportions representing other management roles (e.g. service manager, allied health lead, clinical lead) (n=15; 23%) or general/business managers (n=13; 20%).

The workforce size (the total number of Trust employees) across the represented NHS organisations varied considerably, from small NHS organisations employing fewer than 2500 staff to large NHS organisations employing more than 15000 staff. Almost all respondents (n=63; 98%) had a workforce size greater than 2500 employees, with 10 (16%) NHS organisations employing over 15000 employees. Three quarters (n=48; 75%) of all NHS OH providers were hosted within acute NHS Trusts, with a small proportion representing other sectors of the wider NHS e.g., community/primary care (n=4; 6%), mental health trusts (n= 2; 3%) and ambulance trusts (n=1; 2%). Over 14% (n=9) deliver OH services across multiple NHS entities. The majority of OH providers (n=55; 87%) also deliver contracted services to external organisations.

Most OH providers (n=59; 92%) report directly to the Director (or deputy) of HR, with only a smaller proportion (n=5; 8%) reporting to other members of the Executive (Medical Director, Workforce Director, Chief People Officer, Chief Nurse, Chief Operating Officer, Wellbeing Director)

Description of OH staffing groups

Table 1: Overview of the average OH staffing levels (based on Whole-Time-Equivalent (WTE)) posts across NHS organisations, including staff who are based at external contracted organisations

Occupation	WTE
Consultants (accredited specialists) employed by the Trust	0.83
Other doctors	0.60
Specialist Trainees/registrars	0.46
Nurses (specialist OH)	4.02
Nurses (general)	3.08
Nurses (mental health)	0.38
OH Technicians/Phlebotomists/Health Care Assistants	0.89
Physiotherapists/Occupational Therapists	1.06
Psychologists/Counsellors (OH-based)	1.83
General/Business Managers	0.91
Administrators/Support Staff	4.84
Others	0.88

Note: The following rules were applied during data cleaning: If the respondent reported the staffing level in 'sessions' per month, we assumed one session to be equal to half a day. In other instances where the number of hours worked was unclear e.g., if respondents reported 'part-time' or where they indicated the position was vacant, we then treated the response as missing data.

OH providers employ an average of 1.89 WTE doctors, of which 0.83 (44%) are accredited specialist consultants and 0.46 (24%) are specialist trainees/registrars. An average of 7.48 WTE nurses are employed, of which 4.02 (54%) are specialist OH nurses. Each provider employs on average 3.78 WTE other clinical staff including 0.89 WTE OH technicians/phlebotomists/healthcare assistants, 1.06 WTE physiotherapists/occupational therapists, and 1.83 WTE OH psychologists/counsellors. 5.75 WTE non-clinical staff were employed, of whom the majority (4.84 WTE; 84%) are admin/support staff. 0.88 WTE other personnel, such as wellbeing, health and safety, and IT staff are employed.

In addition to permanent and temporary OH staffing levels representing multi-disciplinary staffing groups, over three quarters (n=31; 76%) of OH providers support nurses who are in training to gain an accredited OH qualification and a quarter (n=13; 27%) also offer work placement opportunities to tertiary or secondary students. A smaller proportion (n=9; 35%) also host specialist doctor trainees.

We asked respondents for their opinions about how OH interacted with the wider trust and senior leadership and the results are displayed in Table 2. Most providers felt that OH was well understood by senior management (71% agree vs 18% disagree). However, there was a strong perception that requirements to make costs savings impacted negatively on core services (67% agree vs 16% disagree) and the health and wellbeing of NHS staff (77% agree vs 9% disagree). In addition, many OH providers indicated that they were expected by the trust to subsidise their budget with income from contracts (52% agree vs 22% disagree).

61% agreed (vs 12% disagreed) that OH initiatives were backed with strong leadership and visible support and most providers expressed support for integration and reconfiguration of OH services to cover larger areas (62% agree vs 17% disagree).

OH providers generally indicated a very productive relationship with senior management during the Covid-19 pandemic, with the vast majority feeling that they were able to influence decision-making (86% agree vs 8% disagree) and that senior management actively engaged with their team (88% agree vs 5% disagree).

Table 2: The role and perceived benefits of OH services in the NHS

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Overall OH and the services it provides is well understood by senior management	12%	58%	12%	16%	2%
The requirement to make cost savings to the OH budget affects the core services that I can provide to staff	31%	36%	17%	14%	2%
The requirement to make cost savings has an impact on the health and wellbeing of NHS staff	36%	41%	14%	6%	3%
Our Trust expects us to subsidise the services we provide to NHS staff with income from contracts	24%	27%	27%	19%	3%
The OH initiatives are backed with strong leadership and visible support	16%	45%	27%	9%	3%
I am supportive of integrated care systems/reconfiguration making larger OH teams that cover bigger areas *	17%	45%	20%	14%	3%
OH was able to influence decision making by senior management during the Covid-19 pandemic	48%	38%	6%	5%	3%
Trust senior management actively engaged with my OH team during the Covid-19 pandemic *	47%	41%	8%	2%	3%
* Due to rounding method total percentage for the row either exceeds or is less than 100%					

Engagement and delivery of OH services during the Covid-19 pandemic

We were particularly interested in exploring the extent to which OH providers were involved at an organisational level in the strategic and operational response during the Covid-19 pandemic period. We found over three quarters (n=49; 77%) of NHS OH providers were required to increase their existing OH staffing levels (e.g., redeploying staff from the wider workforce) to meet the rising demand for OH input during the Covid-19 pandemic period, with over half (n=32; 52%) also needing to buy in extra OH services during this period.

We found the vast majority of OH providers worked in close collaboration with a broad range of other medical specialties (infection control, microbiology) and departments (HR and Organisational Development and Communications) during the Covid-19 pandemic period.

As shown in Table 3, most NHS OH provider respondents were found to play an active role in the strategic planning and operational response to Covid-19 pandemic across their respective workplaces and at other NHS organisations.

Table 3: Involvement of NHS OH providers in trust-wide response during Covid-19 pandemic

	Strategic planning level (e.g. advising executive board)		**Coordination and operational delivery**		**Developing specific policy and standard operating procedures**		**Only indirectly involved**		**No involvement**	
	At host NHS trust	**Other NHS trust**	**At host NHS trust**	**Other NHS trust**	**At host NHS trust**	**Other NHS trust**	**At host NHS trust**	**Other NHS trust**	**At host NHS trust**	**Other NHS trust**
1. What level of involvement did your OH team have in Trust-wide planning and coordination of **Covid-19 risk assessment and management of NHS staff?**	43/63 (68%)	10/63 (16%)	49/63 (78%)	7/63 (11%)	49/63 (78%)	9/63 (14%)	11/63 (17%)	7/63 (11%)	00/63 (0%)	1/63 (1%)
2. What level of involvement did your OH team have in the Trust-wide planning and coordination of **Covid-19 outbreak management in the workplace?**	35/64 (55%)	1/64 (1%)	50/64 (78%)	5/64 (8%)	41/64 (64%)	6/64 (10%)	13/64 (20%)	6/64 (9%)	0/64 (0%)	4/64 (6%)
3. What level of involvement did your OH team have in the trust-wide planning and coordination of in-house **Covid-19 track and trace?**	34/64 (53%)	0/64 (0%)	40/64 (6%)	5/64 (8%)	34/64 (6%)	4/64 (6%)	14/64 (2%)	4/64 (7%)	7/64 (11%)	6/64 (9%)
4. What level of involvement did your OH team have in the Trust-wide planning and coordination of **Covid-19 staff swab testing for symptomatic staff**?	33/63 (52%)	1/63 (1%)	38/63 (60%)	4/63 (6%)	34/63 (54%)	2/63 (3%)	16/63 (25%)	2/63 (4%)	7/63 (11%)	6/63 (10%)

We also found that 53% of OH teams (n=34) provided testing for symptomatic staff households. Only 30% (n=19) of OH providers were involved in their trust's patient Covid-19 vaccination programme.

Furthermore, we found the majority of OH teams were engaged and participated in a diverse range of Executive and Trust-wide committees to support their organisation's strategic response to the Covid-19 pandemic. For example, over half (n=37; 60%) of OH teams were represented at Executive-level meetings and committees, most (n=51; 82%) participated in staff support committees, with fewer OH teams participating in committees that dealt with the redeployment of staff or the provision of PPE for staff (n=30; 48% and n=22; 35% respectively). In addition, over half (n=39; 63%) of OH teams also reported representation at other specific tactical response committees and meetings during the Covid-19 pandemic period. These included Bronze and Silver command meetings, Infection Control (outbreak surveillance) committees, Covid-19 vaccine delivery and planning groups, staff testing groups, daily Covid-19 ICC conference calls, staff health and wellbeing groups, Test and Trace meetings, clinical reference groups, ethics committees, pharmacy cell, workforce planning.

As highlighted above, while all respondents (NHS OH teams) were found to play an integral role in the strategic planning and operational roll-out of staff Covid-19 vaccinations, fewer OH teams (n=19; 30%) contributed to the planning and roll-out of the patient Covid-19 vaccination programme.

As shown in Table 4, many of the NHS OH providers were required to expand the provision of their services to meet the rise in demand during the Covid-19 pandemic period. In addition to offering extended opening hours, expanding availability to staff support services, and also establishing dedicated staff support and wellbeing offerings, many OH providers took the lead in establishing a diverse range of workplace and staff-orientated novel initiatives and activities:

- Dedicated referral pathways (e.g. direct to dermatology, staff psychology)
- In-house staff Test and Trace
- Mental health and wellbeing hubs for staff to access and anxiety and sleep support advice
- Child-care and carer advice lines (to assist staff with resolving practical barriers to accessing support due to Covid-19 restrictions)
- RIDDOR reporting process
- Direct access to OH for all staff before returning to work
- 24-hour telephone advice line for staff and managers (how to deal with risk assessments, how to support staff working remotely)
- Rehabilitation programme for shielded staff and those with Long Covid-19
- Provision of PPE fit testing
- Setting up new Long Covid-19 clinics

Table 4: Additional or enhanced services delivered during the Covid-19 pandemic

Extended operating hours (Mon-Fri)	69%
Extended operating hours (weekends)	73%
Extended operating hours (on-call)	38%
Increased provision of existing staff support (e.g. psychology/counselling support)	70%
Provision of new staff support services (e.g. wellbeing zones, rest and recharge areas)	45%
Community team to deliver home testing for symptomatic staff and family members	8%
None	2%
Other (e.g. developing RIDDOR reporting process, fit testing, PPE utilisation, alignment with IPC guidance, setting up dermatology referral pathway, developing publications)	53%

While OH providers quickly developed new systems of support as the crisis unfolded, a broad range of operational and logistical challenges and difficulties had arisen which placed significant pressure on already overstretched OH resources. These related to:

- Workforce constraints (existing understaffing or limited OH staff to respond, experienced OH nurses redeployed to other non-OH areas, inexperienced non-OH staff redeployed to assist in OH, no availability of bank/agent staff)
- Rapidly changing, and at times conflicting, national, and local guidance caused confusion and impacted confident decision-making by OH staff.
- The rapid expansion of OH clinical services (for Covid-19 matters) without adequate staff resources (moved from a 5 days a week to a 7 days a week service)
- Processing an increase in OH clearances for new starters
- Suspension of externally contracted services to meet internal demands (this has impacted future tender bids)
- Increased workload and pressure on OH staff impacted staff health (rising anxiety and burn-out, increase in sickness absence)

- Perception that senior management had a poor understanding of the impact of Covid-19 on OH service provision and the requirements for setting up new services in keeping with good clinical governance standards
- Unrealistic expectations by others that OH would have the resources and capacity to respond (with knowledge, advice, or support)
- Poor lines of communication between OH and senior management.
- Poor engagement by OH with trust senior management to support trust-wide strategic planning, leaving some OH teams feeling under-valued at some trusts
- Delays in disseminating vital information from government (including NHS England) to local trusts
- Poor or lack of IT infrastructure to support the expansion of OH services e.g., availability of laptops, telephony facilities.
- Lack of OH space to enable adherence to social distancing requirements

Notwithstanding the challenges outlined above, many of the OH providers observed positive outcomes (or 'gains') in response to the Covid-19 pandemic, which inadvertently enhanced the delivery and value of OH at a trust level. Most notable was a greater recognition and appreciation of the role and expertise of OH (teams and individual clinicians) at a trust-wide level and valuable opportunities in which to showcase OH skills and expertise to other stakeholders. In addition, OH providers noted:

- Greater visibility and recognition of the role and value of OH across all staffing levels or departments
- Increased collaborative decision making among a wider MDT team (infection control, microbiology, and other specialties)
- Established stronger working relationships with senior managers and directors, and opportunities to develop new partnerships with others (pharmacy, business intelligence, antibody testing, and vaccination teams)
- Developing new technologies to streamline OH practices
- Increase in interest among non-OH staff to consider a career within OH
- New model, new business case accepted for enhanced staffing and new staffing structure
- Ability to transition to telephone and virtual clinic appointments

Many OH providers expressed concerns that while the short-term impact of the Covid-19 pandemic appears to be improving, the long-term impact of Long Covid-19, coupled with staff burn-out and poor mental health among NHS staff (including OH staff), is now likely to overwhelm OH services.

Phase 2

Twelve accredited specialists were invited to take part in a 1-2-1 interview and from this nine agreed to participate, comprising five females and four males. The average (mean) number of Programmed Activities (PAs) worked by those who took part in the 1-2-1 interviews was 9.08 (range was 5 to 12). Sixteen (OH and non-OH) participants took part in the three focus group sessions following an invitation to forty-one individuals. The information detailed in this section of the report is derived from the qualitative work.

The analysis and interpretation of the data revealed two prominent and overarching themes and six sub-themes and while these themes are interrelated, they are described in more detail separately.

The first theme: '*Professional credibility has currency'* contains four sub-themes *'Establishing oneself as a medical specialist in occupational medicine' , 'Developing and nurturing valued and trusted relationships', 'Harnessing strategic and clinical leadership capabilities to navigate a complex system'* and *'Showcasing clinical expertise in a Covid-19 world'.* This theme explores the attributes and skills development of accredited specialists in OM, the importance of professional collegial relationships across the NHS hierarchy and their unique role within wider the OH landscape, and how they use their clinical and leadership skills at an individual and strategic trust-wide level.

The second theme: *'A visionary future: harnessing opportunities to revolutionise NHS OH services'* has two sub-themes '*Attracting and nurturing multi-disciplinary talent and investing in the next generation of clinical leaders'* and *'Widening the provision of OH services across the NHS'*. This theme explores several prominent issues relating to the future of NHS OH services in England, with a focus on the sustainability of the OH workforce and the potential opportunities for expanding NHS OH practice.

Table 5: Overarching main themes and sub-theme identified from the qualitative data

Main theme	Sub-theme
1. Professional creditability has currency	1. Establishing oneself as a medical specialist in occupational medicine 2. Developing and nurturing valued and trusted relationships 3. Harnessing strategic and clinical leadership capabilities to navigate a complex (NHS) system 4. Showcasing clinical expertise in a Covid-19 world
2. A visionary future: harnessing opportunities to grow the OH workforce and to revolutionise NHS OH services	1. Attracting and nurturing multi-disciplinary talent and investing in the next generation of clinical leaders 2. Widening the provision of OH services across the NHS

Main theme 1: Professional credibility has currency

The most striking finding from this work was the significance and value both OH and non-OH respondents place on the professional credibility of occupational physicians and the distinct and influential role they play within NHS organisations. For many, professional credibility was viewed as important for a variety of reasons. In the clinical context, credibility was considered fundamentally important when managing professional interactions and dynamics across the NHS hierarchy. For example, when working in close collaboration with other medical specialists and senior managements on trust-wide clinical matters; when dealing with complex individual clinical cases, particularly those involving other medical specialties as OH clients; and when providing specialist clinical education and supervision to other OH staff. Extending beyond the clinical domain, we found professional credibility underpins strong communication and interpersonal skills (such as assertiveness) which supports accredited specialists to cultivate and nurture a diverse range of professional relationships and partnerships with influential stakeholders as they navigate across the NHS hierarchy (see: sub-themes: *Developing and nurturing valued and trusted relationships).* For many

accredited specialist respondents' professional credibility was also grounded in the desire to be recognised by others as equally skilled as senior medical clinicians in other specialties.

Sub-theme: Establishing oneself as a comparable specialist medical specialist

Respondents described a broad range of clinical and non-clinical attributes which accredited specialists in OM in the NHS must possess and rely on in clinical practice. In the clinical domain, one of the most reported attributes relates to solid generalist medical education and training which provides the foundation knowledge in which to learn and develop specialist skills (clinical, strategic, and leadership) during their specialty training:

> *…you need to have a good knowledge base in medicine, you need to have a good understanding of a broader range of knowledge as possible of different medical conditions, different surgical procedures….it doesn't need to be in-depth, but I do think you need to be able to talk to people with common conditions and understand what level of treatment they're having…*

In addition, we found many accredited specialist respondents benefited greatly from prior clinical experience gained during clinical rotations and placements in other specialties as this was seen as valuable opportunities in which to further enhance their medical knowledge and develop technical clinical skills which they could later draw upon to deliver a holistic level of OH clinical care. This experiential learning helps to build confidence and competencies among OH clinicians:

> *...it builds confidence for a start but it builds communication skills, it builds clinical acumen and its clinical acumen, and almost hours under your belt of flying as a doctor that are really, really key to good decision making in occupational medicine...*

While a broad degree of generalist medical knowledge coupled with clinical skills was seen as representing basic components of the skill set of accredited specialists in OM, possessing a comprehensive and working knowledge of the legislative and regulatory frameworks which relate to the workplace and employees, and which governs the provision of OH services in England was recognised as essential for the role.

We found a core clinical responsibility of accredited specialists in OM is their direct involvement in, and management of, complex clinical cases which typically involve a degree of clinical uncertainty or cases which fall outside the parameters of established clinical practice protocols or guidelines and therefore require advanced clinical and technical skills. We found complex clinical cases either relate to specific medical conditions (such as psychiatric, HIV/AIDS or substance misuse) which have the potential to cause risk or safety issues in the workplace, statutory referrals (fitness of practice or ill-health retirement

assessments), or specific staffing groups (doctors). We found that it was also within this context that in-house accredited specialists were able to draw upon and use their professional authority and influence at a strategic planning and clinical leadership level which tangibly benefits both the organisation and individual OH clients:

It can save months and months of sickness absence…HR tends to sit on the fence quite a lot in the NHS…you know they basically often just allow people to go off for months. I mean I'm not saying they shouldn't stay off for months but what I sometimes do is run down to HR and tell me to sort this out… so I provide sort of, I am able to speed things up for the Trust

Sub-theme: Cultivating and nurturing valued and trusted relationships

Many accredited specialist respondents working in the NHS were found to place significant emphasis and importance on establishing and nurturing close working relationships and collaborative partnerships with a core set of stakeholders across the trust-wide NHS hierarchy and beyond. Most notably these include the Executive and senior management, clinical leads and senior physicians from other medical specialties (in particular, medical director, chief nurse, microbiology, dermatology, infection control, genitourinary medicine, and psychiatry), non-clinical teams (HR and Workforce) and staff within their own OH teams. These trusted relationships were found to be highly valued and evolve and strengthen over considerable time (often many years), and they facilitate networking opportunities and closer trust-wide integration of OH with other services. This was eloquently expressed by one respondent:

…this is coming to my 18th year in the trust and the full-timer is coming into his tenth year…we've both been around for a long time, people know us because we're fixtures and fittings now

For in-house accredited specialists, in particular, longevity in the role allows them to become a prominent and respected figure across the wider workforce and an integral part of the local corporate identity. Over time this enables them to strengthen close working relationships with key players (or influencers) so they can gain an understanding of different personalities and their ways of working and their expectations and are also able to acquire extensive corporate and organisational knowledge. Importantly, this mutual collegial support and guidance can then be relied upon when dealing with complex (clinical and non-clinical) matters:

….I've worked with very senior management in the Trust from when they were at a lower level and so we've carried on the relationship for years and so they are either the Chief Nurse or the Medical Director or the Chief Operating Officer at the moment so we started as Consultants together….we've moved up the hierarchy….progressed together so they

respect my views, we've built up a relationship, they trust me basically so I am able to access them quite directly if I need to and obviously they value my input.

We also found examples where in-house accredited specialists were able to use their senior-level relationships at a trust- and regional-level which directly benefited individual OH clients (NHS staff) and local OH teams. Specifically, by facilitating priority treatment referrals to other specialties for OH clients; establishing reciprocal regional referral pathways so OH clients can access confidential acute crisis support outside of their local catchment area, and providing informal backup OH clinical support to neighbouring nurse-led OH services where shortages for accredited specialists remained a longstanding issue. These established collaborative relationships also ensure informal discussions (direct contact) can occur between OH and non-OH specialists and senior managers when situations require a rapid or immediate response or intervention.

These cross-specialty relationships also created vital opportunities for several accredited specialists to engage in multidisciplinary research collaborations and contribute their OH expertise to a diverse range of research projects, including Covid-19 research. This has enabled them to build research capacity and generate research activity within the OM specialty and the wider NHS environment which has produced impactful research outputs. These include the development of new health interventions and technologies, and scientific journal publications and conference proceedings (presentations and posters) which have contributed to evidence-based clinical practice in OM or other specialties.

We found others, in particular, senior clinicians and senior managers rely heavily on the specialist knowledge and clinical skills of accredited specialists in OM to influence and shape organisational policy and clinical guidelines as they relate to staff health (e.g. drug and alcohol policy, infection prevention policy, staff wellbeing). This illustrates that accredited specialists can deliver confident and informed decision making at a strategic and operational level:

One of the things that I sort of found was Dr X [accredited specialist] *was sitting on the staff well-being group. It felt like almost everybody who was looking at a specific area in the hospital within the community would automatically all look towards Dr X to see what the national and regional view was. It was almost if Dr X said it was okay then we would all be quite happy to sign off on it because it was us. (NHS Chaplain)*

However, as one respondent pointed out, nurse-led NHS OH services which lack oversight from accredited specialists risk '*policy-lag'* because they lack the technical skills and clinical knowledge needed to make confident informed decisions on policy development and review.

Many respondents (both accredited specialists and their OH colleagues) highlighted the significance of solid interpersonal relationships within OH teams and specifically the clinical leadership role that accredited specialists play in terms of providing direct clinical education and mentoring support to OH staff. This was found to create a safe and nurturing teamwork dynamic which also serves to promote good clinical practice standards. In essence, we found a core component of their role is to inspire and unite their OH teams:

I think the approachability, I don't think anyone in the department would be worried about contacting me and actually just asking for advice and that's just actually built up over the years, you know as a first year trainee, and I think if it wasn't that kind of relationship it would be very hard to go from being a trainee to a consultant in the same department, encouraging other members of staff to come to me with plans, who have just started as nurse advisers, a couple of them used to start coming to me and saying, what shall I do and gradually it's been turned around, so what do you think you should do. I'll still give you the support and the safety net of saying yes or no if you need me to but at least, what do you think you should do.

Sub-theme: Harnessing strategic and clinical leadership capabilities to navigate a complex (NHS) system

Many accredited specialist respondents described clinical leadership as having the skill to identify and harness the clinical capabilities and expertise within their clinical teams and to exploit and use their team's collective expertise and skill set flexibly to ensure the efficiency of service provision. For instance, many OH respondents (including accredited specialists and other OH respondents) describe the presence of a horizontal hierarchy within their local OH teams which appears distinctly different from other medical specialties. Additionally, we found various triaging approaches were adopted across NHS OH services, with some sites employing a top-down (vertical) approach whereby the OH senior clinicians review and triage all OH referrals as they are received, with referrals allocated to appropriately skilled OH staff. Regardless of the approaches taken, we found greater autonomy is given to all members of the OH team:

I'd like to think the team isn't particularly hierarchical so on a day-to-day basis it is mutual respect, so consultants tend to lead on translating guidance into policy but equally respect the nursing team and the non-clinicians in the group on their experience of transactions and operationalising that stuff and try and find that middle ground to make policy reality and reality of what's needed in policy, (OH Head of Service)

Moreover, we found there were different core aspects to clinical leadership provided by accredited specialists in OM. For example, clinical leadership was found to offer significant benefits to the wider frontline OH clinical team as well as to other core staffing groups such as HR personnel. Specifically, they found they can provide direct expert clinical oversight and guidance on a 1-2-1 or group basis which then facilitates speedy decision making when dealing with clinical matters which in some cases avoids unnecessary follow-up appointments or delays in return to work for staff on sickness leave. Additionally, we found they are well-placed to provide local clinical education, supervision, and mentoring support on a regular and ongoing basis. This provides valuable opportunities for multidisciplinary (OH and non-OH) teams to gain new knowledge from their local accredited specialists which they can use to build upon their own skillset and clinical competencies. Furthermore, it enables OH clinical teams, particularly junior medical, nursing, and allied health staff, to access expert mentoring advice and informal reassurance when dealing with individual clinical cases which serves to strengthen confident clinical decision making and clinical practice among OH team members. Inversely, some accredited specialist respondents also highlighted the practical benefits they too gain from these collegial peer interactions when dealing with clinical cases since they provide a valuable opportunity to enhance their professional development. However, what was most evident was the importance many placed on accredited specialists being 'accessible' to others to offer this support and guidance regularly. At its core, this rallying together and a collective team spirit appears to foster and strengthen (OH) team cohesion:

it's a mentoring role, it is also a role that inspires people, it's also a role that provides teaching and training in a very different way…you have a team that is much more developed than a team that is not led by an accredited specialist…

We found it was important for in-house accredited specialists to encourage and support innovation among their OH teams and to promote autonomous working practices as this helps build individual capabilities and competencies. However, in this regard we found clinical leadership also requires difficult, and at times unpopular, decisions need to be made in the interest of the OH team and the wider NHS organisation:

I always think that to get the best out of people you have to give them flexibility and freedom…we discuss an initiative, I let them develop what they want to do, we have equal say in criticising each other's work or promoting each other's work, however, at some stage there are occasions that I have to make a decision where some of the decisions may not be to the liking of a particular person or particular group within the team so I think that from a leadership perspective it is a balance between being democratic enough to let people try and

come up and take ownership but also have a level of being autocratic to make decisions…So there are occasions you have to make a decision. I have to say a lot of times those decisions are unanimously reached but there are occasions that they are not, and you have to take an executive decision.

Their role was found to not only guide but also influence the overall strategic direction of the NHS at a local trust-level and to ensure local trust wide strategic planning and policy and procedure development activities, which relate to staff and workforce matters, are aligned with broader national strategic priority policy objectives. We found there was a range of advantages for NHS organisations employing an in-house accredited specialist in OM (as opposed to locum or out-sourced), most notably, they are better placed to influence the '*key players',* such as trust Boards and senior management, and have acquired an intimate understanding and appreciation of the inner workings and cultural nuances (including internal politics), including organisational and logistical pressures that are having a wider impact on individuals (staff and patients) and systems and importantly have developed corporate memory which they can rely upon. Conversely, it was highlighted that locum OH physicians working in the NHS on a sessional basis are likely to experience significantly reduced capacity to deliver comprehensive strategic and clinical leadership at a trust-wide level because of time and resource limitations:

In terms of leadership and a strategic view comes together naturally if you are in house i.e. if I am employed by Guy's and St Thomas' I have a lot better chance to understand the politics, to recognise who are the players, what are the processes and how to sort of influence the Board and the Trust so that's a lot easier because you are in house.

We found strategic and clinical leadership by accredited specialists in OM extended far beyond their OH teams, with many integrating themselves in the wider managerial and leadership structure of their NHS organisations to contribute to and influence important decision making: This means being a prominent and recognisable figure across workforce hierarchy:

leadership; being highly visible within the Trust, being high profile and visible; being embedded in key trust structures like ward, health, and safety committees, infection control and so on; strategy and planning

Many OH respondents described being adaptive and flexible when working within and across the NHS system to respond to the changing needs and demands at an organisational and individual client level, further highlighting the need to balance working in a dual clinical and leadership role:

I think what is important is that for me personally, you have a bit of a split in your mind that you can separate: one is that you have a clinical mind which is very unique as a skill, but you also have a system mind where you can contribute to improving and achieving in collaboration the objectives of the organisation and strategic themes.

In-house accredited specialists in OM were also found to play a critical role strategically in monitoring and intervening to promote a safe workplace environment for NHS staff and members of the public who access NHS services. For example, by ensuring clinical and corporate governance standards, and compliance with legislative requirements (e.g. Health and Safety at Work Act) as they relate to staff health and wellbeing are being met. We also found in-house accredited specialists deliver senior clinical leadership and provide specialist clinical knowledge to their OH teams to ensure quality assurance standards about the delivery of OH services are maintained and corrective action is taken where necessary. This is often in the context of maintaining SEQOHS accreditation for local OH services. Importantly, we also found there are distinct differences between in-house accredited specialists and non-accredited specialists in OH (OH physician, GP with post-graduate training in OM) in terms of their roles and responsibilities at a local trust-level:

the accredited specialist is largely strategic and the person who isn't an accredited specialist is largely operational, there's very little strategy that our staff grade doctors do, our staff grade doctors are not familiar with what's going on strategically at board level…so the relationships that the accredited specialist will have with the chief executive and the medical director and the HR director, for example, are very different and while those people may ask questions of our specialty doctors, they're largely clinical and they're largely operational and they're largely based on individuals…whereas the kind of questions the accredited specialist is going to be asked are largely strategic and they're largely contributing to trust strategy.

When operating at a strategic level within a complex hierarchical system, we found accredited specialists are uniquely positioned to use their operational and clinical insights to gauge the temperature of the workforce, to monitor workforce and staffing pressures over time, and to intervene at a senior level if required:

…to have skills as a strategic leader and foresight, so anticipation in occupation medicine I think is very important, you should be able to see things long before they have actually occurred so that you don't always be a reactive person, you are proactive and try to handle situations

We found delivering solid and reliable strategic leadership in OM requires strong diplomacy and advocacy skills coupled with an assertive and dynamic style of working in which accredited specialists actively seek out new trust-wide opportunities:

think it is very easy to work in a silo and, I would say hide, not deliberately hide, but generally just keep a sort of low profile, keep quiet, not being so busy but what I think should happen just to make sure Occupational Health delivers what it should be is to have the visibility and to have that visibility you have to be a leader and be seen.

there are occasions that Occupational Health is not particularly considered for an issue whereas it should have been and we have never held back, always been to our Exec Directors to say this particular initiative needs Occupational input so as I said this makes you a lot busier than some other colleagues

We also found in-house accredited specialists often feel able to adopt a confident and authoritative stance with others (including senior management and the Executive) when dealing with complex organisational and individual client issues. This ability and implied authority to confidently challenge and stand their ground with others when necessary was highly valued by many (OH and non-OH) respondents because it appears to ensure neutrality and impartiality in decision-making at an organisational and operational level. Within this context, several respondents highlighted the challenges that others, such as OH nurses or locum OH physicians, would likely experience when operating at this level. This suggests subtle yet powerful (interpersonal) dynamics and bias can play a significant role in senior-level interactions which involve OH:

I look at my nurse colleagues and think if they were still a nurse-led unit, I think they would say that they don't have perhaps the necessary profile within the Trust to be able to say actually this is right, this is wrong and to be able to stand up at those levels and argue or…make the point. They wouldn't, despite their experience and their absolute competence to do so, but they wouldn't have the confidence, I think they wouldn't have been asked in the same way.

Whilst buy-in and support from senior management was viewed as critical for supporting accredited specialists to work effectively in their role from a trust-wide strategic and operational perspective, conversely, we found that a lack of senior managerial endorsement and support for OH input (e.g. blocking proposals for innovation) can become a barrier to achieving positive outcomes which have the potential to benefit staff, patients and the wider NHS.

While we found there was a range of notable benefits to in-house specialists in OM providing clinical and strategic leadership at a trust-wide level, some respondents expressed the firm view that strategic clinical leadership and the operational delivery of NHS OH services should be based on individual competencies and skills regardless of professional

background and training. Furthermore, some considered it irrelevant to distinguish between OH clinical leaders who are medical vs non-medical trained and drew upon real-life examples where the delivery of high-quality NHS OH services was successful because they know how to maximise teamwork and are skilled at utilising the expertise and skills of all OH team members.

We also found some in-house accredited specialists had extended their clinical training and used their clinical leadership position to develop business acumen skills for income generation purposes which resulted in tangible benefits for their NHS organisation and local workforces. These include setting up new external contracts and securing additional funding to deliver enhanced OH services such as future staff health and wellbeing initiatives.

Sub-theme: Showcasing clinical expertise in a Covid-19 world

Many respondents highlighted the significant disruption which had occurred across the NHS in response to the evolving Covid-19 pandemic crisis and described exceptional pressure placed on OH services from the unprecedented surge in work that followed during this period. A notable observation within this context was the extent to which accredited specialists in OM (with the assistance from their OH teams) had used their clinical leadership skills to drive and deliver, at pace, innovation in OH services to further support staff health and wellbeing during the pandemic. For many NHS OH providers, this meant re-orientating existing OH work practices and adopting more dynamic and agile ways of working to meet the rising demand for OH services and to ensure they were able to rapidly respond to continuous requests for specialist OH advice and guidance. These efforts chiefly focused on introducing measures and safeguards to protect the NHS workforce (in particularly vulnerable workers with underlying health conditions and those working in high-exposure risk job roles and clinical areas such as dedicated Covid-19 wards) as well as implementing targeted strategies to minimise the impact on NHS resources and maintain workforce capacity. Examples included developing and implementing staff Covid-19 risk assessment, setting up antibody testing, staff vaccination programmes, a telephone helpline for staff, and piloting multi-specialty long Covid-19 clinics.

In this regard, we found accredited specialists in OM were able to use their specialist clinical skills and knowledge of occupational and non-occupational risk profiles alongside their high-level influence to ensure consistent approaches were applied at a trust-wide level when supporting workers with vulnerabilities to remain in the workplace during the pandemic. Possessing knowledge and an understanding of the diversity of job roles across the wider NHS workplace was crucial for ensuring vulnerable workers in some circumstances were able to be redeployed to safer work areas thereby minimising the need for home shielding.

Accredited specialists in OM were also able to use their position as clinical leaders to exert high-level influence and authority during the pandemic when unpopular decisions needed to be made to safeguard the health and safety of staff and patients e.g. advocating for teams to be stood down due to potential exposure concerns.

The significance of the professional credibility of accredited specialists in OM was further evident by the extent to which others, particularly senior managers/executive, other medical specialties, and HR teams, had relied heavily on swift advice and on the depth and breadth of their specialist clinical skills and knowledge to influence and guide the trust-wide strategic and operational response during the pandemic. We found accredited specialists in OM were relied upon to rapidly interpret and translate evolving and often conflicting scientific information and guidance into comprehensible material for different disciplines and audiences, including lay audiences. This enabled confident evidenced-informed decisions, for example, when rapidly developing and revising policy and clinical guidance about infection prevention and control. Some believed this had resulted in greater recognition and appreciation from others:

I think in terms of the clinical credibility and visibility of occupational health services, they have gone up dramatically during the pandemic and I think the respect and the extent to which opinions are taken from occupational health colleagues has gone up dramatically…a lot of extra people moved in from other departments to help in occupational health and many of them said comments that they only realised by coming into the tent actually what this department did. So I think all of those things have actually helped in terms of the visibility, I mean it is a silver lining in this awful cloud… (non-OH physician)

Additionally, the pandemic period also afforded extraordinary opportunities for accredited specialists for OM and their OH teams to extend their 'traditional' clinical practice and remit, and to work collaboratively across new and uncharted clinical and professional boundaries, unique experiences that many were found to embrace. Many OH respondents expressed a firm view that these experiences, especially their exposure to the broader NHS system during the pandemic, have been enormously beneficial to them as clinicians, to their OH teams, and the OM specialty at large. Most notably, because it has significantly raised the profile of OH teams and has allowed them an opportunity to showcase their specialist clinical skills and expertise more extensively across the NHS. Consequently, some believe this has allowed the specialty to be recognised by many as a distinct and legitimate clinical specialty, comparable with other medical specialties.

I have to say covid has been a phenomenal opportunity for that because they have stood up daily meetings because of the massive operational challenges and because it's gone virtual, 30 or 40 of us at some points were meeting at 8 o'clock every single morning and because vicariously or ridiculously, OH became the expert in covid, I always had something to say, but those linkages were already there….. So again, a positive that's come out of the recent, well 15 months or so now is we are truly embedded in our organisation and we've built on a lot of what we had before but I think that's the added value of an in-house accredited specialist, they can integrate into an HR type role, a health and wellbeing type role, an operational service delivery role, a clinical director and clinical governance role and do a day job as well and then there's the research and academic bits that go on top.

Some respondents highlighted several priorities for NHS OH services as we emerge from the aftermath of the pandemic, highlighting the specific strategic and clinical leadership role that accredited specialists in OM will need to play. This includes working in more close collaboration with other medical specialties and providing specialist clinical advice and support about the ongoing care and management of NHS staff with long Covid-19 as well as dealing with the effects the pandemic has had on the mental health of staff.

Main theme 2: A visionary future: harnessing opportunities to grow the OH workforce and revolutionise NHS OH services.

The continuing decline in the size of the OH workforce in the UK due to natural attrition featured predominately in the qualitative interviews, with respondents attributing this reduction to the growing number of OH physicians who are due to retire in the coming years. As a consequence, several respondents expressed genuine concern that the future provision of multidisciplinary NHS OH services is likely to be further constrained unless the specialty (including wider OH field) can improve its capacity to train and retain more accredited specialists and physicians in OM in the NHS, alongside recruits from across the allied health professions.

In response to these growing workforce challenges, respondents proposed a range of potential opportunities for attracting and nurturing the OH workforce and made recommendations about the reorientation of existing NHS OH services to make better use of limited available resources. Coupled with this, they also foresee opportunities to embed OH within the government's current transformation of healthcare services in NHS and in doing so to expand the offer of OH advice and services to a broader client base.

Sub-theme: Attracting and nurturing multi-disciplinary talent and investing in the next generation of clinical leaders

Several suggestions were proposed for growing a sustainable multidisciplinary OH workforce for the future. First, several respondents argued that it's imperative to rebrand and improve the image of the OM specialty and OH field so that it is seen as an attractive and distinguished career option that health professionals (medical, nursing, and allied health professionals) will want to pursue, and which offers unique benefits when compared to other medical specialties and health disciplines, for example, working conditions such as family-friendly work hours and optimal work/life balance.

In addition, some suggested there are key benefits for introducing OH early into core clinical education and training (i.e. medical school or during foundation year training) and spoke of the need to create more extensive opportunities for specialist clinical placements and rotations in OH during training so that aspiring health professionals learn to appreciate the value of work and the benefits it brings to individual health and the wider society. This would also provide an opportunity for health professionals-in-training to acquire basic (elementary) skills and knowledge which they can incorporate into their clinical practice such as how to facilitate work-focused discussions during clinical consultations and to conduct occupational assessments. Additionally, some recommended offering funded placements and clinical fellowships in OM so physicians from other specialists such as general practice can gain exposure and training to OM discipline.

Notwithstanding these proposals, several barriers to growing the OH workforce were highlighted. Specifically, some spoke of the lack of an established early-career pathway into the OM specialty i.e. during medical foundation year training for recently qualified junior doctors; financial disincentives (i.e. reduction in earnings) for those who wish to retrain from other specialties; the burdensome nature of OM training and accreditation; and the lack of sufficient centralised funding to support an increase in training opportunities within the specialty. Others highlighted the potential role that private OH providers should play in the future training of OH physicians, suggesting special incentives to gain their support may be required.

While the issues describe above are longstanding and persistent challenges for the specialty, it is noteworthy to highlight that important recent developments have been made to address some of these issues. For example, since mid-2021 the Academic Dean at the Faculty of Occupational Medicine (FOM) has set up a working group exploring opportunities to improve undergraduate medical student teaching in OM in England and over fourteen occupational physicians have been appointed as specialty ambassadors to liaise with their

respective medical school to promote undergraduate medical student. In addition, the Faculty now offers free membership to the Faculty for medical students and foundation year doctors. These current activities builds upon a previous (from 2018) joint commissioned work undertaken by Public Health England, University of Kent and the Faculty of Occupational Medicine (and in partnership with Department of Health & Social Care and Department for Work & Pensions) which sought to integrate health and work education into undergraduate medical curricula. Specifically this work comprised the development of a new 'heath and work' content that medical schools can flexibly incorporate into their existing undergraduate syllabus (HEE, 2018).

These efforts to improve medical student education in OM will greatly assist in meeting the General Medical Council (GMC) outcomes for graduates requirements which states that "*Newly qualified doctors must be able to carry out effective consultation with the patients" (p16) (GMC, 2018).* To achieve this, they must be able to '*describe the principles of holding a fitness for work conversation with patients including assessing social, physical, psychological and biological factors supporting the functional capacity of the patient, and know how to make referrals to colleagues and other agencies".*

The Colt Foundation (key funder for OH research in the UK) has recently established a new early/mid-career research fellowship scheme for occupational physicians. The purpose is to support academic research career development for clinicians who aim to pursue OH research in the long term. Importantly, the Colt Fellowship Award will 'buy out' time for clinically active individual occupational physicians for up to two days a week over five years. Additional local initiatives which are aimed at raising the profile of OM and creating training and placement opportunities for non-OH doctors have also been developed and implemented by consultant occupational physicians in local geographical areas.

Despite these persistent workforce or organisational challenges, we found some novel local workforce initiatives have been successfully developed and implemented by several accredited specialist respondents. These initiatives are specifically aimed at attracting and increasing the number of physicians joining the OM specialty in regional locations, with a core focus on creating intake opportunities outside of traditional (and popular) metropolitan training sites such as Birmingham, London, or Manchester. These locally-orientated initiatives include the establishment of a 'Trust doctor programme in OH' targeting qualified doctors at foundation years 2 and 3 training as well as offering regular work experience placements in OH departments for local GPs who have an interest in OH.

Prospectively, some respondents envisage that future efforts to raise the profile of OH beyond its traditional clinical boundaries coupled with the potential expansion of OH services into the wider NHS landscape (in particular, the evolving NHS Integrated Care Systems and primary and secondary care services) is likely to have the additional benefit of encouraging health professionals from other disciplines to consider future career opportunities in the OH field. Several respondents also highlighted the fertile training environment of the OH field which offers health professionals opportunities to acquire specialist clinical knowledge and develop transferrable skills which can benefit the wider NHS and can be readily applied in other clinical specialties:

so my last service manager has now, well one of them, the senior nurse has gone on to be a Head of Nursing in another trust, out of OH, I jumped up a young physio into the service manager job, he's left and has been head of neurology and is now head of the full surgical services in the whole organisation and my current one is pretty much set to do something big as well, so I am known as green fingers…. OH is not a dead-end in our trust with me, OH is an absolute training opportunity for others

Sub-theme: Widening the provision of OH services across the NHS

While many respondents acknowledged the persistent and worsening workforce pressures in OH, we nevertheless found enthusiasm and a keen desire among our respondents to explore innovative and bold new ways of delivering core OH services, including offering OH advice, to a wider client base in the future. Some proponents highlighted the need to focus on breaking down established barriers and traditional (silo) ways of working which were viewed as hampering effective cross-specialty working collaborations. Furthermore, it was generally agreed that efforts to expand the provision of OH services across the NHS in the future would require careful consideration of how best to mobilise and coordinate finite OH workforce resources to meet the rise in demand that would follow.

…we are just simply not producing enough to send an in-house doctor for every Trust. That's the reality of it, so the best solution we will have is to have a, like a sort of regional service where you have two, three, four, 10 specialists who deliver service to a group of Trusts in that region. Again that's a mixture of workforce reality i.e. in the next 10, 20 years we are not going to have so many accredited specialists to deliver the service.

Nevertheless, a range of complementary suggestions were proposed by both OH and non-OH respondents which appear to represent stepped care and hub-and-spoke models of care. These included:

1. Establishment of OH nursing and allied health posts in the primary care setting (i.e. OH posts based in GP practices) to offer prompt generalist OH advice and support on a large scale with backup support and escalation of complex cases to specialist OH consultants where required.

2. Formation of cross-specialty partnerships with local primary care services (groups of local GP practices) and secondary care services (outpatient clinics) to enable direct referral pathways to OH specialists for complex cases.

3. Establishment of sub-specialties within the OH workforce to deliver bespoke OH advice in specific secondary care services e.g. in trauma clinics or orthopaedic (fracture) clinics.

4. Creation of clinical placement opportunities for OH clinicians to work in other medical specialties and health disciplines such as orthopaedics, gynaecology, surgery, primary care, psychology, and speech and language therapy. This would enable specialist OH clinicians to embed themselves in the clinical landscape of other areas so they can provide immediate specialist OH input for complex individual cases as well as providing in-service OH education and training to other health professionals which can then be used to deliver a more holistic level of clinical practice.

I mean there would certainly be a way of doing it where…where you triage what needs to go through a nurse, bearing in mind that…certainly our nurses here are…very highly trained specialist nurses so yeah I mean specialist nurses in other specialties do their own clinics, manage their own workload…I wouldn't see that as being any different. We could do it that way and then yes refer up to a specialist, refer to a Consultant as you would need to. If you look at some of the other specialties where they have started to use more of a Specialist Nurse model and look at doing that…

Despite the novel suggestions that were proposed, several respondents pointed out the potential limitations that could arise if OH clinicians do not have ready access to crucial workplace information, especially the 'employer's perspective' and these issues will need to be taken into careful consideration when exploring new opportunities for the future expansion of OH service provision.

Several respondents also spoke of the significant untapped repository of specialist knowledge and skills which currently exists among accredited specialists working in the NHS due mainly to the restricted nature of their job role and clinical remit. This, according to one respondent, was in addition to the underutilisation of a large number (approximately 120) of

GPs in England who have completed postgraduate training in OM. Taken together, these resources and skills are well-placed to be harnessed and made use of across the wider NHS environment.

Most experienced physicians in the system are occupational health physicians because they've completed their training, they've completed training in some other specialty, they've got loads of skills which is under-utilised, because the ask of them is very narrow, they're not able to deliver anything wider than that

Beyond the suggestions to re-orientate existing NHS OH services, respondents also see worthwhile opportunities to upskill the wider health workforce, particularly clinicians who routinely provide clinical care to the working-age population so they can learn to appreciate the dual relationship between health and work, and where 'workability' is recognised as a core feature of care planning and rehabilitation, and a key clinical outcome for patients. Furthermore, some see scope to acquire clinicians from other specialties with the skills and competencies in which to facilitate basic health and work-focused discussions with their patients. Additionally, some recommended delivering OH training to a core set of local representatives from other specialties and departments who would then be available to offer collegial advice and support on 'OH and work-related matters' within their respective local teams.

This is also a kind of influencing role in terms of influencing all the specialists in all the other specialties about where work fits in their specialty, so you've got your slightly better enlightened psychiatrists and respiratory physicians who recognise the importance of work in causing some of their diseases who are a bit more enlightened to opening that door but in lots of other disciplines, it's not relevant to them, gastro do they ever think about what someone's doing for a job and whether their irritable bowel might be relevant, they don't and we've got (non-OH specialist)

In this regard, some respondents advocated for the wider adoption of a biopsychosocial and public health approach across all clinical services and specialties in the NHS to ensure every contact patients have with the healthcare system provides opportunities for patients and their treating clinicians to discuss and explore health and work issues. Others viewed this as an important opportunity in which to also lessen the huge disparities in people's access to healthcare services, mostly due to the demarcation of distinct clinical boundaries which currently exist between community, primary and secondary care services.

Some respondents also see the potential for accredited specialists in OM to provide specialist guidance, support, and training to GPs around the sick certification (issuing eMED3 (fit notes)) for working-age patients, to minimise unnecessary or prolonged sickness absence among workers. Further, several respondents expressed frustration that the introduction of the new fit note certification directive in 2010 (to replace the former sick note) has largely failed to deliver what was intended, citing particularly concerns about inadequate training and guidance provided to GPs coupled with time constraints that GPs frequently experience during primary care consultations, with one opponent calling for a central review of the current fit note scheme to assess its effectiveness. Others see this as an opportunity in which to expand this delegated responsibility to other suitably skilled and knowledgeable health professionals (e.g. occupational therapists, OH nurses, and physiotherapists) who are adept at providing sound OH advice on workplace issues such as phased return to work, work adjustments.

While creative suggestions for broadening the reach of OH across the NHS landscape were proposed, clinical governance as well as legal and liability (insurance) issues, were highlighted as areas that would need to be carefully considered and addressed in terms of risk mitigations. While most respondents expressed the view that the field of OH must continue to evolve and adapt to meet the changing needs of the working-age population and the ongoing transformation to healthcare services in the NHS, some emphasised the need to first secure political commitment and intent to support and drive change nationally about the expansion or reorganisation of NHS OH services in England. This means ensuring opportunities are created for accredited specialists in OM to engage in collaborative and meaningful discussions with policymakers:

There are lots of people who've got brilliant ideas, they just don't have any voice, they just don't know who to say anything to.

While others recognised the need to ensure realistic expectations for all stakeholders are set early on, with several respondents conceding that embedding OH in the future ICS landscape, for instance, will require a medium- or long-term strategic plan spanning the next 10-20 years to ensure limited resources are used optimally and until the OH workforce can grow, with funding investment to ensure its sustainability.

With specific reference to the development and progressive rollout of integrated care systems across the NHS in England, one accredited specialist respondent highlighted the similar 'integration' framework in health and care services which has been operationalised in Scotland for many years, with its core intention of expanding access to OH services for small and medium-sized enterprises (SMEs). Furthermore, attributing the success of this

integration model to government commitment and support in terms of a significant investment of funding, and a favourable cultural shift within the nation's OH community.

we were all brought into it culturally that it's a good thing for everyone's health in society to close the gap and take referrals from SMEs and charge for them

However as pointed out by several respondents, to realise this potential it's crucial that accredited specialists in OM and OH physicians working in the NHS become fully cognisant of the inner workings of the ICS model as a matter of priority. This sentiment was reflected in the range of feedback obtained during the qualitative interviews which seemed to indicate only a fair degree of knowledge and understanding of the ICS model exist among some of the respondents. Notwithstanding, respondents also argued that gaining a solid knowledge of the ICS model will support OH physicians to understand how the ICS model is proposed to work operationally in their regional catchment areas, to appreciate what potential impact this could have on OH delivery in the future, and to assess new and broader strategic opportunities which they can leverage. Importantly, this will then allow them to use their clinical leadership skills to demonstrate what they can bring to enhance their regional ICS arrangements by influencing discussions with senior-level decision-makers during the early strategic and operational planning period.

Several ideas were proposed for embedding OH within the ICS model. Chief among these was the proposal to provide OH nurse or OH allied health coverage for referrals requiring generalist OH input from across the ICS network, supplemented with clinical oversight provided by accredited specialists operating at a regional level. Operationalising the provision of OH services within the ICS framework in this manner would then optimally utilise the limited available resources of accredited specialists, thereby allowing them to focus on managing complex cases and direct referrals from local GPs. Additionally, some see opportunities for accredited specialists to deliver specialist clinical leadership at a strategic level across the regional ICS network, with a core focus on providing clinical supervision and training to clinical staff as well as advising on and guiding key strategic and operational policy development work e.g. risk management and staff health and wellbeing.

…have smaller units which do the transactional stuff within Trusts which would be potentially nurse-led if you will and then you will have a specialist who sits within the ICS and they deliver the more complicated case management or more strategic sort of delivery of occupational health, which is what you expect from an accredited specialist

However, several respondents cautioned for proper integration of accredited specialists in OM within the wider ICS landscape if they are to operate effectively at a strategic and operational level and underscored the importance of gaining commitment from all NHS and

partner organisations within the regional ICS network to ensure standardisation and uniformity about policy development and implementation.

While some expressed a vision for providing greater access to NHS OH services to the wider working-age population, others proposed a more targeted approach which focuses on OH teams delivering public health promotion across the wider NHS workforce especially given its size (over one million employees) and geographically dispersed workforce population, to improve the health and wellbeing of all NHS staff. This would create valuable opportunities for NHS staff to then become health champions and positive role models within their family and social networks and local communities, specifically in terms of modelling healthy behaviours such as healthy diet and regular exercise and showing the positive benefits that come with healthy work participation. Cultivating a healthy NHS workforce was also seen as contributing directly to patient safety benefits.

Comparisons with previous research

We found several striking similarities and differences when comparing our results with the findings from two earlier studies (in 2001 and 1998) examining OH staffing and the provision of OH services in the UK context (Hughes, Philipp, & Harling, 2003). The present study yielded a response rate of 51% (65/128) which was lower than the 66% and 68% response rate observed from the previous studies (2001 and 1998 respectively). However, we speculate this lower response rate was due to the workload pressures OH departments were under due to the Covid-19 pandemic period at the time this present survey was conducted.

Nevertheless, we found there has been sustained growth in the overall number of OH consultants working in NHS OH departments over the three-time points (i.e. 57% in the present study compared to 41% in 2001 and 27% in 1998). This gradual increase reflects similar tends observed in the wider NHS workforce namely, the increase in the overall number of NHS consultants (in all specialities) from 2010 (n=35,513) to 2018 (n=46,297) (NHS Digital, 2018a, 2018b). However, Coleman and Gilbey (2017) earlier survey of members (NHS OH departments) of the NHS Health at Work Network found that in the preceding three years (2014-2017) OH-consultant staffing levels at individual OH departments had remained broadly the same for the majority (n= 33) of survey respondents, with 15 OH departments reporting a reduction over the same period and six reporting an increase over the same period. This is also set within the backdrop of eight (12%) NHS OH departments in the present study who report no in-house OH medical staff posts, which is far fewer than the 48/154 (31%) OH departments highlighted in an earlier 2001 study. Conversely, over the same period, we found there has been a notable reduction in medical staff from lower grades entering and working in NHS OH departments (42% in the present

study compared to 59% in 2001). Coleman and Gilbey (2017) earlier survey also identified a reduction in 'other physician grade' whole time equivalent (WTE) posts at a small number (n=5) of OH departments between 2014-2017, combined with a notable increase in OH staffing posts for nursing, allied health and counselling posts during the same period. Workforce profile data reported in the annual reports from FOM highlighted a gradual reduction in fellows and members (including accredited specialists) from 2013 to the present period. More specifically, in 2013 the number was 720 (with 83 trainees listed), decreasing in 2018 to 643 (with 72 trainees lists), with a further decrease in 2020 to 624 (with 68 trainees listed). Moreover, the annual report in 2013 also reported that over half of FOM members were aged over 55 years.

In the present study, we found a substantially higher proportion (61%) of OH doctors (across all grades) work full-time in the NHS when compared to 2001 and 1998 (22% and 14% respectively). Similarly, over the same period, we found a substantial reduction in the proportion of OH doctors who work on a part-time basis i.e. 39% in the present only compared to 78% in 2001 and 86% in 1998. This suggests more OH doctor sessions are now being provided in the NHS.

In addition, we found there was a progressive increase in the proportion of NHS OH departments who deliver contracted OH services to other organisations compared to the early studies periods (i.e. 54% in 1998 rising to 84% in 2001 and 87% in the present study period). Although in the present study we did not differentiate between contracted services to other NHS versus non-NHS organisations. In the present study, we found a higher proportion (58%; n=66/114) of NHS OH departments have either part-time or full-time OH-consultants in post compared to the number of posts available in the earlier studies (41%; n=97/236 in 2001 and 27%; n=96-99/362 in 1998). For the same periods, we also found there was an increase in the number of full-time sessions worked by OH doctors compared to part-time working patterns i.e. in the present study, 62%; n=71/114 (worked full-time) and 38%; n=43/114 (worked part-time) compared to 22% n=22/236 (worked full-time) and 78%; n=183/236 (worked part-time) in 2001.

Conclusion

This project sought to explore the role and value of accredited specialists in OM from different perspectives, in particular, the views and opinions of accredited specialists themselves and those of OH and non-OH colleagues who work alongside them. Whilst respondents described a range of clinical- and technical skills as well as non-clinical personal attributes of accredited specialists in OM, the vast majority agreed that a notable core feature of the role of in-house (as opposed to) accredited specialists in OM working in the NHS is their capacity to deliver strong and reliable strategic and clinical leadership at a senior management level. This is a role that extends far beyond their management responsibilities within NHS organisations and also makes the role of in-house accredited specialists in the NHS quite distinct from externally contracted consultant OH physicians and non-accredited specialists such as in-house OH doctors or nurse and allied health colleagues working in OH teams who typically are much more focused on the 'operational' provision of OH practice within NHS organisations. Within this context, respondents characterised the NHS organisation as a complex system that accredited specialists must integrate into and learn to navigate around, particularly at a senior operational and trust-wide level. We found that to operate effectively at this level, in-house accredited specialists must establish and nurture close collegial relationships with a broad range of multidisciplinary colleagues and they need to be skilful at balancing and fulfilling their clinical and corporate duties. This coalescence of responsibilities symbolises their unique role within the NHS landscape, which in many ways renders them distinctly different from other senior medical specialties.

This project provided an opportunity for respondents to reflect upon the Covid-19 pandemic period and to consider how their local OH services have contributed to the wider organisational response across the NHS environment. While undoubtedly the Covid-19 pandemic created significant pressure and challenges for NHS OH departments and the wider NHS system, this period of disruption also provided valuable opportunities to not only raise the profile of NHS OH services far beyond traditional interdisciplinary boundaries but importantly it gave opportunities to showcase the specialist clinical and technical skills and expertise of the OH clinical workforce, particularly the specialist capabilities of accredited specialists and consultants in OM.

We found there was a general consensus among respondents that the transformation of NHS services offers unique opportunities for the accredited specialists in OM working in the NHS to advocate for the expansion and integration of NHS OH services beyond its traditional clinical remit. It also offers exciting opportunities to explore new ways of delivering

OH services and providing OH advice to wider patient groups, and for working more synergistically and collaboratively with other specialties. The suggestions explored for the potential expansion on OH services across the wider NHS landscape are well-aligned with the recently released UK government policy framework ('Health is everyone's business') which recommends the wider health care workforce focus on the rehabilitation of the working-age population to improve work participation, in particular, enhanced access to vocational advice and support, and which recommends greater integration of multidisciplinary working practices across medical and health disciplines and the social care sector and better use of technology to improve access to OH services. (DWP&DHSC, 2021).

However, while many respondents were enthusiastic proponents of expanding the provision of the NHS OH services and see tangible benefits for patients, staff, and the OM specialty, this was tempered by a recognition that the limited OH workforce base which currently exists will have a significant bearing on the specialty's capacity to meet the anticipated rise in demand for services that would follow. In recognition of the ongoing and potentially worsening OH staffing challenge in the coming years, the authors of the report echo the views expressed by Hughes et al (2003) who argued that in the context of the poor growth in the number of doctors joining the OM specialty, *'…this could provide an impetus to a critical evaluation of skills and roles of the different professionals working on OH'*. From this perspective, while we acknowledge there are additional persistent difficulties about the recruitment and retention of OH nurses and OH allied health professionals, there is nevertheless a large cohort of experienced senior OH nurses and allied health professionals currently working in the NHS who possess the requisite skills and competencies that would allow them to take on more clinical responsibilities, particularly those traditionally reserved for medically training OH staff. This suggests there are compelling reasons for conducting a national OH workforce skills and capability assessment and evaluation to identify the current skillset across OH staffing groups working in the NHS. This would allow informed strategic and operational decisions to be made in the future on how best to utilise the finite multidisciplinary OH workforce resources that would be required to support any proposed expansion of NHS OH services under consideration.

Additionally, feedback obtained during this project suggests there is likely to be only a fair degree of comprehension within the OH community of the ICS model and how it is proposed to operate across the NHS and social care landscape. This suggests awareness-raising efforts within the NHS OH workforce in England will need to be prioritised as a matter of urgency so potential opportunities the ICSs may create for OH teams can be considered.

Moreover, decisions on the future expansion of NHS OH services should also ensure they are informed by lessons learned from the rollout of the government's Fit for Work telephone advice service, which found the initiative was underutilised due to poor knowledge of its scope and availability among its target audiences (employers and employees).

VIGNETTE AND CASE STUDIES

The following is a vignette and several case studies reflecting guidance and underpinned by good clinical OH practice.

Vignette: Consultant occupational physicians during Covid-19 pandemic

In early March 2020, a group of NHS OH consultants from across the country recognised the imminence of the Covid-19 threat, anticipated the pressures on the NHS and worked at pace to produce the first information and guidance document titled: **"Covid-19 and Occupational Health (OH) in the NHS'** published jointly by the Faculty of Occupational Medicine and NHS Health at Work Network on 11 March 2020. This guidance, widely used by NHS OH services, other OH providers, NHS managers and clinicians, emphasised the importance of OH as part of strategic planning for the Covid-19 response and identified as key issues:

- return to work after testing, isolation or illness
- management of staff who have concerns about specific vulnerability
- risk assessment of clinical work placements
- deployment of temporary and returning NHS staff
- communication

It was followed by a series of guidance documents, all clinically led by groups of OH consultants, often in collaboration with clinicians in other disciplines. They addressed emerging OH issues throughout the pandemic including testing, vaccination, ethics, ethnicity, pregnancy, individual vulnerabilities and long Covid-19, supplementing agreed national PHE and other guidance to which the OH consultants had also contributed.

Case study 1: Patient Story – Post Covid-19

A surgeon (45 years old) suffered a serious Covid-19 illness requiring two hospital admissions, the second followed significant respiratory complications.

He returned to work, to full duties, following three months of treatment and sick leave but soon self-referred to OH, concerned about his stamina and mental agility, worrying that these might compromise patient care. No concerns from management.

Assessment by a consultant OH physician included cognitive screening and liaison, with consent, with the respiratory consultant who confirmed that lung function was improving, with a good long-term prognosis. There was no objective evidence of cognitive dysfunction.

The surgeon had followed a self-directed cycling programme to improve his fitness, but neither he nor colleagues considered a gradual return to work. The OH physician facilitated a 'rehabilitation in work programme', gradually increasing work activities and initial buddying with a trusted colleague, particularly whilst operating. The surgeon returned successfully to full duties over eight weeks, with renewed confidence and no further sick leave.

Surgeon, colleagues, and ultimately patients all benefitted from this OH intervention, particularly from a consultant in OM who could facilitate confirmation of diagnosis and prognosis, followed by an effective return to work programme.

Case study 2: Patient story- pregnancy during Covid-19

Many nurses working on ICU when pregnant have sought OH advice. Early risk assessment by managers had usually suggested moving to a lower risk environment but the nurses were often reluctant to do so. Preliminary discussion with OH nurses, followed by individual consultations with OH physicians allowed detailed exploration of their balance of risks, taking account of the working environment, and personal health situations. Staff frequently described feeling safe when wearing full personal protective equipment (PPE) on ICU and working within clearly defined systems of work and clinical pathways, rather than in undifferentiated clinical areas where their risk of unanticipated Covid-19 encounters might be increased.

Following assessment by an OH consultant many continued to work in ICU until the third trimester. Their consultations also allowed the potential benefits of Covid-19 vaccination to be discussed and appointments arranged or signposted.

Case study 3: **(Derived from a project conducted by Joint Work and Health Unit at DHSC/DWP)**

Employer background

The employer is a hospital unit who have their own internal OH service. Frontline medical staff may be affected by a lack of resources, heavy workload, and a pressured environment. The employees in this case study work in a unit for adults with challenging behaviour and there is a high risk of physical, verbal, and sexual assault.

The HR department advises line managers on OH referrals and action required from the OH provider's report. 'Huge' caseloads mean HR is dependent upon line managers to act upon their recommendations and there is limited oversight of how policy is implemented.

The OH department is part of an NHS hospital, providing an in-house OH service, but also operates as a 'mini-business' providing services to other public or private organisations. It is one of the largest OH providers in its region. For NHS clients they provide immunisations,

absence management, and advice, as well as in-house health and wellbeing activities for the hospital.

They use a ‘biopsychosocial’ model to assess cases and aim to ‘facilitate and empower’ employees to return to work, stressing the importance of everyday activity.

Around 60% of staff are healthcare professionals. They have a sizeable workforce of around 15 but struggle to hire senior skilled staff – they have to recruit at more junior levels and train staff up. They provide internal and external, structured training but find it hard to fund training for national OH specialist qualifications.

Referral process

Usually, line managers refer cases to the OH service, though they do cater for self-referral this is rarely used.

Employee story 1

Lesley is a senior staff nurse. She reported struggling due to a lack of staff and management support and feeling ‘burnt out’. She received ‘criticism’ of her role following a serious assault on a colleague by a patient. This led to insomnia, loss of appetite, a ‘low’ mood, and Lesley was unwilling to work in the ward where the incident occurred.

Lesley had prior knowledge of her employer’s OH provision through referring others but suggested it was a colleague, Maria (not her line manager at the time), who advised referral a few weeks after the incident. Maria, though supportive of the request, reported that it was Lesley who requested she makes the referral.

Lesley had a consultation with the OH provider over the phone and had one face-to-face meeting. She was referred to a telephone counselling service which gave her advice she followed to decrease her stress (e.g. exercise, discussing with others). She would though have preferred more, face to face sessions with a specialist experienced in helping people affected by assault or challenging patient behaviour. The OH provider report they do offer face-to-face counselling if needed, but employees have to start with a phone consultation to meet their budget demands.

Lesley reported she waited around eight weeks for the telephone counselling (once she spoke to the OH provider she had to wait around three weeks for an appointment). Maria felt the turnaround was much quicker – 10 days from referral to report, and found it ran smoothly. The discrepancy between their recollections could be due to Lesley confusing

length of time since the incident with the length of time from the initial referral to seeing the OH department

Lesley did not take any time off and felt she largely 'got through it herself' by talking to family and colleagues, as well as the psychologist at her workplace – this may have been partly due to the gap between the incident and the telephone counselling.

Employee story 2

Frances has been a nurse with the hospital for over a decade, part of her reason for returning from the private sector was the support available should she be ill. She was 'bullied' by her line manager. Their team frequently refers staff to OH services but Frances explained that her line manager did not refer her until three months after her first absence. The HR team's advice of immediate referral for staff absence related to stress, anxiety, or depression appear not to have been followed. Frances felt she should have been referred much sooner, and that if she had had their advice during her first period of absence she should not have become so mentally unwell.

Frances felt the OH provider gave her strategies to help her return to work and improve her mental health (e.g. keeping physically fit). She turned down the offer of counselling (she had undertaken it in the past and didn't think it would help in this situation) but found it useful talking to the OH as an independent listener. Separately, she spoke to a consultant who prescribed medication and regularly saw her GP.

OH encouraged Frances to see a phased return to work as part of her recovery. Frances found the OH service 'really good' and largely attributed being able to return to work to their advice. She subsequently saw a specially trained colleague twice and wished she had been aware of their services earlier. The HR department was aware of her case their only involvement was through her line manager.

Outcomes and lessons

Staff feels fortunate to have access to OH services. Those who have used them have found them useful. OH provision helped avoid absence, and aid return to work. HR and provider staff are aware of the tension between providing sufficient time to recover and meeting the high demand for staff. Delays in referral may add to ill-health and prolong absence unnecessarily but despite their knowledge of the service employees may feel uncomfortable requesting referrals and/or speaking to their line manager – there is a case for promoting other referral routes, e.g. self-referral, referral by a colleague or an independent team.

Similarly, referral, and follow-up support is largely at the discretion of line managers, greater HR oversight may be beneficial in some cases.

Recommendations

Based on the findings of this project we strongly argue that this is an important and timely opportunity for widespread strategic and operational reform to the deployment and utilisation of in-house NHS accredited specialists in OM in England. Accordingly, we propose the following two primary recommendations:

1. That a regional group of in-house accredited specialists in OM working in the NHS in England should be integrated into each of the forty-two ICS across England and deliver high-level specialist strategic and clinical leadership. This would allow them to support the establishment and optimal functioning of enhanced strategic multi-agency partnerships with health, community, and social care agencies, and influence the development of enhanced and coordinated services designed to improve population health. Additionally, allowing them to use their expertise in OM to enhance the provision of patient care for the working-age population in England.

2. To create a National Chief Medical Officer in Occupational Health role that would facilitate and support co-ordination and consistency across the 42 ICS's, and would enable the development of patient as well as staff focused future Occupational health model. This would provide the national level strategic and political voice for the largest employer in the UK.

To underpin this recommendation the following complementary activity is proposed:

- Provide accredited specialists in OM with practical guidance on how to effectively embed themselves within their local ICS environment along with useful strategies to harness and maximise new opportunities that exist for enhancing clinical practice and improving patient care for the working-age population. To achieve this, we propose producing and disseminating (to the OH community and key partners) a short video facilitated discussion drawing upon the lessons learned from an experienced consultant occupational physician well-versed with the inner workings of the ICS landscape as it relates to the provision of OH practice, and who has practical experience integrating into and working collaboratively with local multi-agency ICS partnerships. A method to rigorously evaluate the impact of accredited specialists working in the ICS landscape will need to be incorporated.

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Appendices

Phase 1: OH survey questions

1. Name of NHS Trust (host organisation):
2. Is your service SEQOHS accredited?
3. What is your job role?
4. How many NHS staff does your OH team support (host Trust plus any other NHS organisations)?
5. How would you define your HOST (Trust) organisation?
6. Does your OH service provide contracted services to other organisations?
7. How many staff are currently employed in your OH team (include staff based in host organisation and external services if applicable)? Please confirm the following in each field (WTE):
8. Does your OH service host the following:
    a. Nurses training for a recognised OH qualification
    b. Specialist doctor trainees
    c. Students on work placements
9. Who does your OH service report to?
    a. HR Director/Deputy
    b. Medical Director/Deputy
    c. Chief Nurse/Deputy
    d. Other (please specify)
10. In general please state how much you agree or disagree with the following statements:
    a. Overall OH and the services it provides is well understood by senior management
    b. The requirement to make cost savings to the OH budget affects the core services that I can provide to staff
    c. The requirement to make cost savings has an impact on the health and wellbeing of NHS staff
    d. Our Trust expects us to subsidise the services we provide to NHS staff with income from contracts
    e. The OH initiatives are backed with strong leadership and visible support
    f. I am supportive of integrated care systems/reconfiguration making larger OH teams that cover bigger areas
    g. OH was able to influence decision making by senior management during the Covid-19 pandemic?
    h. Trust senior management actively engaged with my OH team during the Covid-19 pandemic?
11. Did your OH team have to increase OH staffing numbers due to the Covid-19 pandemic (including drafting in redeployed staff from other specialties)?
    a. Yes
    b. No
    c. Unsure
12. Did your OH team buy in additional OH support/expertise during the COVID-19 pandemic to help meet any additional demand?
    a. Yes
    b. No
    c. Unsure
13. Which specialties/departments did your OH team work closely with during the COVID-19 pandemic?
    a. Infection prevention/control

b. Microbiology/pathology
c. Dermatology
d. Respiratory
e. Psychology
f. Emergency Department
g. Health and Safety
h. HR (including Organisational Development/Workforce)
i. Communications
j. Other (please specify)

14. What level of involvement did your OH team have in Trust-wide planning and coordination of Covid-19 risk assessment and management of NHS staff? Please tick all that apply.
    a. Strategic planning level (e.g. advising executive board)
    b. Coordination and operational delivery
    c. Developing specific policy and standard operating procedures
    d. Only indirectly involved
    e. No involvement
15. What level of involvement did your OH team have in the Trust wide planning and coordination of COVID-19 OUTBREAK MANAGEMENT IN THE WORKPLACE? Please tick all that apply.
    a. Strategic planning level (e.g. advising executive board)
    b. Coordination and operational delivery
    c. Developing specific policy and standard operating procedures
    d. Only indirectly involved
    e. No involvement
16. What level of involvement did your OH team have in the trust-wide planning and coordination of in-house COVID-19 TRACK AND TRACE? Please tick all that apply.
    a. Strategic planning level (e.g. advising executive board)
    b. Coordination and operational delivery
    c. Developing specific policy and standard operating procedures
    d. Only indirectly involved
    e. No involvement
17. What level of involvement did your OH team have in the Trust wide planning and coordination of COVID-19 STAFF SWAB TESTING FOR SYMPTOMATIC STAFF? Please tick all that apply.
    a. Strategic planning level (e.g. advising executive board)
    b. Coordination and operational delivery
    c. Developing specific policy and standard operating procedures
    d. Only indirectly involved
    e. No involvement
18. Did your OH team also provide TESTING FOR SYMPTOMATIC (STAFF) HOUSEHOLDS?
    a. Yes
    b. No
    c. Unsure
19. What level of involvement did your OH team have in the Trust wide planning and coordination of COVID-19 STAFF SWAB TESTING FOR ASYMPTOMATIC STAFF (lateral flow tests)? Please tick all that apply.
    a. Strategic planning level (e.g. advising executive board)
    b. Coordination and operational delivery
    c. Developing specific policy and standard operating procedures
    d. Only indirectly involved
    e. No involvement

20. What level of involvement did your OH team have in the Trust wide planning and coordination of COVID-19 STAFF ANTIBODY BLOOD TESTING? Please tick all that apply.
    a. Strategic planning level (e.g. advising executive board)
    b. Coordination and operational delivery
    c. Developing specific policy and standard operating procedures
    d. Only indirectly involved
    e. No involvement
21. What level of involvement did your OH team have in the Trust wide PLANNING AND COORDINATION OF THE REDEPLOYMENT OF ATRISK STAFF (in terms of developing risk assessment process/ education and training for managers and establishing referral pathways into OH)?
22. Please tick all that apply.
    a. Strategic planning level (e.g. advising executive board)
    b. Coordination and operational delivery
    c. Developing specific policy and standard operating procedures
    d. Only indirectly involved
    e. No involvement
23. What level of involvement did you OH team have in the Trust wide PLANNING AND COORDINATION OF STAFF COVID VACCINATION? Please tick all that apply.
    a. Strategic planning level (e.g. advising executive board)
    b. Coordination and operational delivery
    c. Developing specific policy and standard operating procedures
    d. Only indirectly involved
    e. No involvement
24. Was your OH team involved in the PATIENT COVID-19 VACCINATION PROGRAMME?
    a. Yes
    b. No
    c. Unsure
25. What additional involvement did your OH team have in the Trust-wide STRATEGIC RESPONSE TO COVID-19? Please tick all that apply.
    a. Representation at executive level meetings/committees
    b. Representation at Trust wide response committee for staff support
    c. Representation at Trust wide response committee for PPE
    d. Representation at Trust wide response committee for redeployment
    e. Representation at other Covid-19 committees (please specify)
26. What additional or enhanced services did your OH team deliver during the Covid-19 pandemic? Please tick all that apply
    a. Extended operating hours (Mon-Fri)
    b. Extended operating hours (weekends)
    c. Extended operating hours (on-call)
    d. Increased provision of existing staff support (e.g. psychology/counselling support)
    e. Provision of new staff support services (e.g. wellbeing zones, rest and recharge areas)
    f. Community team to deliver home testing for symptomatic staff and family members
    g. None
    h. Other (e.g. developing RIDDOR reporting process, fit testing, PPE utilization, alignment with IPC guidance, setting up dermatology referral pathway, developing publications) please specify below
27. In a few words, describe any problem(s) your OH team experienced during the pandemic period in terms of preparedness, impact on service delivery, engagement with senior management?

28. In a few words describe any positive (unexpected/expected) outcome(s) your OH team experienced during the pandemic which helped to further enhance the value of OH at a Trust level? For example:
29. Establishing new and sustainable working relationships or networks with other teams or departments in your Trust, a greater recognition and appreciation of the role of OH etc.

Phase 2 Interview schedules

1-2-1 Interview questions

1. Are you an in house (employed) OHP?
2. What is your job title?
3. How many PA's do you work (broken down in clinical and non-clinical)?
4. What do you consider are important attributes of an accredited specialist in occupational medicine working the NHS?
5. Can you please describe the specific attributes (in terms of skills, knowledge and experience) an in-house accredited specialist in occupational medicine brings to the OH service. Please use examples to illustrate where possible? (*Compare this with a visiting physician and a nurse led service*)
    a. How do they use these skills of benefit to the Trust at a strategic level?
    b. How do they use these skills of benefit to individual clients?
    c. How do they use these skills of benefit to other colleagues within the department or Trust?
6. Can you describe how the relationships which can be developed by an in-house accredited specialist in occupational medicine supports delivery of OH services in the NHS (please use examples to illustrate where possible)? If so how?
7. Can you describe how they use these relationships as a benefit to the Trust at a strategic level?
8. Can you describe how they use these relationships as a benefit to individual clients?
9. Can you describe how they use these relationships as a benefit to other colleagues within the department or Trust?
10. Can you describe any other benefits of an in-house accredited specialist OHP, please use examples to illustrate where possible?
11. Thinking about the role of an accredited specialist, do you think their role could also sit within the Integrated Care Services (ICS) landscape to bring benefits to NHS OH services across the ICS at primary, secondary and community level? If so, can you describe how this might function and work in practice?
12. Do you think their role could also sit within the ICS landscape to bring benefits to the wider NHS patient community? If so, can you describe how this might function and work in practice?
13. Can you describe how we might optimise and embed occupational medicine practice as a part of patient-centred primary and secondary healthcare? Can you describe what the needs and expectations of different stakeholders might be?

Focus group 1 (to address theme 1)

OBJECTIVE: To explore, from the perspective of other clinicians and non-clinicians, the added value accredited specialists or consultants in occupational medicine bring in supporting the Trust and colleagues in other specialities at a clinical and strategic level before and during covid.

1. From your own perspective, can you describe the role of a consultant in occupational medicine within your organisation?
2. Prompt questions:

a. What are they responsible for at a strategic level, before and during covid period?
b. What are they responsible for at a clinical level, before and during covid period?

3. From your experience what do you consider are important skills and qualities of a Consultant in Occupational Medicine?
4. Thinking about your own role in your organisation, can you describe what value (such as advice and support) a consultant in occupational medicine provides to you?
5. How can the skills and the value that has been identified above further promote an enhanced level of occupational health provision for NHS staff?
6. How can the attributes (skills, knowledge, experience and relationships) of an accredited specialist in occupational medicine further promote an enhanced level of occupational health provisions for NHS staff in primary, secondary and community services?
7. Can you describe how the provision of OH services, including the role of consultants in occupational medicine, could be expanded in the future to enhance patient-centre care in primary and secondary care services in your organisation?
   Prompt questions:
   a. What would be the advantages (benefits) / disadvantages?
   b. What would be the expectations of different stakeholders?
   c. What role would a consultant in occupational medicine play and what potential benefits could they bring?
   d. What would be the enablers to facilitate this (stakeholders/resources etc)?
   e. Would there be any barriers or limitations or risks?
   f. What type of referrals pathway would work best to encourage primary and secondary clinicians to refer their patients to such services?
8. In the absence of a consultant in occupational medicine where would you seek senior clinical OH advice locally?
9. Can you describe any organisational risks associated with a lack of long term senior OH advice provided by a consultant in occupational medicine?
10. Can you think of ways in which a consultant in occupational medicine could bring additional value to the Trust and its patients beyond services to staff?

Focus group 2 (to address theme 2)

OBJECTIVES: To explore opportunities for enhancing and expanding the provision of OH services, including the role of consultants in occupational medicine, across the wider NHS landscape (in particular primary and secondary care).

1. Can you describe the potential benefits for patients having access to Health and Work advice when they access healthcare services in the wider NHS (e.g. when attending orthopaedic outpatient appointments or primary care)? Give examples
2. Can you describe how the provision of OH services, including the role of consultants in occupational medicine, could be expanded in the future to enhance patient-centred care in primary and secondary care services in your organisation?
   Prompt questions:
   a. What would be the advantages (benefits)/ disadvantages?
   b. What would be the expectations of different stakeholders?
   c. What role would a consultant in occupational medicine play and what potential benefits could they bring?
   d. What would be the enablers to facilitate this (stakeholders/resources etc)?
   e. Would there be any barriers or limitations or risks?
   f. What type of referrals pathway would work best to encourage primary and secondary clinicians to refer their patients to such services?
   g. How could OH services and advice be integrated into the developing Integrated Care Services environment?

Focus group 3 (to address theme 1& 2 – OH professionals only)

OBJECTIVE: To explore, from the perspective of OH colleagues (clinical (not medics) and non-clinical staff), the value which accredited specialists bring to an OH department, to clients (staff), managers and to their Trusts. To consider how the skills of an accredited specialist can be further used to enhance OH provision to the NHS for staff and patients?

1. In your opinion what and will be the benefit of an in-house accredited specialist in Occupational Medicine before and during the covid pandemic and afterwards?
2. Has the pandemic changed your perceptions of the value of an in-house accredited specialist?
3. What are the benefits to your OH service?
4. What are the benefits to your OH clients?
5. What are the benefits to your wider organisation?
6. How are these benefits different from having a non-accredited specialist input?
7. Can you describe any other benefits of an in house accredited specialist OHP?
8. How can the attributes (skills, knowledge, experience and relationships) of an accredited specialist in occupational medicine further promote an enhanced level of occupational health provisions for NHS staff in primary, secondary and community services?
9. Do you think their role of an accredited specialist could also feasibly sit within a wider Integrated Care Systems (ICS) landscape to bring benefits to the wider working community?

    Prompt questions:

    a. What role would an accredited specialist in occupational medicine play and what potential benefits could they bring?
    b. What would be the advantages (benefits) /disadvantage?
    c. What would be the enablers to facilitate this (e.g. back-up support from OH colleagues)?
    d. Would there be any barriers or limitations or risks?
10. Can you describe how the provision of OH services, including the role of accredited specialist and consultants in occupational medicine, could be expanded in the future to enhance patient-centred care in primary and secondary care services?

    Prompt questions:

    a. What would be the advantages (benefits) / disadvantages?
    b. What would be the expectations of different stakeholders?
    c. What role would a consultant in occupational medicine play and what potential benefits could they bring?
    d. What would be the enablers to facilitate this (stakeholders/resources etc)?
    e. Would there be any barriers or limitations or risks?
    f. What type of referrals pathway would work best to encourage primary and secondary clinicians to refer their patients to such services?
11. How can OH make better use of technology to improve capacity and transform the service?

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