



Invisible patients

*Report of the Working Group on the health of
health professionals*

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Foreword

The staff of the National Health Service make up the largest single group of patients it serves, but it ignores this fact so often that ill health in health professionals may effectively become invisible. The consequence of that is profound: ranging from loss of resources to the Service – current levels of sickness absence in the NHS mean that more than 10 million working days are lost every year, equivalent to 4.5% of the entire workforce and at a direct cost of £1.7 billion every year – to rare but very public tragedy, as in the case of Dr Daksha Emson, who took her own life and that of her daughter Freya during an acute episode of mental illness.

I have had the great privilege of chairing the Working Group on the *Health of Health Professionals* commissioned as part of the work of implementing the White Paper *Trust Assurance and Safety*. I am pleased to present this report, which sets out the results of its work.

In my role as the Director of the National Clinical Assessment Service, I am only too aware of the impact health status can have on the work and the personal lives of health care professionals – and of how frequently health concerns form part of the reason why my organisation is contacted for help – in 23% of cases referred to us with concerns about the performance of individual practitioners, health concerns form part of the reason for referral.

At its heart, the purpose of this report is to set out a framework which enables all health care organisations, whether in the NHS or the independent sector, to build healthy workplaces and a healthy workforce. Our Group believes not only that these are fundamental to the effective delivery of health care, but also that building and sustaining them are everyone's business.

To build this framework, to base it on clear evidence, and to ensure its practicality, our Working Group reviewed evidence from three substantial pieces of work commissioned by the Department of Health on the health of regulated health professional staff, and from the first year's experience of a prototype specialist health service for doctors and dentists. In addition, the Group considered carefully earlier work undertaken by Dame Carol Black and by Dr Steve Boorman on the health and wellbeing of the wider workforce.

Creating and sustaining healthy workplaces and a healthy workforce begin at the very start of professional education, training and regulation, and continue throughout all the key stages of professional and career development. The framework set out in this report therefore addresses the key responsibilities for delivering and fostering a professional and workplace culture in which the risks for ill health are minimised, and in which those professionals who do fall ill can tackle these challenges without fear of stigma or discrimination. And it addresses these responsibilities at the four core levels of professional governance: the individual health professional, the clinical team, the health care organisation itself, and the relevant national bodies.

As part of its work, the Group saw much good practice already in place, not only within the health sector but also more widely. The key challenge, it seemed to us, is to ensure health care services can build on these and ensure a consistent approach across all services and

parts of the country. Much work needs to be done to achieve this, and we believe that the framework document sets out practical approaches to doing so. For example, the London based prototype Practitioner Health Programme (PHP) for doctors and dentists, after only a year of service, has had considerable success in supporting and treating clinicians with complex needs. Furthermore, the Boorman Review recommended that all Trusts ‘... *should provide a range of additional staff health and wellbeing services targeted at the needs of their organisation*’. His recommendations are reflected in the five year plan for the NHS published in December 2009: *NHS 2010–2015: from good to great. Preventative, people-centred, productive* and the Operating Framework 2010/11. Experience of PHP and the wider evidence base from our review supports these recommendations in respect of regulated health professional staff and further suggests that those staff would benefit from a tiered range of services, with interventions provided in accordance with need.

As the health professions get to grips with the changing face of professional regulation and begin to take forward the principles set out in the *Next Stage Review* and the recommendations in *NHS 2010-2015*, looking after the health and wellbeing of our frontline staff has never been more important. I believe that this report sets out practical steps to deliver this central responsibility, grounded on clear evidence not only of what is needed but also of what works.

Alastair Scotland

Acknowledgements

In as wide-ranging work as this there are inevitably a great number of people without whose time, effort and tireless commitment the work could not have been accomplished.

This report is the result of work over many months by a widely drawn expert Reference Group, supported by a Technical Group and a team drawn from the Department of Health and from my own organisation, the National Clinical Assessment Service. Annex A sets out in full the membership of those groups. I am indebted to everyone listed there for their time, effort and enthusiasm.

The report and framework would not have been possible without the underpinning evidence yielded by the commissioned work streams. In particular, my thanks are due to Dr Clare Gerada and the Practitioner Health Programme team for their leadership and clinical expertise in managing the complex patients who presented to them for care and demonstrating the value of this service. My thanks are also due to the Institute of Psychiatry team led by Professor Matthew Hotopf, to the Institute of Occupational Medicine led by Dr Joanne Crawford and to the Ipsos MORI team led by Katy O'Malley who expertly delivered the commissioned work.

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Executive Summary

1. Ill health in health professionals may remain hidden, leading to worsening of their condition and to possible adverse effects on the quality of care provided to their patients. The evidence provided in this report supports this assertion and, from this, moves on to provide a framework for preventing, identifying and managing the difficulties. It looks in particular at the issues that affect regulated health professionals and their fitness to practise – and how these need to be addressed by the individual, their team, their workplace and the health professional regulators.
2. There is evidence for higher rates of depression, anxiety and substance misuse in health professionals than in other groups of workers and the health care environment can be inherently more challenging, also the workload is high. Research shows that the way work is structured and organised – at a personal and organisational level – seems to have a much greater influence on the risk of developing a mental health problem than dealing with sick and dying patients and their relatives.
3. In terms of the impact of ill-health on the quality of care, there is evidence for the impact of depression on doctors' performance, and working under the influence of drugs or alcohol increases the chance that health care workers will make mistakes and communicate poorly with colleagues and patients. Lower levels of productivity and quality of care from sick health professionals may increase workload and stress among their colleagues, leading to lower morale and motivation, poor communication and adverse effects on the quality of care. Health problems may be a contributory factor when concerns are identified about an individual's performance, but may be difficult to identify.
4. Sickness absence costs the NHS £1.7 billion each year and presenteeism – coming to work and performing at less than full capacity as a result of ill health – has been estimated to cost one and a half times this amount.
5. Health professionals often find it difficult to seek help for their health problems, because they feel they are letting down their patients or colleagues, or for practical reasons such as workload or because they fear stigma and adverse effects on their career.
6. To address these issues requires a response led by national bodies, involving the individual health professional, their team and their employing or contracting organisation. The framework provided in this document sets out a range of measures which should help to prevent ill-health and assist with early identification and effective management. Most of the proposed measures are not new, but simply bring together existing good practice. What is new is the proposal for developing health professionals (GPs, occupational physicians and psychiatrists) with enhanced skills to treat their colleagues and refer on to a small number of specialist services to manage those whose complex problems cannot be dealt with locally and may adversely affect the quality of care. These measures should benefit health professionals, their families, their colleagues and, most importantly, their patients

Chapter 1 Introduction

Background and context

- 1.1. The White Paper, *Trust Assurance and Safety — The Regulation of Health Professionals in the 21st Century*, published in February 2007, recognised that the increasing complexity of modern clinical practice had added to the pressures health professionals face in their working lives¹.
- 1.2. The White Paper proposed that regulatory reforms for health professionals causing concern needed to be balanced by greater support for those with any kind of health problem, to help them maintain their own health and wellbeing and make it easier for them to seek appropriate advice or treatment should they become ill.
- 1.3. Many of the health issues facing health professionals are not unique to them or the environments in which they work, but what is different is how they go about seeking help for health problems and how these are managed. The evidence, such as it is, indicates that health professionals, especially doctors, do not deal with illness in the same way as the general public². They often find it difficult to see themselves as a patient and are either unable or unwilling to access relevant services, where these are available^{3 4}.
- 1.4. This is particularly true of health professionals with mental health and addiction problems. The Chief Medical Officer's 2006 report on medical regulation, *Good doctors, safer patients*, highlighted significant gaps in the provision of care to doctors with these health problems and the attendant risks to the safety of their patients⁵.
- 1.5. If not dealt with swiftly and effectively, health problems can blight the lives of the individual and his or her family: the death of Dr Daksha Emson, who killed herself and her baby Freya during a psychotic episode of bipolar affective disorder, is a case in point⁶. The investigation into her death prompted recommendations in *Mental health and ill health in doctors* for the establishment of rapid access to specialist confidential services for doctors with mental health concerns⁷.
- 1.6. But all types of health problem can put work colleagues and/or employers under additional pressure. They can also prove costly for employers in terms of lost productivity, sickness absence cover and, potentially, litigation if errors are made.
- 1.7. Health problems can also compromise the quality of care. *High Quality Care for All: Next Stage Review*, published in June 2008, emphasises that a healthy workforce is integral to ensuring the highest quality of care possible for patients⁸. Patients need to be treated by health professionals who are in good health themselves.
- 1.8. The NHS has a duty of care to its staff. The NHS Constitution, published in January 2009, reiterates their entitlement to a healthy working environment and commits the NHS to providing support and opportunities to enable them to maintain their health, wellbeing and safety wherever they work⁹.
- 1.9. The review of the health of Britain's working age population, published in March 2008, *Working for a Healthier Tomorrow*, calls for new approaches to health, work

and wellbeing¹⁰. As Europe's largest employer, the NHS and its contractor organisations have the opportunity to be exemplars of good practice and innovation.

- 1.10. This report complements and reinforces some of the recommendations made in the Boorman report, *NHS Health and Wellbeing*, published in 2009 which takes a broader view of the health of the NHS workforce¹¹. This document specifically focuses on the health issues facing regulated health professionals and identifies some priorities for addressing them. It looks at how ill health in health professionals may affect their professional practice, the difficulties they face in seeking help and the role of the health profession regulatory bodies. The report covers contractor professionals (general medical and dental practitioners, pharmacists, optometrists) and health professionals working in the independent sector who are not included in the Boorman review.

The regulators

- General Chiropractic Council (GCC)
- General Dental Council (GDC)
- General Medical Council (GMC)
- General Optical Council (GOC)
- General Osteopathic Council (GOsC)
- Nursing and Midwifery Council (NMC)
- Pharmaceutical Society of Northern Ireland (PSNI)
- Royal Pharmaceutical Society of Great Britain (RPSGB) — General Pharmaceutical Council (GPhC) from April 2010
- Health Professions Council (HPC)

The Council for Healthcare Regulatory Excellence (CHRE) scrutinises and oversees all these bodies.

Scope and aims of this report

- 1.11. *Trust, Assurance and Safety* prompted the government to set up a national reference group, whose members are listed in Annex A. The group was charged with producing a strategic framework for the health of health professionals that would be applicable to all regulated health professionals in England, including those working in social care, independent and third sector organisations and those who are self employed.
- 1.12. Rather than adding to the wealth of guidance that already exists on dealing with workplace ill health, the remit was to draw on current evidence and good practice to ensure an effective, fair and proportionate response to identifying and managing health issues in regulated health professionals, with the aim of safeguarding patients and the public; promoting good employment practice; and strengthening professional and public confidence in the regulatory process.
- 1.13. The creation and sustainability of healthy workplaces and a healthy workforce are everyone's business, beginning at the very start of professional education, training and regulation and continuing through key stages of employment, career development and role progression.

- 1.14. The framework therefore addresses the responsibilities of the individual health professional, the team, the organisation and relevant national bodies in fostering a professional and workplace culture in which the risks for ill health are minimised and where those professionals who do fall ill can recover without fear of stigma or discrimination.
- 1.15. Health professionals are entitled to the same principles of compassionate, confidential and respectful care that should be afforded to patients, clients and their families. As many health professionals have discovered, an episode of ill health need not be a wholly negative experience. It has the potential to inform practice and help professionals better understand what it means to be a patient.

The evidence base

- 1.16. In pursuit of these aims, the Department of Health commissioned two reviews of the current research evidence. One primarily focused on the physical health of health professionals and also included interviews with six health professions' regulators². The other focused on the mental health of health professionals and additionally drew on submissions from 21 regulatory authorities, unions, counselling associations and professional bodies³. A further 16 experts in occupational medicine, psychological health and performance issues were consulted.
- 1.17. The Department of Health also commissioned Ipsos MORI to survey a representative cross section of the general public (1075 people) and 600 health professionals from different regulated groups for their views in June and July 2009⁴. In-depth discussions were held with 30 respondents, including trade unionists, health professionals and members of the public.
- 1.18. The reviews show that the body of research on the prevalence and type of workplace ill health among health professionals has several major limitations in terms of its scope and design. Much of it focuses exclusively on doctors and nurses. There is little published information or research on the impact of age, gender, or ethnicity and the evidence for which treatment approaches work best and how these affect workplace performance is thin. Nevertheless, some important findings have emerged from the reviews and the survey and these inform the framework proposed in this report.

Signposting this report

- 1.19. Chapter 2 summarises the themes behind the proposed framework.
- 1.20. Chapter 3 is the key chapter in the document, setting out a framework for improving the way that health concerns in health professionals are prevented, identified and managed.
- 1.21. The evidence base for and further exploration of each of the issues covered in Chapters 2 and 3 are included in the remainder of the report which is divided into four further chapters.

- 1.22. Chapter 4 looks at the extent of health issues among health professionals. It includes evidence for the impact of work on health, the impact of poor health on fitness to work and the ways in which health professionals seek help for their problems.
- 1.23. Chapter 5 considers how health difficulties in health professionals are managed, including where the responsibilities for detecting and dealing with them lie; and the provision of occupational health and specialist services for health professionals.
- 1.24. Chapter 6 covers the roles of employers and the regulators in dealing with fitness to work and fitness to practise and in safeguarding patients and protecting the public.
- 1.25. Chapter 7 lists useful publications and websites that are not included in the references at the end of each chapter.

Using the report

Health care organisations

- 1.26. The report may be used by Boards and health service managers to review and develop further their processes and services for preventing, managing and treating health problems in health professionals and handling any related issues around patient safety. The evidence provided strengthens the statements and recommendations and can be used to support the business case for services.
- 1.27. The report also provides more detail to support the implementation of the recommendations in the Boorman report *NHS Health and Wellbeing* and the NHS Operating Framework 2010/11.

Health professionals

- 1.28. Health professionals may use this as a resource document which brings together the evidence for the impact of their work on their health and the impact of ill health on work, to raise awareness about the need for effective workplace arrangements for preventing and managing ill health and for specialist services for sick health professionals.

Professional and educational bodies

- 1.29. Professional and educational bodies may wish to draw on the evidence provided to increase the educational activities available for health professionals in maintaining health and in managing their own ill health and that of their colleagues. They may also draw on this report to promote the development of effective services for sick health professionals.

Health professions' regulators

- 1.30. The health professions' regulators may like to use the evidence in this report as they consider consistency of approach to regulating health professionals whose health may be adversely impacting on their fitness to practise.

References for Chapter 1

- 1 Department of Health. *The White Paper Trust Assurance and Safety: The Regulation of Health Professionals in the 21st Century*. Crown, 2007.
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- 3 Harvey SB, Laird B, Henderson M, Hotopf M. *The mental health of health care professionals: a review for the Department of Health*. King's College London Institute of Psychiatry, 2009 www.dh.gov.uk
- 4 Ipsos MORI. *Fitness to practise. The health of health care professionals*. 2009 www.dh.gov.uk
- 5 Chief Medical Officer. *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*. Crown, 2006.
- 6 North East London Strategic Health Authority. *Report of an independent inquiry into the care and treatment of Daksha Emson, MBCS, MRCPsych, MSc, and her daughter Freya*. North East London SHA, 2003.
- 7 Department of Health. *Mental health and ill health in doctors*. Crown, 2008.
- 8 Professor the Lord Darzi of Denham KBE. *High Quality Care for All: NHS Next Stage Review Final Report*. Crown, 2008
- 9 Department of Health. *The NHS Constitution for England*. Crown, 2009
- 10 Dame Carol Black's Review of the health of Britain's working age population. *Working for a Healthier Tomorrow*. TSO, 2008. www.workingforhealth.gov.uk
- 11 Boorman S. *NHS Health and Wellbeing. Final Report*. Crown, 2009.

Chapter 2 Key themes – the health of health professionals

- 2.1. This chapter sets out key themes which inform the framework in Chapter 3, drawing on two reviews of evidence about the health of health professionals commissioned by Department of Health (DH), a commissioned survey and the views of the Working Group. The evidence base is provided in Chapter 4 and the full reviews available on the DH's website (www.dh.gov.uk).
- 2.2. The themes in this chapter are grouped:
 - ill health in health professionals
 - the work environment
 - the impact of poor health in health professionals
 - barriers to seeking help
 - the role of the health professional regulatory bodies.

Ill health in health professionals

- 2.3. The body of research on the prevalence and type of workplace ill health among health professionals has several major limitations in terms of its scope and design. Much of it focuses exclusively on doctors and nurses. There is little published information or research on the impact of age, gender, or ethnicity and the evidence for which treatment approaches work best and how these affect workplace performance is thin.
- 2.4. It is difficult to draw definitive conclusions on whether particular groups of health professionals are more vulnerable to certain workplace health hazards because the research has either not been done or is not of sufficiently good quality. But there is moderate evidence to suggest that certain activities and professions carry higher risks of health problems.
- 2.5. What is clear is that the top three causes of sickness absence among NHS employees are musculoskeletal disorders; mental ill health, including stress, depression and anxiety; and skin problems.

Musculoskeletal and skin disorders

- 2.6. Musculoskeletal disorders account for almost half of sick leave taken (45%) by NHS employees, with nurses, physiotherapists, occupational therapists, radiographers and paramedics most at risk. Health care workers may have higher than average rates of occupationally acquired dermatitis, possibly as a result of allergic reactions to gloves and drugs and the need for frequent hand-washing as part of infection control measures.

Mental ill health

- 2.7. The current evidence points to higher rates of depression, anxiety and substance misuse in health professionals than in other groups of workers. Similarly, rates of suicidal thoughts and completed suicides are significantly higher among doctors. Health professionals feel more stressed than other workers and stress has been linked to mental ill health.
- 2.8. Several studies have suggested that personality factors, such as self criticism or neuroticism, may contribute to the development of mental health problems among some health professionals. Behavioural analysis of doctors and dentists shows that strengths considered ideal for the job can become weaknesses under persistent stress.
- 2.9. Most mental health issues can be effectively treated using a combination of drugs, cognitive behavioural therapy (CBT) and other talking therapies but it is unclear what impact these treatments have on workplace activity and performance.

The work environment

- 2.10. Evidence suggests that the health care environment can be inherently more challenging than other non-health sectors and the workload is high. Health professionals may be well informed about how to maintain good health and the consequences if they fail to do so. But the current organisation, culture and volume of work in health care can combine to make health professionals as vulnerable to unhealthy lifestyles as the general public.
- 2.11. The research shows that the way work is structured and organised — at a personal and organisational level — seems to have a much greater influence on the risk of developing a mental health problem than dealing with sick and dying patients and their relatives.
- 2.12. Shift work, dysfunctional teams and poor communication can increase vulnerability to mental health problems, as can interpersonal conflict, low levels of support and the feeling of being poorly managed. Conversely, good relationships with colleagues and supervisors, high levels of job satisfaction and a feeling of accomplishment can be protective. Staff shortages, funding cuts, inadequate space, equipment and administrative back-up, and poor peer and supervisory support also drive up stress levels.
- 2.13. Excessive workload not only increases stress but can also increase the risk of errors. Bullying and harassment, violence and verbal abuse have all been linked to stress, depression, intention to leave and sickness absence. Persistent stress and ill health have been linked to early retirement — taken by 2500 NHS staff each year — with the resulting loss of expertise to the service.
- 2.14. Many of the organisational factors contributing to stress can be prevented or relatively easily remedied, but this requires an organisation-wide response. Health professionals do not always feel that their managers fully appreciate the impact of stress on health. But the evidence shows that where staff perceive employers to be responsive and supportive, stress levels are lower.

Impact of poor health in health professionals

- 2.15. Evidence from the National Clinical Assessment Service (NCAS), which advises health care organisations on the handling of performance concerns in doctors, dentists and pharmacists, suggests that ill health is a contributory factor in around one in four of the cases it deals with. Other research links depression with increased rates of medication errors, poor time management and low productivity.
- 2.16. NHS staff have some of the highest rates of sickness absence among public sector employees, averaging 10.7 days each year. Sickness absence for mental ill health accounts for over a quarter of the total among NHS staff and the average length of time someone with a mental health complaint will be unable to work is twice as long as the average for all other conditions.
- 2.17. It may be easy to spot a health professional who is obviously under the influence of drugs or alcohol, but persistent and long term substance misuse can be harder to pick up and the consequences for quality and safety of care harder to predict.
- 2.18. Presenteeism — defined as coming to work and performing at less than full capacity as a result of ill health, as opposed to working during a period of recovery from illness — is as much an issue for health care as absenteeism. A long working hours culture, having a senior role, working in a small unit, guilt about taking time off for ill health and fear of repercussions, especially for mental health problems, all increase the likelihood of presenteeism.
- 2.19. The Boorman review of the health of the NHS workforce showed that current levels of sickness absence in the NHS directly cost £1.7 billion every year, of which most is attributable to mental illness, while the overall costs of early retirement are in the region of £150 million a year. Presenteeism among staff with mental health problems is thought to cost 1.5 times the amount of working time lost through absenteeism.
- 2.20. Health and wellbeing programmes in the commercial sector show that these can significantly cut the amount of sick leave taken, speed up the return to work after a period of illness and increase productivity levels. Healthy employees are three times more productive than those in poor health and the evidence suggests that they are likely to be safer employees.
- 2.21. Given the costs to the NHS and the potential impact of health professionals' poor health on quality of care and patient safety, putting in place adequately resourced services for preventing ill health and managing it promptly when it occurs should both save money in the long term and improve patient care.

Barriers to seeking help

- 2.22. The available research indicates that health professionals face several barriers which deter them from accessing timely and appropriate services.
- 2.23. These include:
- workload, both in terms of the facility to take time off and access to services during unsociable/irregular hours
 - fear of stigmatisation and discrimination
 - fear of jeopardising future job prospects, especially in relation to a mental health problem
 - concerns about lack of confidentiality and privacy.
- 2.24. There is a financial disincentive for self-employed contractor professionals and locums to take time off work for ill health.
- 2.25. Health professionals do not use health services in the same way as the general public. Informal 'corridor consulting' with a colleague and self prescribing are popular among doctors. But even when health professionals do access formal channels of care, the evidence suggests that they tend to be treated as colleagues rather than as patients and that they are expected to make faster rates of recovery and comply better with treatment. They may not receive appropriate follow up care either.
- 2.26. Ideally, health professionals should act promptly when they become aware of health problems, but they do not always feel able to judge their own fitness to work.
- 2.27. While colleagues and team members may be well placed to recognise problems when they arise, many do not know where to take their concerns. The same goes for members of the public who seem confused about where and how to raise a health concern about a regulated health professional.
- 2.28. Most health professionals would approach a line manager about the health of a colleague. But fewer than half of line managers surveyed for this report had ever received any formal training in these matters and there were significant gaps in their knowledge around correct procedures and available options for support and rehabilitation.
- 2.29. Occupational health services have a key role in not only managing health issues in the workplace, but also in proactive prevention and health promotion. However, they are not well publicised and are frequently under resourced. Although largely trusted and seen as reliable, there are issues around confidentiality and the capacity of hospital based services to cope with demand. Many primary care contractors and their staff and locums do not have ready access to occupational health services. Access to occupational health services may also be limited in some parts of the independent sector.
- 2.30. Occupational health services are not set up to provide specialist assessment and treatment services for health professionals with complex health problems such as those associated with mental ill health and addiction. Referral on to specialist

services is needed but health professionals with these problems are unlikely to feel comfortable being treated by colleagues with whom they work closely. There is widespread support among health professionals and the public for dedicated health services for staff.

- 2.31. Research suggests that a holistic approach to ill health in doctors, taking account of social and personal factors and the complex interactions between them, is more productive and effective than focusing on single issues.
- 2.32. Experience to date at a specialist health service for doctors and dentists has shown that they often present very late for treatment, having developed serious problems before they access help. In addition, some Trusts find it difficult to manage concerns about an individual's health, asking doctors to take paid or unpaid 'gardening leave'.
- 2.33. Even where health care organisations do provide health and wellbeing services, few health professionals are aware of what's available to them, what the services provide, or how to go about accessing them. Some have little or no understanding of their organisations' policies and procedures for handling poor health. Junior staff and those without managerial responsibilities are the least well informed.
- 2.34. The transition period from student to practitioner can be problematic for those with health difficulties, with the potential for health problems to fall through the net, amid confusion as to who should take responsibility for handling them.

The role of the health professional regulatory bodies

- 2.35. The regulatory bodies need to know about a health problem in a health professional when
 - the condition may affect a health professional's ability to practise safely *and*
 - the health professional is not complying with assessment or treatment or heeding advice to take time off workor
 - there is significant misconduct, including ongoing criminal activity such as use of illicit drugs, drink driving offences, forged prescriptions.
- 2.36. There is currently considerable misunderstanding about requirements for referral to the regulator of health professionals with health problems. This may lead to the misapprehension among some doctors working with, or treating doctors that any doctor with a mental health problem needs to be referred to the GMC. In most cases this is not required. This point is extremely important because health professionals will continue to be reluctant to admit to a health problem if they expect immediate referral to the regulator.
- 2.37. Health professionals with health problems who do need to be referred to the regulator should expect to be managed in a way which is fair and objective and which protects their confidentiality as far as possible, while at the same time ensuring the safety of patients and protection of the public. Health might be relevant

to compliance with competence or conduct standards, but the diagnosis is not relevant in determining competence or conduct.

- 2.38. Distinguishing between fitness to practise and fitness to work can cause confusion. Fitness to practise is a legal term that relates to whether someone meets the standards a regulatory body sets for competence or conduct. The word 'fitness' is not intended to describe any state of physical or mental health. Fitness to work is normally used to describe the state of physical or mental health which is compatible with the individual fulfilling their contractual obligations to their employer. A health professional must be fit to practise before s/he can work, but s/he does not have to be fit to work to be considered fit to practise by the regulator. While it is for the regulator to determine fitness to practise, it is not their role to decide whether someone is fit to work.
- 2.39. The Council for Healthcare Regulatory Excellence (CHRE) advises that regulatory bodies do not need formal stand-alone health requirements either at registration or during fitness to practise procedures, because health is important only in so far as it relates to an individual's ability to meet the necessary competence and conduct standards.

Chapter 3 Framework for the health of health professionals

- 3.1. This chapter sets out a framework for managing the health of regulated health professionals, with four levels of responsibility:
- the individual
 - the team
 - the organisation (including access to occupational health and specialist health services)
 - national bodies.
- 3.2. It also makes seven key recommendations, which point to how the current gaps in service provision, knowledge, processes and the evidence base can be filled.
- 3.3. The framework draws on the evidence reviewed for this report (Chapters 4 and 5) and the examples of good practice in some health care organisations in the UK. It accords with many of the principles and recommendations set out in the *NHS Health and Wellbeing: Final Report*.
- 3.4. The framework may be used by organisations and national bodies to review their systems and services for the health of health professionals with a view to improving health of staff, reducing costs of sickness absence and improving services for the patients.

Responsibilities of the individual

- 3.5. Health professionals have a professional responsibility to look after their own health as it affects the quality and safety of care given to patients. This includes:
- registering with a GP
 - taking advantage of vaccination programmes for infectious diseases
 - seeking professional advice about ill health, managing illness and accessing appropriate treatment and follow-up
 - seeking advice promptly about fitness to work when symptoms arise
 - not coming to work when ill, unless part of a managed recovery programme
 - having adequate insurance for sickness absence and the provision of sufficient locum cover in the case of self-employed professionals
 - notifying the regulator when s/he becomes aware of a health problem that could impair fitness to practise.

Responsibilities of the team and line managers

- 3.6. Responsibility for managing the effects of an illness on the health professional's work lies with that individual, his/her manager (advised by occupational health and human resources), often with support from his/her clinical colleagues.
- 3.7. Colleagues and team members can help identify early signs of illness, support individuals to manage workplace stressors, prevent health issues from escalating and support those recovering from ill health to continue working.
- 3.8. Line managers have responsibility to:
 - take the health and wellbeing of their staff seriously, listening and responding to their concerns and helping them handle workplace stressors
 - encourage their staff to be open about their own and their colleagues' health concerns
 - seek advice from human resources professionals, particularly around implementation of relevant policies
 - encourage staff with health problems to seek help through occupational health services or counselling
 - consider whether there may be an underlying health problem when there is a concern about an individual's performance.
- 3.9. To enable them to fulfil these responsibilities, line managers need training in how to identify and support staff with health issues, particularly mental ill health and how to access expert advice. They also need strong support from occupational health on fitness to work and sickness absence and awareness of the role of the health professions' regulators and when referral to the regulator may be required.

Responsibilities of the organisation (including access to occupational health and specialist services)

- 3.10. Employers and contracting organisations have a duty to safeguard patients and the public when the health of a health professional may be adversely affecting their work. They also have a duty of care to their staff to ensure that they work in a healthy environment and have the appropriate support and opportunities to enable them to maintain their health, wellbeing and safety wherever they work. These dual responsibilities need to be led from Board level.
- 3.11. To discharge these responsibilities organisations will require:
 - risk management
 - effective policies and procedures
 - training and information for staff
 - access to mentoring
 - access to occupational health and other services.

3.12. In addition, an open, accountable and supportive workplace culture in which any concerns can be raised without fear of reprisals reduces harassment and bullying, enhances quality of care and boosts recruitment and retention.

Risk management

3.13. Risk management in relation to health concerns involves identifying and reducing any risk to the quality and safety of patient care caused by sick health professionals and identifying and reducing the risk of organisational factors adversely affecting the health of health professionals. This can be achieved by:

- promoting the need for managers to have a low threshold for referral to occupational health for advice about a professional's health, particularly when there are concerns about an individual's performance
- proactive management of ill health and sickness absence in the organisation, which may include, for example, identifying potential hotspots of sickness absence where additional support from occupational health or human resources may be needed
- equipment reviews to assess the likely impact on health of design, use, maintenance of equipment and any required changes to the physical environment and work practices.

3.14. The risk of health professionals developing musculoskeletal disorders can be reduced by close monitoring of trainees and newly qualified health professionals, emphasising the promotion and maintenance of good health. The evidence supports multifaceted approaches, involving a mix of training and education, changes to working practice and equipment reviews.

Effective policies and procedures

3.15. Policies and procedures need to cover:

- access to occupational health and other health and wellbeing services
- arrangements for raising concerns about the health of a colleague
- confidentiality, including processes governing the internal and external exchange of information between staff involved in the management/treatment of a sick health professional
- access to funding for locum cover for primary care contractors to enable sick staff to take sick leave and equivalent in the independent sector
- the situation when it is not possible for a health professional to return to work after a period of sickness absence and his or her contract will be terminated or not renewed
- handling of proposed early retirement to include consideration of any issues behind it (such as bullying and harassment) and whether alternative employment may be an option.

Training and information for staff

- 3.16. Training for all staff can help them handle workplace stressors better and lessen the risk of developing mental health problems. This may include effective communication and leadership skills, working in teams, handling complaints, handling violence and conflict resolution.
- 3.17. Training should be provided for all line managers in acute sector health care organisations and senior staff in primary care organisations in handling health concerns that may affect fitness to work, particularly mental health, including procedures, sources of support and information.
- 3.18. Health and wellbeing services, occupational health and specialist health services need to be highly visible and well signposted for health professionals, with information on the services that are available, what they provide, where they are located and how they can be accessed.

Mentors

- 3.19. Mentoring and support can be especially important at points of career transition, for professional development and to enable flexible working arrangements.
- 3.20. The availability of mentors and supervisors throughout a health professional's period of rehabilitation following sickness absence helps to ensure an effective return to work. Those involved in mentoring and supervisory roles need to be appropriately trained and supported.

Occupational health services

- 3.21. Occupational health services have responsibility for health promotion, coordinating the care of health professionals with poor health and managing rehabilitation and return to work.
- 3.22. Features of effective occupational health services include:
 - compliance with service standards set by the Faculty of Occupational Medicine
 - adherence to strict protocols on confidentiality and the terms of disclosure of sensitive information to third parties, including the health professions' regulators
 - direct access for all staff (without the need for referral through a line manager)
 - providing guidance to managers on making referrals
 - providing advice on the use of local and national peer support services
 - access to necessary specialist services for assessment and treatment of sick health professionals
 - expertise in advising on fitness (and supporting return) to work across the range of health professions
 - promoting health and wellbeing among the organisation's staff
 - adequate funding to support the range of services
 - provision tailored to the organisation's needs.

- 3.23. Health and wellbeing services need to be part of a normal commissioning cycle within a quality framework and properly needs assessed, tailored to the needs of different health professionals.
- 3.24. Primary care organisations have a particular role in ensuring that all primary care staff, including self employed health professionals have access to occupational health services.

Specialist services for sick health professionals

- 3.25. A tiered approach to services for sick health professionals could be achieved by providing
- GPs and occupational physicians with enhanced skills in managing health professionals with health problems, with rapid access to
 - specialist assessment and treatment services (particularly mental health and addiction services).
- 3.26. These services are needed for health professionals who cannot access suitable local services and whose complex health problems may compromise the safety of their patients. This approach would enable all sick health professionals to seek help promptly without fear of stigma or discrimination and minimise any potential impact of ill health on the quality and safety of care. It should also reduce the operational and financial costs of long term sick leave and minimise the costs of ill health on the career and personal life of the health professional.

Health professionals with enhanced skills in managing the health of health professionals

- 3.27. Work was taken forward during 2009 to identify the competencies required for GPs, psychiatrists and occupational physicians to assess and manage sick health professionals. From this a training and accreditation programme will be devised to achieve a panel of GPs and occupational physicians with enhanced skills whom any health professional can approach with confidence. These GPs and occupational physicians will, in turn, refer on those complex cases that cannot be managed within their local health services to a specialist service.

Specialist service

- 3.28. A specialist service is needed for those health professionals whose complex health problems may compromise the quality of patient care they provide to patients and cannot be managed effectively within local services.
- 3.29. The specialist service should provide in-depth assessment of health professionals with health problems, including social and personal factors. An appropriately skilled and trained multidisciplinary team would provide case management, continuing care and follow up. They would also arrange referral for additional specialist assessment or treatment (inpatient or outpatient) or access to a range of interventions, as required, including CBT, occupational psychology, family therapy, mentoring, financial advice, career guidance or peer support.

- 3.30. The specialist service will need to develop strong links with occupational health services of employing and contracting organisations, with appropriate safeguards to maintain the confidentiality of the health professionals while still meeting the requirements of the service and protecting the safety of patients.
- 3.31. The specialist service may also advise and provide specialist services to other health professionals managing practitioner-patients.
- 3.32. The service will need good understanding of when health professionals need to be referred to the regulatory body, which could build on a memorandum of understanding with the relevant health profession regulator.
- 3.33. While currently there is only one specialist service of this type in England (the prototype Practitioner Health Programme in London), there are others providing some of the services required who have expressed an interest in developing a full service along the lines of the Practitioner Health Programme. It is likely that two to four additional such services would be required for England.

Responsibilities of national bodies

Education, training and peer support

- 3.34. Education and training bodies, professional bodies and the regulators have key roles in changing the culture in which trainees and health professionals study, train and work, to enable them to understand better the critical importance of their health to the quality of care and the need to take responsibility for addressing health issues promptly.
- 3.35. Students, postgraduate trainees and fully qualified health professionals need to understand that ill health is not a sign of incompetence or failure for which they will be punished. Student education, further training, continuing medical education and professional development need to equip health professionals with the skills to recognise and cope with the signs of stress and ill health and to recognise drug and alcohol misuse in themselves and professional colleagues.
- 3.36. The development of competencies and training for enhanced skills for health professionals treating sick health professionals by the Royal College of General Practitioners, the Royal College of Psychiatrists, the Faculty of Occupational Medicine and the Association of NHS Occupational Physicians is an important initiative to improve the quality of care provided to health professionals. Other professional groups (such as nurses and psychologists) could develop similar standards and competencies.
- 3.37. Proposed training for Responsible Officers involved in systems for revalidating doctors provides an opportunity for including a module on handling health concerns.
- 3.38. Some health professions have established peer support schemes which are well used and valued – these need to be available for each health profession and well publicised.

The health professional regulatory bodies

Guidance

- 3.39. Health professions' regulators should provide clear guidance on the circumstances when a health professional with a health problem does (or does not) need to be referred. This could help address the reluctance of some health professionals with a health problem to seek help by providing information about how few health issues need to be referred to the regulators and the circumstances in which referral is required.
- 3.40. The health professions' regulators could also provide information about the health risks professionals face and where to access help and support.
- 3.41. The health profession regulators need to explain the distinction between fitness to practise and fitness for work. They should assure applicants to the register that if they are deemed fit to practise, their application for registration will not be refused or revoked on the grounds that illness or disability prevents employment. Equally, the regulators do need to identify those individuals who should not be registered because their health prevents them meeting the professional standards required by the regulator. Advice and written guidance for managers and health professionals faced with difficult decisions about colleagues will be important.

Consistency

- 3.42. A consistent approach across each of the regulatory bodies to handling the impact of health on fitness to practise would include a single requirement of fitness to practise and a single route for all fitness to practise issues to be heard by panels rather than separate consideration of health cases by some regulatory bodies. Consistency would also be enhanced by guidance for those interpreting fitness to practise requirements and agreement on the type and classification of data for fitness to practise cases involving health issues.
- 3.43. The establishment of the Office of the Health Professions Adjudicator (OHPA) provides an opportunity to increase consistency of approach. OHPA should ensure that suitably qualified and experienced health professionals advise on health matters of registrants subject to fitness to practise hearings.
- 3.44. More work is needed to agree health declaration requirements, both at initial registration and subsequently, preferably with the aim of achieving consistency across all regulated health professionals. This might also include consideration of removing the term "good health" from the legislative frameworks governing the regulators' registration procedures.

Roles and responsibilities

- 3.45. Clear delineation is needed of the roles and responsibilities of each party involved in managing a fitness to practise case, so that the treating doctor is neither the workplace supervisor nor the medical supervisor providing reports to the regulator.
- 3.46. Specialist occupational health practitioners could advise the regulator on adjustments to an individual's workplace environment to enable the health professional to fulfil the regulator's requirements for fitness to practise.
- 3.47. Undertakings and conditions arising from fitness to practise procedures need to be workable, manifestly aimed at patient protection and drafted with input from a specialist adviser in the health professional's area of practice, where necessary.
- 3.48. Unannounced clinical testing at the health professional's place of work can be a useful tool in supervisory arrangements for registrants with addiction problems subject to fitness to practise procedures.

Confidentiality and information sharing

- 3.49. It will be useful for each regulator to provide a clear statement on the circumstances in which they will share undertakings and conditions that relate to a health professional's health with the individual's workplace supervisor, medical supervisor, treating doctor and employer (and normally with the professional's consent).

Research

- 3.50. Research is needed to improve the understanding of the health of health professionals and provide the evidence base for future action.
- 3.51. Large, long term, prospective cohort studies of the health of health professionals — similar to those that have already been carried out into military personnel — would be useful to cover a range of health professional groups across different health care settings and to track individuals from good health to ill health and through rehabilitation.
- 3.52. It would also be useful to investigate the impact of ill health in the workplace on the quality and safety of services provided for patients and the impact of particular treatment approaches on workplace health and how these affect symptom reduction, work performance and sickness absence.
- 3.53. The use of routinely collected data on ill health and sickness absence and its causes could be a cost effective way of answering important research questions, providing there are appropriate safeguards in place to protect the privacy of personal information. Data could be used to build up a national picture of the trends and causes of ill health among health professionals, broken down by staff group and grade, age, time since qualification, gender and ethnicity.

Recommendations

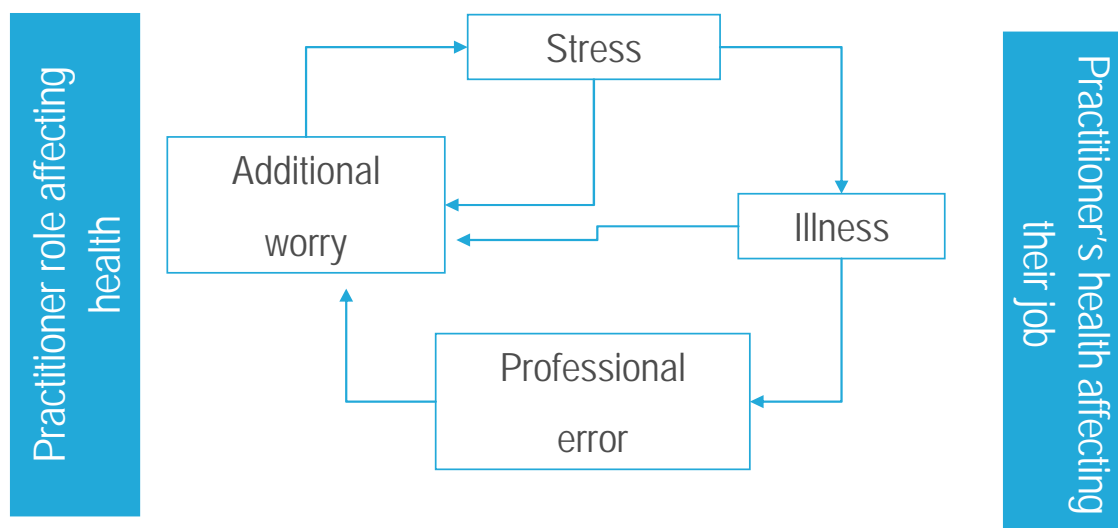
- 3.54. These recommendations are priorities from the framework to improve the health of health professionals
- 3.55. Sick health professionals who cannot access suitable local services and whose condition may compromise the quality of patient care should have prompt access to GPs and occupational physicians with enhanced skills and to confidential specialist assessment and treatment services, staffed by appropriately trained and accredited health professionals. This will require
- training to establish a group of health professionals with enhanced skills in treating health professionals
 - arrangements to make their services available (funding, supervision and support, publicity)
 - two to four specialist services in England for health professionals to provide specialist expertise, particularly for health professionals with complex mental health problems or addiction.
- 3.56. Occupational health services should be strengthened and accredited, with appropriately trained staff and adequate funding and provided for all health professionals (including locums) working in primary and secondary care, also the independent sector.
- 3.57. Maintaining good health and how to cope with ill health should become an integral component of the undergraduate and postgraduate curricula for all health professions.
- 3.58. A review should be undertaken of how health information about sick students/trainees/health professionals can be shared among organisations and managed appropriately to ensure continuing care and safeguard the confidentiality of the individual as well as protect patient care.
- 3.59. Proposals for regulatory reform provide opportunity for the nine health profession regulators to consider how they might adopt a consistent approach in relation to health and fitness to practise, share good practice and provide information to all registrants on the circumstances when health problems do and do not need to be brought to their attention.
- 3.60. Procedures for revalidation of each health professional should set out clearly how concerns about health matters should be handled when these may impact on fitness to practise.
- 3.61. Long term studies should be carried out to look at the health and wellbeing of different groups of health professionals in different health care settings.

Chapter 4 Health of health professionals – the evidence

- 4.1. This chapter brings together the evidence for the impact of work on health and of poor health on work and outlines the barriers to health professionals seeking help for health issues. The first section covers physical health, mental health, drugs and alcohol, workplace stressors and how these issues can be addressed. The second section looks at evidence for the impact of poor health on quality of care, patterns of sickness absence, presenteeism, the effects of substance misuse and the costs of ill health. The last section considers barriers to health professionals getting help and focuses on workload, confidentiality, financial factors, stigma and how health professionals use services.
- 4.2. The chapter summarises evidence from work commissioned by the Department of Health for this report. DH commissioned literature reviews from the Institute of Psychiatry, the Institute of Occupational Medicine and staff and public perception survey undertaken by Ipsos MORI. Their full reports are available on www.dh.gov.uk
- 4.3. Key points are:
- much of the evidence on the prevalence of health issues among health professionals is of limited scope and quality and has largely concentrated on doctors and nurses in secondary care
 - musculoskeletal disorders, mental health issues and skin complaints top the list of health conditions among health professionals
 - drug and alcohol dependency are becoming more common
 - chronic drug and alcohol misuse in health professionals can be hard to detect
 - health care staff have some of the highest rates of sickness absence among levels of presenteeism — defined as coming to work and performing at less than full capacity as a result of ill health, as opposed to working during a period of recovery from illness — are also high
 - the organisation and structure of work have a much greater impact on health than the nature of the work itself.

Impact of work on health

- 4.4. Working for a Healthier Tomorrow makes the point that work can be good for health and that the workplace can have a key role in promoting the health and wellbeing of its employees. But the environment in which work is carried out can lead to ill health, initiating a cycle of further health and professional problems¹.



© Opinion Leader 2009 Impact of work on health and health on work

- 4.5. It is difficult to draw definitive conclusions on whether particular groups of health professionals are more vulnerable to certain workplace health hazards, because the research has either not been done or is not of sufficiently good quality^{2,3}. However, what we do know is that the top three causes of sickness absence among NHS employees are musculoskeletal disorders, mental ill health (which includes stress, depression and anxiety) and skin problems⁴.
- 4.6. While these conditions are not unique to health care, the evidence suggests that the health care environment can be inherently more challenging than other non-health sectors. NHS staff, for example, are more prone to work related injury and illness than employees in other non-health sectors. They are around 1.5 times more likely to fall ill and 1.7 times as likely to sustain an injury⁴.
- 4.7. Health and safety regulations and infection control measures curb exposure to many potential hazards, but health care is nevertheless a highly pressurised environment that is often in the media spotlight. The workload is considerable and it is frequently both physically and emotionally demanding.
- 4.8. Although health professionals are well informed on how to maintain good health — and the consequences if they do not — the current organisation, culture and volume of work in health care can combine to make them as vulnerable to unhealthy lifestyles as the general public, despite their increased understanding⁵.
- 4.9. Half of the general public surveyed by Ipsos MORI do not believe that health professionals are any healthier than they are⁵. Health professionals are similarly unconvinced, although more than one in four of the doctor respondents (27%) disagreed. But the in-depth discussions conducted as part of the survey reveal that even though the public recognises the demands of working in health care, they feel that health professionals should be healthier, because they are more knowledgeable about health matters⁵.

Physical health

- 4.10. Musculoskeletal disorders account for almost half of sick leave taken (45%) by NHS employees⁴. These disorders affect a wide range of health professionals, but nurses, physiotherapists, occupational therapists, radiographers and paramedics seem to be most at risk³. Vulnerability seems to be greatest during training and on entry to the profession⁶ suggesting scope for greater emphasis on prevention and monitoring during these periods.
- 4.11. Risk factors for musculoskeletal disorders include³:
- high physical workload
 - manual therapy
 - patient handling
 - use of equipment
 - awkward or forced postures
 - older age
 - working long hours
 - enforced overtime
 - poor job control
 - being under pressure.

Importance of good posture

- 4.12. Published research suggests that between 64% and 93% of dental staff will have general musculoskeletal pain at some point during their careers — usually in the neck or back. No research specifically attributes poor posture to the cause of this pain, but correct posture, taught early in the clinical career, with repeated reinforcement throughout training, may reduce it.

Training for good posture

A simulated dental learning environment, which mimics a 'real' dental clinic, bar the presence of an actual patient, is used to teach correct posture at Peninsula Dental School. It aims to inculcate good postural habits from the very start of clinical training and teach students about the importance of good posture in maintaining their own wellbeing.

- 4.13. Training does not lessen the risk of injury by itself and would normally be part of a multifaceted approach, including risk assessment, reviewing how equipment is designed, purchased, used and maintained and making changes to the physical environment and work practices⁷.
- 4.14. Evidence suggests that health care workers may have higher than average rates of occupationally acquired dermatitis⁸ possibly as a result of allergic reactions to gloves and drugs⁹ and the need for frequent hand-washing as part of infection

control measures¹⁰. Regularly handling cancer drugs may also carry some health risks¹¹.

4.15. There is moderate evidence for higher rates of the following³:

- occupational asthma in nurses
- hand dermatitis in biomedical scientists
- musculoskeletal symptoms and carpal tunnel syndrome in dental hygienists
- long term conditions, including eczema, gut problems and back complaints among doctors
- exposure to violence among doctors and nurses
- breast cancer in night shift workers
- increased risk of metabolic syndrome (linked to higher risk of cardiovascular disease) among male and female nurses working night shifts¹²
- vulnerability to airway inflammation in occupational therapists
- musculoskeletal disorders, circulatory diseases and mental health issues among paramedics.

4.16. Research shows that there is a link between physical and mental health and wellbeing³.

Mental health

4.17. The research looking at the prevalence of mental ill health among health professionals is of limited scope and quality, but the current evidence, such as it is, suggests higher rates of depression, anxiety and substance misuse in health professionals than in other groups of workers.²

4.18. Compared with other professional groups, rates of suicidal thoughts and completed suicides are significantly higher in doctors, dentists, nurses and pharmacists¹³⁻¹⁵. This may be because health professionals know how to take their own lives successfully and have access to the means to do so. But the figures nevertheless point to significant levels of distress².

4.19. Suicide rates among doctors are the highest of any health professional group and are more than twice those of the general population¹⁴. GPs, community health doctors, psychiatrists, anaesthetists and female doctors seem to be at particular risk^{16 17}.

4.20. Many mental health issues can be effectively treated using a combination of drugs, cognitive behavioural therapy (CBT) and other talking therapies, but it is unclear what impact these treatments have on workplace activity and performance^{2 18}.

4.21. Pre-employment assessments were principally designed to pick up individuals who might be susceptible to physical illness and evidence suggests that they do not detect vulnerability to mental health issues, which tend to be more complex¹⁹. The Netherlands abandoned the use of pre-employment assessments in 1998 and they are now used only in very specific circumstances²⁰.

4.22. Several studies indicate that health professionals feel more stressed than other workers and stress has been linked to mental ill health²¹. One in 10 health care

respondents in the staff and public perception survey cited 'stressed or overworked staff' as their main concern⁵.

'I've certainly recognised that I've had a lot more staff off with varying levels of stress related illness in the last couple of years.'

Physiotherapist⁵

- 4.23. A survey of pharmacists' health undertaken for the National Clinical Assessment Service (NCAS) showed that stress is a key health problem for the 907 respondents²². It was cited as a health concern for most of the 41% who had experienced a health problem in the previous five years.
- 4.24. Several studies have suggested that personality factors, such as self criticism or neuroticism, may contribute to the development of mental health problems among some health professionals². MedNet, the confidential counselling and psychotherapy service for doctors and dentists in London, reports that the professionals who consult it are often self critical, obsessional, conscientious, high achieving and driven².
- 4.25. Behavioural analysis of doctors and dentists shows that traits considered desirable for the job can become overplayed under stress. These strengths then become counterproductive and turn into weaknesses^{23 24}.

'Certainly for doctors, being highly obsessional and conscientious is a good thing but under pressure that will crack.'

Doctor²

- 4.26. Some selection procedures for training programmes for health professionals take account of personal attributes, which, the research suggests, lead to success in that profession. Peninsula Dental School has adopted this approach.

Including personal qualities in the selection process

Applicants to the Peninsula Dental School are selected for personal attributes considered to be desirable for a dentist, according to the published evidence. Every applicant takes part in a scenario based interview, which objectively assesses communication skills, personal insight, empathy, social aptitude, healthy behaviours, honesty, team player qualities, resilience and capacity for reflection. The premise behind this approach is that the curriculum delivers the clinical, academic, and technical competence required of a dental professional, but that certain innate personal qualities are also key to the quality of patient care.

Drugs and alcohol

- 4.27. Recreational drug use is relatively common in British society. Forty per cent of the British workforce under the age of 40 have experimented with illicit drugs²⁵ and figures from the Home Office indicate that lifetime drug use in England and Wales has gone up over the past decade²⁶. In 1996, 30.5% of 16 to 59 year olds questioned in the British Crime Survey said they had used any drug; by 2008/9, this figure had risen to just under 37%. Lifetime use of class A drugs during this period rose from 9.6% to 15.6%²⁶.

- 4.28. It is not surprising, therefore, to find evidence of drug use among any large profession. In a survey of 18 NHS trusts reported in a letter to the Lancet in 1998, more than one in three of the male junior house officers and almost one in five of their female peers said they used cannabis; 13% said they used ecstasy, cocaine and other hallucinogenic drugs²⁷. It is not known if similar figures apply to other groups of health professionals. Doctors may be more vulnerable to substance misuse than other health professionals because of their knowledge/expertise and relatively easy access to a range of drugs²⁸.
- 4.29. Alcohol is also an issue: hazardous/harmful drinking has become more prevalent in British culture as per capita consumption of alcohol has risen over the past 60 years²⁹. In 2006, men in Britain aged 45 to 64 and women aged 16 to 24 were the heaviest drinkers: 8% of men were drinking more than 50 units a week and 5% of women were drinking more than 35 units week. Most UK teenagers are now drinking fairly regularly by the time they are 15 and 16²⁹.
- 4.30. A study of GPs shows that 7% admitted to using alcohol frequently to cope³⁰ while the 1998 NHS Trusts survey found that over 60% of junior doctors exceeded the recommended safe alcohol limits; and one in 10 were drinking at hazardous levels²⁷.
- 4.31. These findings do not necessarily predict an inevitable progression to serious dependency problems, but the British Medical Association has estimated that one doctor in 15 (7%) could have some form of drug/alcohol dependency at some point in their career³¹.
- 4.32. Most of the research on drug and alcohol dependency among health professionals has focused on doctors, but evidence is also beginning to emerge of substance misuse problems among nurses, dentists and pharmacists³²⁻³⁴. When the specialist drug and alcohol treatment service opened for health professionals at the Maudsley Hospital in London, many nurses used the service³⁴. A questionnaire study of UK dental professionals revealed that 6% of the 545 respondents had a 'drink problem,' while 9% had alcoholic tendencies³⁵.
- 4.33. These problems are not unique to health professionals, but when they are not dealt with promptly, particularly among safety critical staff who manage their own caseloads, they have the potential to compromise the quality and safety of patient care as well as the professional's career.

Workplace stressors

- 4.34. It is difficult to predict the impact of specific workplace stressors on susceptibility to mental ill health, because parental influences, personality and coping style all play a part in an individual's response to them^{2 36 37}. But the research shows that the way work is structured and organised, both at a personal and organisational level, seems to have a much greater influence on the risk of developing a mental health problem than dealing with sick and dying patients and their relatives² contrary to what might be expected.

'Stress and anxiety are accepted parts of the pharmacist's job these days. I don't know any pharmacists who are not stressed and anxious at, or because of, work.'

Pharmacist²²

- 4.35. Experience from the London based specialist assessment and treatment Practitioner Health Programme (PHP) for doctors and dentists shows that shift work and poorly functioning teams can precipitate mental health issues in vulnerable individuals³⁸. This is a particular issue for young trainees who may find themselves stranded without a social support network — a situation that is worsened by working unsociable hours and the move away from a traditional consultant-led firm structure³⁸.
- 4.36. Workplace factors can either promote or undermine mental health and wellbeing, depending on how work is organised and managed. For example, good relationships with colleagues and supervisors are protective, while interpersonal conflict, low levels of support and the feeling of being poorly managed are not³⁹⁻⁴¹. Poor communication and lack of clarity on departmental/organisational objectives can also increase work related stress; on the other hand, high levels of job satisfaction and a feeling of accomplishment can stave off burnout^{42 43}.
- 4.37. The recent National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report on deaths within four days of admission to hospital indicates that poor communication between and within clinical teams was a key issue in 13.5% of the cases studied and that these factors seemed to affect adversely the quality and safety of patient care⁴⁴.
- 4.38. Workplace stressors highlighted in the staff and public perception survey carried out for this report included staff shortages, funding cuts, an undue emphasis on budgets and targets and concerns about quality of care⁵. Additional stressors ranged from inadequate space and equipment, through interpersonal conflict and poor peer and supervisory support, to insufficient administrative back-up and unhelpful management styles. Externally imposed targets, change without consultation and pay issues also featured⁵.
- 4.39. Persistent stress and ill health have been linked to early retirement, which 2500 health professionals in the NHS choose to take every year. A survey of UK consultants over the age of 50 who were planning to retire early showed that the main drivers behind their decision included too much red tape, heavy caseloads and poor work-life balance⁴⁵.
- 4.40. A 2005 Royal College of Nursing Survey of 6000 nurses' health and wellbeing showed that nurses were exposed to higher levels of stressors in their jobs than the Health and Safety Executive average⁴⁶. The same survey showed that only 13% of nurses working night shifts had received a health assessment and less than a quarter of respondents said that their employer had consulted them about how best to achieve a work-life balance⁴⁶.
- 4.41. Working at night also increases fatigue and reduces alertness, both of which can directly affect performance and learning capacity and increase the risk of making a mistake without noticing⁴⁷. Tired junior doctors in the USA and Denmark, who worked at night, lost concentration more often and made more clinical errors than during periods when they were able to get more sleep⁴⁷.
- 4.42. According to the Royal Pharmaceutical Society of Great Britain (RPSGB), an increased risk of accidents and errors develops as soon as two hours into a night

shift as a result of disrupted sleep patterns⁴⁷. Four night shifts in a row are particularly disruptive, prompting the RPSGB to suggest that shifts should be scheduled for no more than a maximum of three consecutive nights and include regular rest periods⁴⁷.

- 4.43. Excessive workload is perceived as a key contributor to rising levels of stress among pharmacists⁴⁸. Although workload, per se, has not increased between 2004 and 2008, the effects of a heavy workload have worsened. The incidence of dispensing errors has risen in tandem with an increase in hospital dispensary workload⁴⁸.
- 4.44. A Finnish study of 16 hospitals providing specialist care shows that an average bed occupancy rate 10% above the recommended limit was associated with new antidepressant treatment among doctors and nurses⁴⁹. The greater the degree of overcrowding, the greater was the likelihood of starting antidepressant treatment. The average bed occupancy rate for NHS hospitals in 2008/9 was 85.5%, but for some specialties, such as medicine for the elderly, it was 92%. To curb the spread of infection, bed occupancy rates should be 82-85%⁵⁰.
- 4.45. Bullying and harassment and exposure to violence and verbal abuse, are common hazards in health care and have been linked to stress, depression, intention to leave and sickness absence⁵¹. Assault alone accounted for 14% of sick leave in the NHS, according to a Cabinet Office report published in 2005⁵².
- 4.46. The evidence suggests that younger, less experienced members of staff, those born overseas and those working in emergency care and psychiatry may be more vulnerable^{51 53}. It has also been suggested that doctors may be less willing than other health professionals to admit that they have been on the receiving end of bullying or harassment⁵⁴.

Addressing the issues

- 4.47. Many of the frequently mentioned organisational factors contributing to stress can be prevented or relatively easily remedied. But the in-depth discussions carried out for the staff and public perception survey show that health professionals believe that managers do not always appreciate the impact of stress on health⁵.
- 4.48. An organisational culture that fosters openness, transparency and accountability, especially in its handling of serious untoward incidents, complaints and litigation will allow concerns to be raised without fear of reprisals and help discourage bullying and harassment⁵⁵. It also enhances quality and safety and boosts recruitment and retention.
- 4.49. The evidence shows that where staff perceive employers to be responsive and supportive, stress levels are lower⁵⁶. Strong leadership and effective change management, good clinical supervision and educational support increase feelings of competence, wellbeing and job satisfaction, all of which help promote the safety of staff and patients⁵⁷.
- 4.50. Provision of training in issues, such as handling violence, conflict resolution, effective communication, dealing with complaints and leadership skills can all

equip staff to handle workplace stressors better and lessen the risk of mental health issues/sick leave in the long term^{43 55 58}.

'The real killers are patient complaints and relationship difficulties with colleagues... mainly peers.'
Doctor²

- 4.51. Other influential factors include the provision of adequate mentoring and support (especially important for those working alone and in primary care), flexible working arrangements and opportunities for professional development⁵⁹.
- 4.52. Undergraduate training has a part to play in more adequately preparing students for the inevitable stressors they will face in their working lives in health care, such as running a practice in primary care and teaching future professionals the skills to recognise and cope with the signs of stress^{60 61}.

Improving the evidence base

- 4.53. A strong body of evidence about the health of health professionals could be used to inform improvements in policy and practice, as has been achieved in the UK Armed Forces.

Building up the evidence: UK Armed Forces Personnel

After the 1991 Gulf War there was an upsurge of interest in the mental health of UK service personnel. Media reports suggested that many soldiers returning from this conflict had multiple physical and psychological symptoms, dubbed 'Gulf War Syndrome'. Similar concerns were expressed in the lead-up to the 2003 War in Iraq. In response to this, several funders, including the Ministry of Defence, supported the formation of the King's Centre for Military Health Research (KCMHR) as a joint venture between the Institute of Psychiatry and the Department of War Studies at King's College London.

The flagship project of this new centre was a cohort study of the health and wellbeing of UK Armed Forces personnel. This study monitored the physical and psychological health of 12,000 UK service personnel, some of whom took part in the 2003 War in Iraq. The results showed that there was no 'Iraq War Syndrome', but it did identify some groups, such as reservists, frontline combat troops and those on very long deployment, who had significantly higher rates of mental health issues.

These findings have precipitated numerous positive policy changes, such as alterations to the organisation of mental health services, including the establishment of the Reservists' Mental Health Programme, improved welfare support and updated guidance on length of deployment.

Impact of poor health on work

- 4.54. The impact of poor health on service delivery — including the effect of mental ill health on cognitive performance (concentration, memory, planning) — and the consequences for the quality of care and patient safety, have not been well researched²³.
- 4.55. Evidence from NCAS,, which advises health care organisations on the handling of performance concerns in doctors, dentists and pharmacists, suggests that ill health is a contributory factor in around one in four of the cases it deals with⁶².

Details of NCAS referrals featuring health concerns ⁶² (N = 1472)

Physical/mental ill health and disability

Changes in mood	7%
Concentration	4%
Energy/fatigue	4%
Mobility	1%
Manual dexterity	2%
Lifting and carrying	1%
Sight	1%

Possible cognitive impairment

Memory	1%
Problem solving	1%
Planning	1%

Specific health issues affecting performance

Anxiety/stress/burnout	6%
Depression/hypomania	6%
Alcohol misuse	5%
Drug misuse	3%

- 4.56. A US study of 123 junior doctors from three urban hospitals shows that those who were depressed made six times as many medication errors each month as their colleagues in good mental health. The sample was self selected — through response to an advertisement — but the findings nevertheless indicate that depression has an impact on performance⁶³.
- 4.57. One study has shown that depression affected time management and productivity more than any other health problem and was the equivalent of rheumatoid arthritis in terms of its impact on physical capacity⁶⁴. Depression is also associated with poor memory and fatigue⁶⁵.

‘Stress and lack of support led to depression with suicidal ideation. My interest in helping my patients and colleagues declined, which led to a couple of errors going out, at least one of which led to patient harm.’

Pharmacist ²²

- 4.58. Working while ill can impair performance, but health professionals do not always recognise this. A survey of 907 pharmacists carried out for NCAS showed that pharmacists do not prioritise their own health and that they are often unaware of the impact going to work when ill can have²².

- 4.59. Lower levels of productivity and quality of care increase workload and stress among colleagues. This in turn can lower morale and motivation and increase the likelihood of poor communication and decision making, both of which can affect quality of care and patient safety⁶⁶.
- 4.60. A questionnaire study looking at doctors' perceptions of the impact of stress on lowered patient care suggests they perceived a link between stress and quality of care in half the incidents of lowered clinical care considered; doctors were demonstrably angry or irritated in four out of 10 incidents; serious mistakes were made in 7%⁶⁷.

Patterns of sickness absence

- 4.61. Sickness absence has the potential to affect the delivery of services to patients either as a consequence of increasing the workload of colleagues or the employment of temporary staff³. In 2005, the former Healthcare Commission found that levels of patient dissatisfaction correlated with the use of bank and agency nurse staff, which could be associated with sickness cover⁶⁸.
- 4.62. NHS staff have some of the highest rates of sickness absence among public sector employees, averaging 10.7 days each. This is significantly higher than the average of 6.4 days for the private sector⁴. According to NHS Employers, the proportion of working days lost to sickness absence at Trusts varies from 2.8% to 6%.
- 4.63. Sickness absence for mental ill health accounts for over a quarter of the total among NHS staff and the average length of time someone with a mental health complaint will be unable to work is twice as long as the average for all other conditions².
- 4.64. Staff in the NHS are more likely to be off sick for longer than a week than other workers; women, who make up 80% of the workforce and those with more than 15 years of service, who make up 43%, are more likely to take sick leave⁴. In 2007 the Confederation of British Industry found the greatest levels of sickness absence among nurses were within services/specialties that have a high proportion of older patients, such as stroke and rehabilitation units, geriatric care and general medicine⁶⁹.
- 4.65. Screening for depression has been trialled in the US as a means of picking up symptoms before they turn into more serious problems. This was not carried out in health care organisations, but the results showed that screening reduced sickness absence rates, to some extent⁶³. This approach has not been piloted in the UK and it could potentially 'medicalise' minor, fleeting illness and normal stress².

Presenteeism

- 4.66. Presenteeism is also an issue. Defined as coming to work and performing at less than full capacity as a result of ill health — as opposed to working during a period of recovery from illness — it seems to be particularly prevalent in the NHS where staff are encouraged to remain at work² and among more senior staff and those with mental health issues⁷¹.

4.67. A study, which looked at the prevalence of presenteeism in relation to job role among almost 4000 Swedish employees, found that people in the caring professions were among those most likely to go to work when ill⁷². Women were more likely than men to do so, while doctors were more than twice as likely, and nurses and midwives between three and more than four times as likely, to go to work when ill than other types of worker. Difficulty finding a suitable stand-in seemed to be a key factor in the decision⁷².

'Nursing is an extremely tough profession really. When you're at work you're either full on or not and therefore it's quite difficult to function properly if you're not well.'²

4.68. Rates of presenteeism could be as high as those of sickness absence, according to research based on a sample of almost 13,000 Danish employees⁷³. This showed that 70% of the core workforce had gone to work when ill at least once over a period of 12 months. Overall, workplace factors seemed to be slightly more influential than personal circumstances or beliefs in making that decision, but the authors concluded that these factors still did not fully explain their findings⁷³.

Workplace and personal factors involved in presenteeism⁷³

- having a supervisory role
- working more than 45 hours a week
- working in small organisations/units
- working non-standard hours
- degree of cooperation with colleagues
- treating work as home
- overcommitment to work
- conservative attitude to sick leave.

4.69. It is also clear from the staff and public perception survey carried out for this report that health professionals feel guilty about taking time off for ill health, on the grounds that they will let down both patients and colleagues⁵.

'Doctors are hopeless... they kind of work themselves to death... They feel themselves to be invulnerable and they feel they should be looking after others and not themselves.'
Doctor²

Effects of substance misuse on performance

4.70. Substance misuse can aggravate and/or contribute to existing anxiety and depression and impair sleep⁷⁴. And research shows that working while under the influence of drugs or alcohol increases the chances that health care workers will make mistakes and communicate poorly with colleagues and patients⁷⁵.

4.71. The public questioned in the staff and public perception survey also perceives addiction as a significant threat to patient safety⁵. When questioned about various scenarios that could have implications for patient safety, members of the public considered a dentist smelling of alcohol or a GP with depression to be medium risk. But a surgeon with an addiction problem was regarded as high risk⁵.

Impact of drug and alcohol misuse in the general workforce ²⁵

- Absenteeism is 60% higher among drug users
 - 75% of those dependent on alcohol are also employees
 - One in four accidents at work is reported as being related to alcohol
 - A member of staff under the influence of drink or drugs will only achieve two thirds of his/her work potential.
-

- 4.72. It may be easy to spot a health professional who is obviously under the influence of drugs or alcohol, but persistent and long term substance misuse can be harder to pick up and the consequences for quality and safety of care harder to predict².
- 4.73. This has prompted the British Medical Association and the Dentists Health Support Programme to advocate rapid access to specialist assessment and treatment, together with supportive rehabilitation services, as essential steps to minimising the risks to patient safety^{76 77}.
- 4.74. Despite these potentially serious risks, student education, training, continuing medical education and professional development offer little information about drug and alcohol misuse among health professionals and how to recognise it in themselves and professional colleagues^{78 79}.
- 4.75. The Independent Inquiry into Drug Testing at Work (2004) concluded that drug testing can have an important role in 'safety critical and other occupations where the public is entitled to expect the highest standards of safety and probity', provided that it is 'approached with caution and implemented in a fair, transparent and inclusive way⁸⁰'. But it goes on to say: 'For most businesses, investment in management training and systems will have more impact on safety, performance and productivity than drug testing at work⁸⁰'.

Costs of ill health

- 4.76. Current levels of sickness absence in the NHS mean that more than 10 million working days are lost every year, equivalent to 4.5% of the entire workforce and at a direct cost of £1.7 billion every year⁴.
- 4.77. Mental illness sickness absence in the health service is estimated to cost the NHS £1.3 billion, while stress related disorders alone are thought to account for almost a third of sick leave at an estimated cost of £300-£400 million a year⁸¹.
- 4.78. Spending on agency staff is closely related to sickness absence and staff turnover, with the average spend across all types of NHS Trusts amounting to almost 4% of the wage bill or £1.45 billion⁴.
- 4.79. Swedish research estimates that presenteeism, overall, may be as costly as sickness absence⁷². Presenteeism among staff with mental health problems is thought to cost 1.5 times the amount of working time lost through absenteeism⁷¹.
- 4.80. The NHS Employers Partnership Review has estimated the overall costs of early retirement to be in the region of £150 million a year⁴.

- 4.81. Yet comprehensive health and wellbeing services can pay dividends in the long term. A report from the think tank Reform suggests that the NHS could save £1 billion a year if it followed good practice and provided workplace health and wellbeing initiatives for its staff⁸¹, although there is as yet little evidence on the impact of such initiatives on sickness absence or productivity.

Barriers to health professionals getting help

- 4.82. Most of the research has focused on doctors. Although all health professionals are likely to be affected by similar difficulties to some extent, currently, it is not clear whether different professional groups react to health problems in the same way².
- 4.83. And it is not always clear whether organisational or professional cultural factors drive certain behaviours, although it is likely to be a mixture of both. For example, the evidence suggests that doctors frequently either do not register with a GP or do not use GP services when they are registered⁸², while nurses seem to be more willing to take time off for health problems⁸³.
- 4.84. But research indicates that health professionals face several barriers which deter them from accessing timely and appropriate services, including pressures of work and fear of stigmatisation^{2 3}.

Workload

- 4.85. The most common barrier highlighted by health professionals in the staff and public perception survey is lack of time and pressure of work⁵.
- 4.86. Long working hours, peripatetic job patterns and shift work can make it difficult for health professionals to register with a GP⁸⁴. Confidentiality concerns may deter those working in isolated rural areas from registering with a local GP practice, which may be the only one in the vicinity.

Confidentiality

- 4.87. The second most commonly cited obstacle to seeking help for a health problem, mentioned by 11% of respondents in the staff and public perception survey, was a concern about confidentiality and the potential for sensitive information to be leaked through the organisation's grapevine. Doctors and those working in general practice were significantly more likely to cite this as a deterrent⁵.
- 4.88. Three quarters of health professional respondents said they would trust their line manager not to breach confidentiality, but nurses and pharmacists were significantly more likely to trust their line managers with health information than doctors⁵.

Financial

- 4.89. There is also a financial disincentive for self employed health professionals to take time off work for ill health.
- 4.90. Work carried out for the NCAS on pharmacists' health showed that locum pharmacists did not want to take time off for ill health because they feared that not only would this leave a pharmacy without adequate cover, but might also jeopardise their future chances of work²².

'I actually am 67 years old...I need the money because I didn't work for a big company and I didn't have a pension, but it can be a very stressful job sometimes.'

Pharmacist²²

- 4.91. Primary care organisations may also incur costs by supporting sick GPs. The Statement of Financial Entitlement sets out the obligations of primary care organisations in this area⁸⁵. Costs will vary depending on the PCT's own guidelines and the individual circumstances of contracted practitioners.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4107508

Stigma

- 4.92. Stigma is another powerful deterrent, especially when it comes to mental health issues. Despite a change in attitudes, a diagnosis of mental ill health may still engender stigma and discrimination — or the fear of it.

'I think it's possibly stigma and confidentiality [that are barriers to seeking help]. I think those would be the two things. And certainly in our area, it's quite a close knit community and I think [orthodontists] would be concerned about other people knowing about it. So confidentiality would be an issue.'

Orthodontist⁵

- 4.93. Doctors were more concerned than other health professional groups responding in the public and staff perception survey about the reaction of colleagues to a mental health problem. Three out of four of those surveyed feared being labelled or stigmatised for a mental health issue, compared with two thirds of pharmacists and around half of nurses⁵.

'I think there's almost a sort of embarrassment thing. It's sort of physician heal thyself thing almost, so seeking help for what potentially may be an embarrassing problem, or an addictive problem, or a stress problem, certainly in the hospital specialties, the culture is that you just sort of feel free to cope and carry on.'

Surgeon⁵

- 4.94. Doctors were also significantly more likely to voice concerns about the impact on their jobs/career of admitting to health issues at work (17% compared with 10%, overall)⁵.

- 4.95. Health professionals also fear that taking sick leave may be viewed as a sign of weakness and inability to cope, particularly if it's a mental health issue that could compromise employment and career prospects and call into question fitness to practise. Shame may also stop a health professional from seeking treatment⁵.

'People are worried about losing their jobs. People are under so much pressure to meet their patient targets. Admitting you have a health problem can be considered as a weakness, especially if the illness is stress as everyone in the health service is working under stress.'

Dentist⁵

- 4.96. Addiction was regarded as the most likely problem to prompt this response, with eight out of 10 doctors, three quarters of pharmacists and almost two thirds of nurses (64%) expressing fear of stigmatisation⁵.
- 4.97. A postal survey of 3500 doctors' attitudes to becoming mentally ill showed that most would rather disclose a mental health issue to family or friends than to another health professional, with a third of respondents citing the perceived adverse effect of such a disclosure on their career for their reluctance to do so⁸⁶.

'I sincerely hope that discrimination against people with mental illness can be ended. I therefore need to believe that I can be open about my own disorder with future employers and also my current colleagues. Surely it would be better for my colleagues to find out about my illness from me, on my terms, then through some other means? If having well controlled bipolar affective disorder is not really an issue for me (any more) then nor should it be for anyone else.'

General practice trainee⁸⁷

- 4.98. While most health professionals felt comfortable approaching their line manager about a personal health problem, around a third said they would not feel comfortable raising an addiction problem and more than one in five would not mention a mental health issue⁵.
- 4.99. Health professionals may be concerned about the impact of a health problem on their reputation for good reasons. The public are also somewhat wary of receiving treatment from a health professional with known addiction or mental health issues. Almost half (46%) say they would not feel comfortable being treated by a former addict and 39% would not feel comfortable being treated by a health professional with a previous mental health problem⁵.

Destigmatising mental illness

The Doctors' Support Network (DSN) aims to reduce the stigma of mental illness and improve mental health services for doctors. It has around 600 members — most of them GPs and psychiatrists — who offer peer support for doctors with mental illness. Several members also give talks to students and trainees about their own personal experiences of mental ill health and the organisation has provided sessions for consultants on how to help trainees with mental illness.

- 4.100. There are other health issues, which are still stigmatised, including carriage of the blood-borne viruses hepatitis B and C and HIV. A recent report from the National AIDS Trust, based on a survey of 1800 gay men, almost one in 10 of whom worked in health and medicine, showed that a third said they either faced or

feared a negative reaction on disclosure of their HIV status. And one in five who had disclosed their status had experienced discrimination in the form of exclusion, breaches of confidentiality, or being treated differently from their colleagues⁸⁸.

- 4.101. A health professional who is infected with any of these blood-borne viruses should not be prevented from working, but they will be restricted from carrying out procedures that could increase the risk of passing on the virus to patients.⁸⁹ These mostly arise in surgery, including some minor surgery, obstetrics and gynaecology and dentistry. Infected health professionals may need to be redeployed, or retrained if they cannot carry out their usual duties. This is not always straightforward, however and can be difficult for older professionals or for dentists, most of whose work exposes them to the potential for viral transmission.
- 4.102. 'Action on Stigma' is a helpful initiative to combat stigma in the workplace, also implementation of the Improving Working Lives standards.

Key themes of Action on Stigma

- Help employees look after their health
 - Promote a culture of respect and dignity
 - Encourage awareness of mental health issues
 - Show that no one will automatically be refused employment because of mental illness or disability.
-

Use of services

- 4.103. Health professionals don't use health services in the same way as the general public^{2,3}. Informal 'corridor consulting' with a colleague and self prescribing are popular, possibly because they save time and are relatively easy to do. Doctors in particular, favour self treatment⁹⁰. Fewer doctors (60%) considered that treating oneself is unacceptable compared with 80% or more of the pharmacists and nurses questioned in the staff and public perception survey⁵.

'Typically, they [doctors with mental health issues] are poorly managed and under managed and either self prescribing or getting [their] mate to do it in the corridor.'

Doctor²

- 4.104. Almost two thirds of the public don't think it's acceptable for health professionals to self prescribe, while almost half (48%) believe that health professionals should not diagnose their own health problems⁵.
- 4.105. Self diagnosis and self prescribing may work reasonably well for straightforward minor ailments, but more serious and complex physical and mental health issues are unlikely to receive the best and most appropriate care².
- 4.106. This approach may also enable health professionals to remain in denial about the severity of a health problem, raising the possibility that it will not be picked up and will worsen, with the attendant risks for their own health as well as the quality and safety of care.
- 4.107. But even when health professionals do access formal channels of care, the evidence suggests that they tend to be treated as colleagues rather than as

patients and that they are expected to make faster rates of recovery and comply better with treatment. They also don't receive appropriate follow up care^{2 75}.

'When they're treated by a colleague, they're treated as experts, not as patients... You have a certain amount of knowledge behind you... so you're not treated the same way as a normal patient.'

Doctor²

4.108. Health issues that are allowed to persist can be harder to treat and more damaging for the individual and his/her employer and they can increase the potential for poor quality care and patient harm^{2 78}.

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Chapter 5 Managing health concerns

- 5.1. This chapter considers the roles and responsibilities of those involved in detecting, managing and treating health problems in health professionals and then considers services for sick health professionals and how they may be developed in the future.
- 5.2. It draws on the reviews and survey commissioned for this report and other material contributed by members of the HHP Reference group.
- 5.3. Key points are:
 - health professionals don't feel well qualified to gauge their own level of fitness to work
 - individuals, team members and line managers all have a role in identifying possible health problems
 - line managers are given little formal training on handling health problems in the workplace and their knowledge of the relevant systems and procedures is patchy
 - occupational health services are often poorly funded and understaffed and do not always include health promotion as part of their work
 - provision of health and wellbeing services can save an organisation money in the long term and improve quality of care and patient safety
 - both the public and health professionals back the provision of specialist assessment and treatment services for health professionals.
- 5.4. Preventing health problems from arising or escalating to the point where quality of care and patient safety are compromised and referral to the regulator is necessary is clearly preferable for the individual, his/her patients, colleagues and the organisation concerned. Prevention of ill health and relapse of enduring conditions is especially important as the evidence for which treatment approaches work best and how they affect workplace performance, is thin^{1 2}.
- 5.5. Problems that have been allowed to persist for some time can be harder and more expensive to tackle as well as potentially more damaging for the individual and potentially the organisation^{1 3}.

Who picks up problems?

The individual

- 5.6. Responsibility for dealing with health issues should start with the individual concerned, but the staff and public perception survey commissioned for this report indicates uncertainty among health professionals about their ability to judge their own fitness to work⁴.

- 5.7. Around half of nurses and four out of 10 pharmacists think that health professionals are best placed to gauge whether they themselves are fit to work⁴. Only one in five of the doctors questioned agreed. Health professionals should not have to make this judgment by themselves, but should have prompt access to the expertise to help them and this is particularly important for those working alone⁴.

Colleagues and team members

- 5.8. Colleagues and team members may be well placed to recognise problems when they arise. In recognition of their professional duties, most respondents would not hesitate to flag up concerns about the health of a colleague: over 90% agree that ill health could pose a threat to patient safety⁴.
- 5.9. But the willingness to report a concern may depend on who the colleague is and the length of service. A quarter of those surveyed reveal that they would not feel comfortable raising concerns about a senior colleague's fitness to work. And a third of those who had worked in health care for up to 10 years would not feel comfortable reporting concerns about a senior colleague.⁴
- 5.10. Significantly, around a third of health care respondents did not know where to take their concerns, suggesting that such information should be made more widely available and much better signposted⁴.

'If at work tomorrow I thought that somebody had an alcohol problem, I wouldn't be absolutely certain of the process. I'd find out and I'd get it sorted, but I'm quite a confident person in a fairly senior position.'

Nurse⁴

Patients and the public

- 5.11. The staff and public perception survey showed that the public greatly trust health professionals and rate highly the health services they use⁴. But although half of those questioned claimed that they would know where to take a health concern about a regulated health professional, when probed more deeply, the variety of answers indicated a degree of confusion⁴.
- 5.12. The Nursing and Midwifery Council provides information for women on how supervision and supervisors of midwives, who oversee the work of every midwife, can provide help and support. <http://www.nmc-uk.org/aArticle.aspx?ArticleID=3773>

Line managers

- 5.13. The staff and public perception survey shows that line managers — their own (56%) or that of the person in question (26%) — were the favoured option for health professionals to voice their concerns about the health of a colleague. But fewer than half of line managers questioned had ever received any formal training in how to handle these concerns⁴.
- 5.14. There were significant gaps in line managers' knowledge. Around one in four (23%), rising to 28% of pharmacists and 30% of doctors, admitted they would not know

what to do if a fitness to work concern about a colleague arose. One in three (34%) said they did not know what systems were in place and two thirds did not know what vocational rehabilitation schemes were available for staff in these circumstances⁴.

- 5.15. Nurses were the most likely (61%) and doctors the least likely (30%), to say they had been formally trained. Those who line managed more than 10 staff were also significantly more likely than those with five or fewer staff to have received training or support (57% vs 29%)⁴.
- 5.16. The in-depth interviews indicate that managers tend to acquire 'on the job' experience of dealing with the impact of serious health issues on performance, such as ill health and addiction⁴. While experience is invaluable, gaps in knowledge suggest that there is room for more formal training — especially for doctors and those with fewer staff to manage — including provision of information on systems and procedures.
- 5.17. The 2009 guidance from the National Institute for Health and Clinical Excellence (NICE) on managing long term sickness indicates that training for managers can increase the long-term effectiveness and cost effectiveness of any workplace health intervention¹⁰.

Mental Health First Aid

The Mental Health First Aid Program (MHFA) training course, which was originally developed in Australia for the public, is not aimed at diagnosis, but at helping those in need of services to access them promptly. It consists of five key tenets: assess; risk; listen; reassure; encourage help seeking and self help. It is now being run in England. (www.mentalhealthfirstaid.csip.org.uk)

Beyondblue

Beyondblue (www.beyondblue.org.au), another Australian programme to tackle depression in the workplace, has been reviewed by the Sainsbury Centre for Mental Health and they concluded that it increased line managers' knowledge of depression and increased their preparedness to support a colleague with depression. Pilots have been run in the UK¹¹.

- 5.18. Almost two thirds of health professionals (61%) surveyed for this report said they had not discussed health factors affecting their fitness to work with their line managers, mostly because they had not had cause to do so. Doctors were the least likely to talk to their line manager about health⁴. Line managers could be more proactive and raise the topic of health and wellbeing before ill health becomes an issue, including during the annual appraisal.
- 5.19. Many health professionals working in primary care and the independent sector don't have a line manager/senior staff member to whom they can turn and the in-depth interviews suggest they instead rely on a mixture of experience, common sense and informal professional networks⁴.
- 5.20. A brief guide for health professionals on how to raise a concern about any aspect of a colleague's health or performance is available from NCAS¹².

Collating workplace data

- 5.21. Ill health and sickness absence in the NHS could be managed in acute care much more proactively than at present using information routinely collected for the Electronic Staff Record (ESR). The data could be used to identify potential departmental hotspots of ill health where additional support may be needed.

Managing organisational hotspots: Royal Free Hampstead NHS Trust, London

Organisations often miss the opportunity to pick up hotspots of sickness absence and take prompt effective action, because information that could identify health and wellbeing problems is kept in separate data streams and not cross checked.

In a bid to spot problem areas, the Royal Free Health and Work Centre psychology service set up an organisational hotspots group. The group, which is chaired by the consultant lead psychologist in occupational health, includes directors from medicine and nursing, human resources, risk management and occupational health.

The group carries out a quarterly review of the following sets of data, submitted by each of the directorates represented: sickness absence; clinical incidents; recruitment and retention; grievances and disciplinary procedures; referrals to occupational health.

This information is collated to give each department a priority ranking, according to the number of 'hits' it has. The group then identifies appropriate interventions, taking account of risk issues and comes up with sensitive ways of involving relevant managers in developing solutions.

Sickness absence management in the private sector

Rolls Royce developed an effective sickness absence management programme by implementing a policy across the entire company, setting out the responsibilities of managers and introducing an IT programme to monitor employee absence, including the reasons and costs. Sickness absence of four or more weeks triggers an action plan, including access to relevant services. Sickness absence has fallen by 15% and saved the company around £11 million.

- 5.22. In the NHS Electronic Staff Record (ESR) data on sickness absence in acute care could be used to build up a national picture, broken down by staff group and grade, time since qualification, ethnicity and gender. This would provide a rich source of information for research, providing the appropriate safeguards were in place.
- 5.23. Other data streams, such as those collected by local occupational health services and human resources on sickness absence, could also be used for future national research if anonymised and summarised³.

Health services for health professionals

5.24. This section looks at examples of health and wellbeing programmes and the role of occupational health services. It then summarises the need for specialist services for health professionals and draws on the experience of the London based prototype Practitioner Health Programme which was a key component of the Health for Health Professionals work stream. The section goes on to consider the skills of health professionals require to treat their professional colleagues and how specialist services may be developed in the future.

Health and wellbeing

5.25. Examples of health and wellbeing programmes in the commercial sector show that these can significantly cut the amount of sick leave taken, speed up the return to work after a period of illness and increase productivity levels¹³. Healthy employees are three times more productive than those in poor health¹⁴.

Examples of health and wellbeing initiatives which may be helpful

- Counselling
 - Healthy eating/weight loss initiatives
 - Stop smoking sessions
 - Exercise programmes
 - Relaxation/yoga classes
 - Anger management courses
 - Stress management
-

5.26. Healthy employees are also likely to be safer employees. One health care study suggests that a comprehensive stress management programme across the whole organisation, involving a raft of anti stress policies and targeting the most stressed departmental managers, significantly reduced the number of drug errors¹⁵.

5.27. Many organisations provide counselling services. These are often relatively simple and inexpensive to put in place and are valued by staff⁴, but there is a danger that employers might see these as the bare minimum needed to take care of employees' health and to fulfil their legal obligations¹.

5.28. However, even where health care organisations do provide these services, few health professionals are aware of what's available to them⁴, what the services provide, or how to go about accessing them. And some have little or no understanding of their organisations' policies and procedures for handling poor health⁴.

5.29. Junior staff and those without managerial responsibilities feel they are particularly in the dark about health and wellbeing services⁴. Pharmacists qualified for fewer than six years reported poor awareness of health and wellbeing services¹⁶. This suggests not only the need for better information about these services and how to access them, but also much more effective means of publicising them to ensure that all staff know about them⁴.

5.30. Given the low profile of these services, it's not surprising that health professionals do not rate them very highly⁴. Fewer than four out of 10 (38%) were satisfied with the provision of health and wellbeing services for their personal use and only just over a third were satisfied with services available to health professionals in general. Doctors, who were the least well informed about wellbeing services provision, were also the least satisfied of all the professional groups⁴.

Improving access to services: Royal Free Hampstead NHS Trust, London

Doctors are one of the professional groups least likely to access the in-house staff psychology service at the Royal Free Hampstead NHS Trust, London. The Health and Work Centre psychology service increased take-up of the service by 'normalising' work stress at every opportunity, using neutral language and focusing on access to resources, building up resilience to stress and personal effectiveness rather than on stress, coping and pressure.

Regular mandatory workshops were provided for junior doctors, emphasising the link between wellbeing, effectiveness and productivity, with the aim of preventing the experience of work stress from becoming internalised and developing into a health problem. These workshops help participants think about their experience of stress in context rather than in isolation and highlight the extent to which stress is universal. The sessions identify a range of options for increasing resilience to stress and provide information on how to access support quickly and in confidence.

5.31. Prevention and health promotion is particularly important. The average age of the British worker is set to rise over the next 20 years as the population ages. Health professionals, in line with the general population, will therefore be more vulnerable to long term conditions associated with ageing, such as diabetes, arthritis, heart disease and declining cognitive function¹⁷.

A comprehensive approach to wellbeing: Derbyshire County PCT¹⁸

The trust has put in place a raft of policies to increase the health and wellbeing of its staff. These include:

- Workplace Wellbeing strategy developed and approved by the Board
 - Employee wellbeing manager appointed
 - Occupational health services available to staff through manager and self referral
 - Staff support service which offers counselling, mediation, incident support, psychological therapies, team development, workshops, coaching and consultancy
 - Annual wellbeing reports using staff survey data, followed up with discussion groups and action plans; improvements in all scores noted
 - Extensive range of family friendly employment policies
 - Cycle to work scheme
 - Engaging Leadership strategy adopted
 - Manager training and guide to support absence management
 - The 'staff conversation' method adopted
 - Health and Safety Executive standards used for risk management of stress and improvement planning
 - New absence management policy, process and procedure being developed
 - Disability awareness training for managers.
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Occupational health

- 5.32. In the staff and public perception survey occupational health was the service most widely perceived as being able to deal with the impact of health problems on fitness to work, especially addiction or mental ill health (56%). But the in-depth interviews revealed that occupational health is poorly publicised and that staff need to be 'in the know' to take advantage of it⁴.
- 5.33. Although largely trusted and seen as reliable, respondents raised concerns about confidentiality and the capacity of hospital based services to cope with demand.⁴ Many doctors view occupational health departments as irrelevant and concerned primarily with starting a new job or vaccinations¹. They often only come into contact with these services after performance issues have arisen¹⁸.
- 5.34. Occupational health services have a key role in not only managing health issues in the workplace, including a supported return to work after a period of sickness absence, but also in proactive prevention and health promotion.
- 5.35. A recent survey of the 175 on-site occupational health units in England, points to high vacancy rates and variable levels of specialist staff provision and expertise¹⁹. *The Health and Wellbeing Report* also suggests that occupational health services are under-funded, with the average trust spend amounting to £218,000 a year or 0.13% of the total trust budget and the amount determined by history rather than current need¹⁹.

'I think a lot depends on the quality of the occupational health service and in some cases they can be very good... But quite often these occupational health departments are quite small and one or two sicknesses in their own department cause major problems for this organisation in terms of if you want to refer anybody to them.'

Pharmacist⁴

- 5.36. Many contractors, locums or those working in the independent sector do not have ready access to occupational health services.
- 5.37. The Department of Health has set out the requirements for occupational health services in primary care, including the need to encourage staff to refer themselves to occupational health services, if they have a health problem and to register with a GP outside their own practice, if possible²⁰.

Model for occupational health services in primary care

- Independently run service, backed by the local representative committees, primary care practitioners, the primary care trust and the strategic health authority
 - Proactive services, including stress management skills and advice on health promotion
 - Advice on referrals to specialist expertise for drug and alcohol problems
 - Access to a team which includes experienced occupational health physician, occupational health nurse, educationalist, independent psychologist or counsellor.
-

Occupational Health Service for Primary Health care in Cornwall and South West Devon

This confidential service provides a full range of occupational health services as well as practical advice and support on issues of occupational health and safety to GPs, dentists

and their employed staff and locums. It also provides tertiary care for acute trusts and other PCTs outside the catchment area. Self referral is encouraged.

The service provides detailed psychiatric and occupational health consultant assessment and a wide range of psychotherapeutic interventions. Two consultant psychiatrists/psychotherapists now oversee a network of around 20 experienced and supervised psychotherapists. In addition, the service is staffed by an integrated team of specialist GPs and occupational physicians and nurses. It has assessed over 500 GPs and dentists since it started 10 years ago. Rates of commitment to treatment, recovery and return to work are high.

Funding is provided by the PCTs in the area the service covers.

www.youmatter.org.uk

- 5.38. Occupational health has a key role in helping to track the health of vulnerable students and trainees and ensure that they are given the right support and job structure. Help and support can be obtained from NHS Plus.
- 5.39. Vocational rehabilitation schemes available through occupational health help sick health professionals stay safely in work or manage their return to work.

The need for specialist services for sick health professionals

- 5.40. Occupational health services advise on fitness to work issues and manage cases, but they do not provide specialist assessment and treatment of health professionals with complex health problems, such as those associated with mental ill health and addiction.
- 5.41. As set out in chapter 4, there can be significant barriers to health professionals accessing effective health care. These include:
- workload and shift work
 - fear of stigmatisation and discrimination
 - fear of jeopardising future job prospects
 - lack of confidentiality and privacy
 - high mobility of junior staff
 - financial disincentive for self-employed contractor professionals and locums
 - access to informal 'corridor consulting' with a colleague and self prescribing.
- 5.42. But even when health professionals do access formal channels of care, the evidence suggests that they tend to be treated as colleagues rather than as patients and may not receive appropriate follow up care.
- 5.43. Many doctors and nurses feel uncomfortable and ill-equipped to treat a health professional who has become a patient, especially those with mental health issues. However, other sickness in health professionals may be challenging for their colleagues to handle.

‘Thus I am dispatched to the kingdom of the sick permanently and irretrievably... One’s guides in this world have a dual role: to read the map and direct you accordingly, but also to be with you on the terrain, a place of great uncertainty. Perhaps, as a doctor, I present an unusually severe challenge to fellow clinicians — I am too much like them — and the horror of what lies before me deflects clinical carers from straying on to that territory. No one can imagine the unimaginable except those, like me, who are experiencing it²³.’

Kieran Sweeney, Professor of Primary Care, on his diagnosis of mesothelioma

Specialist services for sick health professionals

- 5.44. Most of those questioned in the staff and public perception survey agreed that the NHS should prioritise the health of its staff and provide dedicated services for those who are ill⁴. More than eight out of 10 (86%) health professionals and a similar number of the general public (78%) agreed that much greater emphasis needed to be given to staff health and fitness. Three quarters of health professionals wanted dedicated services and around seven out of 10 (69%) of the public backed this approach⁴.
- 5.45. There are now a small number of examples of health programmes tailored to the needs of health professionals.

5.46. Case management: OHSxtra Case Management Programme

The service

OHSxtra was an 18 month pilot looking at the effectiveness of case managing staff dealing with difficult health issues at work, or on sick leave, as a result of a health problem. Trained case managers provided dedicated support for staff working in NHS Fife and NHS Lanarkshire in Scotland, who either self referred or were referred by occupational health, human resources, or their line manager.

A face to face assessment was made using validated health assessment tools, after which referral to other specialist services, including physiotherapy, occupational therapy, cognitive behavioural therapy (CBT) and counselling, was available. The individual was then re-assessed after treatment.

Evaluation

Over 12 months (March 2006 to March 2007), the service dealt with 540 clients, of whom 250 were discharged, 142 were still receiving treatment, 126 had voluntarily withdrawn and 22 had been inappropriately referred.

Almost three quarters of the cases involved musculoskeletal disorders, with the remainder common mental ill health issues, such as stress and depression. Over half of the clients (56%) were nurses and midwives.

Of those with challenging health problems before accessing the service, virtually all remained in work (99%); of those who had been on sick leave for more than 21 days, almost two thirds (65%) returned to work after using the service. A significant number of those taking medicines before referral were no longer doing so afterwards.

A cost analysis showed that saving around four days of sickness absence per staff member covered the cost of providing the service.

Practitioner Health Programme

- 5.47. The Chief Medical Officer's report, *Good Doctors, Safer Patients*²¹ proposed the setting up of a prototype London based specialist health programme for doctors. This is the other key area of work for the *Health of Health Professionals* work stream.
- 5.48. The service is an example of a confidential specialist assessment and treatment service for sick doctors and dentists that could be applied elsewhere and extended to other health professionals. The experience to date underlines some of the key findings and recommendations of this document.
- 5.49. The Practitioner Health Programme (PHP) was set up in 2008 as a two year prototype to provide health care services to doctors and dentists living or working in the London area with any type of health problem which may impair performance. It was designed to complement existing NHS GP and occupational health services, rather than replace them.
- 5.50. Research into the performance concerns of doctors suggests that a holistic approach to ill health, taking account of social and personal factors and the complex interactions between them, is more productive and effective than focusing on single issues²². This is reflected in the wide range of interventions PHP provides.
- 5.51. The service offers:
- assessment and treatment of doctors and dentists with mental health, addiction, or physical health problems
 - brief intervention, cognitive behaviour therapy, relapse prevention, psychodynamic psychotherapy
 - access to inpatient care for acute mental health problems
 - community based and inpatient alcohol detoxification
 - treatment for drug addiction
 - case management
 - access to financial advice and signposting to peer support programmes
 - support for practitioners whose health problems have resulted in regulatory referral.
- 5.52. Originally conceived as a programme with two distinctive tiers — PHP 1 for generalist assessment, case management and some treatment and PHP 2 for specialist treatment — PHP now provides an integrated service with close communication between health professionals involved in the care of sick health professionals.

First year's experience

- 5.53. Demand for the service has been high, suggesting substantial unmet need. During its first year PHP saw 184 sick health professionals. Fifty seven per cent of cases

related to mental health problems and 34% to addiction. Nine per cent of practitioners had physical health problems or a mixture of physical and other health issues. At entry, 57% of practitioners were working; 39% were not. One in three (33%) were involved in a regulatory or disciplinary procedure.

- 5.54. Comprehensive evaluation of the service is ongoing and feedback shows high levels of satisfaction among service users. The report of the first year is available on the PHP website www.php.nhs.uk/

'I feel I have proper care and confidentiality. I am now back at work, thanks to PHP. If something like this had existed before my problem got out of control I would have sought help sooner and saved myself and my employers a great deal of grief.'

Practitioner-patient

- 5.55. The progress of practitioners accessing the service has been carefully measured and improvements documented. Forty six per cent of those who were not working when they came to the service have returned to work.

- 5.56. The practical experience of PHP over the past year has underlined some of the themes identified in this report:

- doctors and dentists often present very late for treatment, having developed serious problems before they access help
- alcohol has a major role in ill health
- bullying can precipitate and perpetuate mental ill health in doctors and dentists
- shift work and poorly functioning teams can precipitate mental ill health in vulnerable individuals.

Costs

- 5.57. The cost of PHP is around £1 million a year, covering 30,000 doctors and dentists in London. The service is currently funded by the Department of Health until March 2011. If funding were to be provided by London PCTs and Trusts in the future, the cost would be covered by an average sum of £29,000 per Trust per year, about equivalent to the cost of excluding one doctor from work for seven weeks.

- 5.58. A preliminary estimate of cost-benefit of the service suggests that it can save the NHS a considerable sum. For example, PHP treated an acute sector practitioner with an addiction problem and helped him return to work for under £7,000. An alternative route might have been exclusion from work for the six months pending a disciplinary investigation, which could cost a Trust around £108,000. The practitioner might have been lost to the NHS, with the consequent waste of the cost of basic training — estimated to be at least £250,000. In addition, if he had continued to work despite deteriorating health, patients may have been harmed.

Peer support

5.59. Peer support services for sick health professionals are invaluable and there are now a considerable number.

Example of a peer support service for pharmacists

Listening Friends provides free and confidential telephone advice to pharmacists who are suffering the effects of stress brought on by work, family issues, bereavement or illness. Although this scheme was set up by the Royal Pharmaceutical Society of Great Britain (RPSGB), it operates independently under Pharmacist Support. Callers can talk to a trained pharmacist who understands the specific pressures of the job.

The Pharmacists' Health Support Programme is a separate confidential service that helps pharmacists with drug or alcohol problems and other issues that may affect fitness to practise. This also operates under Pharmacist Support and will fund pharmacists who require treatment from specialist services.

Example of a peer support service for nurses

The Royal College of Nursing provides two key support services for its members.

It provides free short term counselling and psychological support where necessary. Members have the opportunity to approach the counselling service when they have issues, either inside or outside of work, which they wish to discuss. The service provides advice, consultancy and training for RCN staff and activists and promotes the psychological health of nurses through research, dissemination, policy work and project activity.

The RCN also operates the Welfare Rights and Guidance service which provides support and advice on a number of financial and career related issues. This houses the Work Injured and Disabled Nursing Group, a discretionary fund and matching service for all members affected by injury, ill health or disability.

Skills of health professionals who treat their professional colleagues

5.60. The Royal College of General Practitioners, the Royal College of Psychiatrists, the Faculty of Occupational Medicine and the Association of NHS Occupational Physicians (ANHOPS) have been working to define the competencies required for practitioners caring for sick health professionals. The aim is to set up a fully accredited training programme that will support continuing professional development and revalidation.

5.61. Drawing on the Fundació Galatea model²⁴, health professionals who treat professional colleagues with mental health problems need to:

- establish a fruitful therapeutic partnership
- acknowledge and use the patient's expertise in a constructive and collaborative way
- understand the health professional's beliefs about their illness

- use assertive consultation skills
- maintain confidentiality
- be familiar with the requirements of the professional regulatory fitness to practise procedures
- understand fitness to work and the need to work closely with occupational health services.

Future services

5.62. The experience of PHP and other services for sick health professionals points to the value of specialist services. To ensure equity of access to such services, they should be available to all health professionals whose health problems are complex and may compromise the safety of patients and who cannot access suitable local services. This could be achieved by a two-tier service involving

- GPs and occupational physicians with enhanced skills in managing health professionals with health problems, with rapid access to
- specialist assessment and treatment services (particularly mental health and addiction services).

Panel of GPs and occupational physicians

5.63. The work during 2009 to identify the competencies required for GPs, psychiatrists and occupational physicians to assess and manage sick health professionals will be taken forward to devise a training and accreditation programme

5.64. Trained and accredited GPs and occupational physicians will form a panel of doctors whom any health professional can approach with confidence. The GPs and occupational physicians will refer on those complex cases that cannot be managed within their local health services, to a specialist service whose staff have enhanced skills and experience in treating health professionals.

Specialist service

5.65. The specialist service should provide in-depth assessment of health professionals with health problems, including social and personal factors. An appropriately skilled and trained multidisciplinary team would provide case management, continuing care and follow up. They would also arrange referral for additional specialist assessment or treatment (inpatient or outpatient) or access to a range of interventions as required, including CBT, occupational psychology, family therapy, mentoring, financial advice, career guidance, peer support.

5.66. The specialist service will need to develop strong links with occupational health services of employing and contracting organisations, with appropriate safeguards to maintain the confidentiality of the health professionals while still meeting the requirements of the service and protecting the safety of patients.

5.67. The specialist service may also advise and provide specialist services to other health professionals managing practitioner-patients.

- 5.68. The service will need good understanding of when health professionals need to be referred to the regulatory body and may devise a memorandum of understanding with the relevant health profession regulator.
- 5.69. While currently there is only one specialist service of this type in England (the prototype Practitioner Health Programme in London), there are others providing some of the services required who have expressed an interest in developing a full service along the lines of the Practitioner Health Programme. It is likely that two to four additional such services would be required for England.

A model for health services for health professionals

- 5.70. Figure 1 shows how health services for health professionals might be achieved, using a combination of GPs and occupational physicians with enhanced skills to assess and manage sick health professionals, backed up by a small number of specialist services to advise on and handle complex health needs.
- 5.71. Strong, explicit links and effective communication between each tier would be crucial, especially around the rehabilitation and return to work of a sick health professional. No service should exist in isolation or work in parallel.

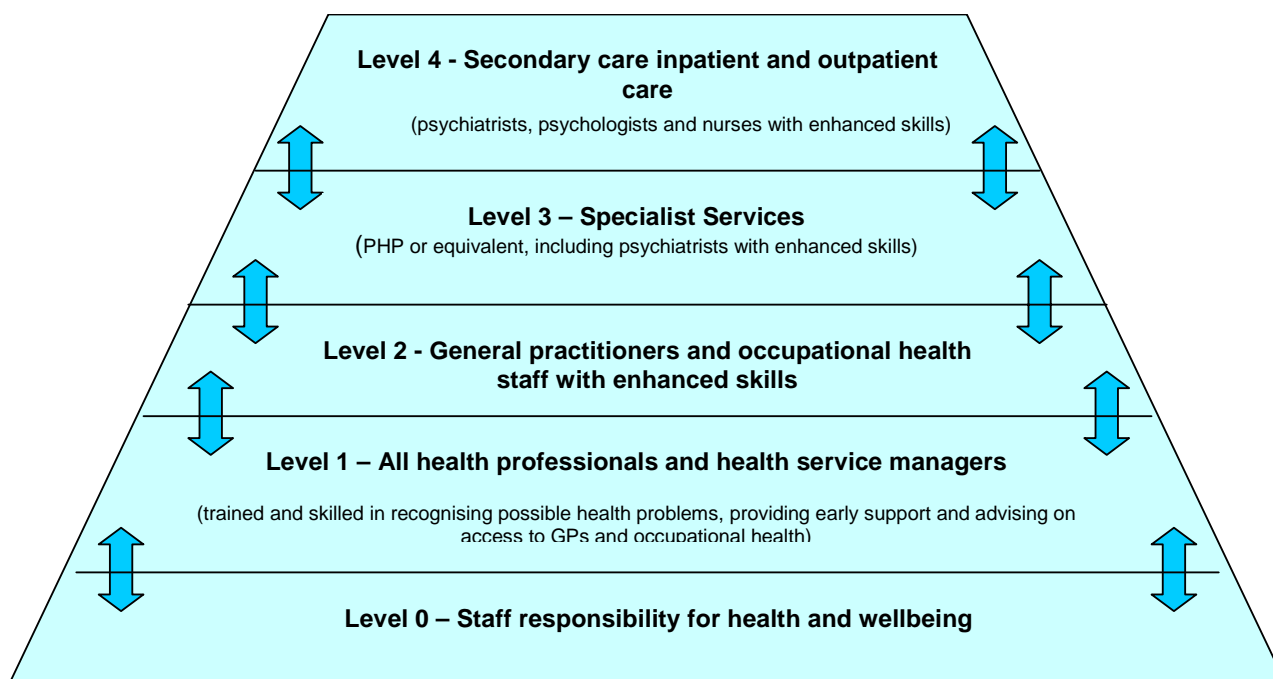


Figure 1 A model for health services for health professionals

Levels of health care for health professionals

- 5.72. **Level 0: taking responsibility for personal health and wellbeing**
This would draw on existing training for health professionals to help them take care of their own health, manage stress and recognise health problems when they arise. Training and information can be provided to students and postgraduate trainees at

induction and at other employer events.

5.73. Level 1: health professionals and managers trained to recognise possible health problems

Programmes for training health professionals and managers in how to recognise and handle possible health problems, particularly mental health, are already available. These involve providing support to the individual and ensuring s/he has access to appropriate GP and occupational health services.

5.74. Level 2: trained and accredited health professionals with enhanced skills

These would be mainly GPs and occupational health staff in the first instance, spread throughout England. They would provide:

- first line assessment
- referral to the specialist services (levels 3 or 4) for advice and further treatment
- referral back to the individual's GP
- local management and follow-up
- ongoing care, including case management for those assessed and treated at level 3 services.

5.75. These professionals would need to maintain good communication with local occupational health services and provide an ongoing resource for professionals with health problems to reduce the number of patients needing specialist services. They would help sick health professionals to access services in good time.

5.76. Level 3: specialist services for sick health professionals

Specialist services for health professionals should provide:

- in-depth assessment, addressing health and wellbeing needs in the round
- access to multidisciplinary team expertise either within the service or via referral
- assessment and treatment of mental health and addiction problems
- assessment of physical health problems that may compromise safe practice
- continuing care and follow up, with access to a range of clinical interventions, such as CBT, occupational psychology, family therapy, mentoring, financial advice, career guidance, educational support
- referral for specialist assessment or treatment — inpatient or outpatient (level 4)
- case management or liaison with level 2 services responsible for case management
- strong links with employing and contracting organisations, normally through occupational health services, with appropriate safeguards to maintain confidentiality while still fulfilling the requirements of the service and the safety of patients
- advice to other practitioners managing health professionals.

5.77. The clinical team working in specialist services for health professionals should be specifically trained and experienced in treating health professionals and be aware of the requirement to protect the safety of patients who may be cared for by the sick health professional, including the requirements of the regulatory bodies.

5.78. Experience from specialist health programmes for doctors in other parts of the world and from clinical services in the UK shows that strong clinical leadership is crucial. The lead for the service needs to be able to champion the cause of health

professionals with health problems.

- 5.79. Up to four specialist level 3 services would probably be needed in England if the level 2 (GP and occupational physician) service were established. The London PHP is a level 3 service and there are services elsewhere which could be developed further to upgrade to level 3. A specification for level 3 services would be required and funding identified.
- 5.80. Specialist health services should work closely together, sharing learning and experience, drawing on a common dataset and working towards consistency of services provided. They would support the network of level 2 professionals, providing opportunities for shared learning. They would also be in a good position to provide support and training to other health professionals on how to prevent and spot health problems in health professionals and how to provide treatment for mental health and addiction problems.
- 5.81. **Level 4: specialist secondary care services**
A few sick health professionals will require highly specialised assessment and treatment services from mental health professionals, either as an outpatient or inpatient. Referrals would be made through level 2 or 3 services.

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Chapter 6 Safeguarding patients and the public

- 6.1. This chapter looks at the role of the regulators and employers and contracting bodies in safeguarding patients and the public where the health of a health professional may compromise the quality of the care they provide.
- 6.2. The first section of the chapter covers the regulators, exploring the difference between fitness to practise and fitness to work; when a regulatory body needs to know about a health problem; and handling of referrals. It considers the regulators' requirements about health in relation to registration.
- 6.3. The second section of the chapter reviews the role of employers and contracting organisations, referring back to the chapter on managing health concerns in this report and covering risk management, policies and procedures, training and information of staff, access to health services. It considers the need for identifying and tracking individuals with health difficulties from undergraduate to postgraduate practice.
- 6.4. The chapter draws on recommendations in the Fifth Report of the Shipman Inquiry¹; a review of the fitness to practise health procedures of the General Medical Council (GMC)²; guidance published by the Health Professions Council (HPC)³; a report from the Council for Healthcare Regulatory Excellence (CHRE)⁴; a report from the former Disability Rights Commission (DRC)⁵.
- 6.5. For further details of individual health profession regulators' registration and fitness to practise requirements, please refer to their websites (Annex B).
- 6.6. Key points are:
 - individual health professionals, their employers or contracting bodies and the professional regulators all have a role in ensuring that patients and the public are safeguarded
 - in most cases the regulator does not need to be informed about a health professional's ill health, except where this is likely to pose a threat to the safety of their patients, but this is not widely known
 - health professionals and managers often struggle to know when the regulator needs to be informed when a health issue arises or worsens
 - sometimes employers do not pay sufficient attention to the need to make reasonable adjustments under the terms of the Disability Discrimination Act (DDA) to enable postgraduate trainees/health professionals to stay in post or return to work
 - all staff need to know when and how to raise any concerns they may have about the performance or health of a colleague
 - clear procedures and responsibilities are needed for handling health issues during the transition from undergraduate training to postgraduate practice
 - a consistent approach to the handling of fitness to practise cases by all the health professions regulators would be helpful

Role of the regulators

- 6.7. The regulators safeguard patients and the public by ensuring that the health professionals on their registers and those applying to be registered, meet the professional standards they set. While the detail of the fitness to practise procedures of each regulator will vary, some core principles apply to the identification and handling of health issues which may affect fitness to practise.

The regulators

- General Chiropractic Council (GCC)
- General Dental Council (GDC)
- General Medical Council (GMC)
- General Optical Council (GOC)
- General Osteopathic Council (GOsC)
- Nursing and Midwifery Council (NMC)
- Pharmaceutical Society of Northern Ireland (PSNI)
- Royal Pharmaceutical Society of Great Britain (RPSGB) — General Pharmaceutical Council (GPhC) from April 2010
- Health Professions Council (HPC)

The Council for Healthcare Regulatory Excellence (CHRE) scrutinises and oversees all these bodies.

- 6.8. The nine regulatory bodies for health professionals and the body that scrutinises and oversees them — CHRE — have a key role to play in ensuring that the health of each registrant is such that they are fit to practise. This is facilitated by:
- clear statements about the fitness to practise requirements for the health of health professionals and the difference between fitness to practise and fitness to work
 - identifying before registration those individuals who should not be registered because their health prevents them meeting the professional standards required by the regulator
 - identifying those professionals whose health may be adversely affecting their conduct or competence
 - ensuring that health professionals are referred to the regulator when their health raises a question about fitness to practise
 - protecting the safety of patients while ensuring that health professionals who are referred to them are dealt with in a fair and confidential manner.

Distinguishing between fitness to practise and fitness to work

- 6.9. Where concerns about the health of a health professional arise, the employer, colleagues, the treating doctor and the health professional may all be unclear about whether the regulatory body needs to be notified.
- 6.10. The confusion may stem, at least in part, from the term ‘fitness to practise’. This is a legal term that relates to whether someone meets the standards a regulatory body sets for competence or conduct. The word ‘fitness’ is not intended to describe any state of physical or mental health.

- 6.11. Similarly, the term 'impairment' is used by regulatory bodies in a legal sense, when an individual's fitness to practise is impaired on account of their conduct or competence; the term is not intended to relate to any physical impairment or health condition a person may have.
- 6.12. Fitness to work, on the other hand, is normally used to describe the state of physical or mental health which is compatible with the individual fulfilling their contractual obligations to their employer. A health professional must be fit to practise before s/he can work, but s/he does not have to be fit to work in order to be considered fit to practise by the regulator.
- 6.13. Local managers seek advice from occupational health services about fitness for work and occupational health and human resources departments may advise on the circumstances when referral to the regulator may be required. The regulators also provide advice on an 'in principle' basis.

Fit to work or fit to practise?

A registered occupational therapist develops pneumonia. She is on sick leave for several weeks while she recovers. She is not fit enough to work, but her fitness to practise is not affected by her illness.

A prosthetist and orthotist has back pain for which she has negotiated adjustments to her working environment with her employer, including rest periods and a specially designed chair under the terms of the Disability Discrimination Act. These arrangements have no effect on her fitness to practise.

A doctor who is dependent on alcohol comes into work drunk and admits to drinking while on call several times. He is signed off sick as he is not fit to work. He is referred for treatment and complies with this. After six months on sick leave he is deemed fit to work by his treating psychiatrist and the occupational health team and arrangements for appropriate workplace monitoring are put in place. In this case, the GMC did not need to be notified because the doctor complied with the need to take sick leave and undergo treatment.

- 6.14. The degree of insight and understanding into their own health will affect a health professional's ability to practise safely. For example, an individual with epilepsy for which medication is required, who informs his colleagues of his condition and keeps a supply of medicine at work, has a degree of insight and understanding into his health. On the other hand, someone with epilepsy who is reluctant to take medication because of the side effects and who does not advise his employers of his condition, may not be fit to practise because he has not fully understood the way in which his condition might affect his competence or the quality of care and safety of his patients.

When the regulator needs to know about a health problem

- 6.15. The regulatory bodies need to know about a health problem in a health professional when
- the condition may affect a health professional's ability to practise safely *and*
 - the health professional is not complying with assessment or treatment or heeding advice to take time off work

or

- there is significant misconduct, including ongoing criminal activity such as use of illicit drugs, drink driving offences, forged prescriptions.

- 6.16. CHRE recommends that regulators should provide further guidance to registrants and potential registrants on how health requirements are considered only in relation to an individual's ability to practise safely and effectively and that these will not be used to place them at a disadvantage⁴. If this was more widely known, health professionals might be willing to seek help more promptly.
- 6.17. CHRE also calls for the regulators to ensure that appropriate guidance is given to those who interpret regulatory bodies' requirements and standards for practice: education and training institutions, occupational health departments, employers and contracting bodies⁴.
- 6.18. Collaboration among the regulators and with CHRE in producing guidance may be helpful in achieving clarity and consistency and building on existing guidance.

Policy statement from the GMC on the meaning of fitness to practise

The GMC does not need to be involved merely because a doctor is unwell, even if the illness is serious. However, a doctor's fitness to practise is brought into question if it appears that the doctor has a serious medical condition (including an addiction to drugs or alcohol) AND the doctor does not appear to be following the appropriate medical advice about modifying his or her practice. Referral will then be necessary to minimise the risks to patients.

- 6.19. Where a treating doctor considers that the case should be brought to the attention of the regulator, s/he seeks consent from the health professional to do so and, if consent is not provided, notifies the health professional of his/her intention to alert the regulator and takes forward the notification.
- 6.20. The Practitioner Health Programme (PHP) has memoranda of understanding with the GMC and the GDC (available on www.php.nhs.uk). In those rare cases where a health professional is in the programme, but who is not willing to comply with advice on managing their health problem and his/her condition seems to pose a risk to patients, PHP takes action. This could be advising the employing or contracting organisation to restrict the health professional's practice and refer to the GMC/GDC or, very rarely, PHP may refer directly to the regulator.
- 6.21. While all health professionals working with, or treating, regulated health professional colleagues need to be aware of the circumstances in which they must alert an individual's regulator, they also need to know that in most cases, the regulator does not need to be informed about a health professional's health problem.
- 6.22. Very few health professionals with health difficulties come to the attention of the regulatory bodies, as the figures show. In 2008/9 the Nursing and Midwifery Council (NMC) considered 149 health cases out of a total of 1759 cases referred to the Investigating Committee. Referrals to the NMC represent 0.2% of the numbers on the NMC Register. In 2008/9 the Royal Pharmaceutical Society of Great Britain (RPSGB) considered 24 health cases: seven involved alcohol misuse, 12 involved mental health issues and five physical impairment.

- 6.23. Of 81 fitness to practise hearings completed in 2006/7 by the HPC, six were referred to the Health Committee. Of the remaining 75, 15 cases involved misconduct such as driving under the influence, arriving at work drunk, or self medicating at work.
- 6.24. Direct comparisons about the types and frequency of health issues arising in fitness to practise hearings among different groups of health professionals are difficult to make because of the variation in procedures and data collection.

Referrals to the regulator

- 6.25. Health professionals with health problems who are referred to the regulator should expect to be managed in a way which is fair and objective and which protects their confidentiality as far as possible, while ensuring the safety of patients and protection of the public.
- 6.26. The facts regarding a person's health and management of the condition may be relevant in determining whether and, if so, how s/he is able or unable to meet the regulator's standards. However, the detail of the diagnosis is not required for concluding whether or not a person's fitness to practise is impaired. In its report, *Maintaining Standards*, the former Disability Rights Commission noted: 'Health might be material to compliance with competence or conduct standards, or it may not be, but diagnosis is irrelevant in determining competence or conduct⁵'.
- 6.27. Regulators may face a variety of challenges in dealing with health in fitness to practise cases. These include the variety of cases; the relapsing nature of illness such as severe depression; and the need to balance the rights of the health professional with the need to protect the safety of patients and the public⁶.
- 6.28. The regulators do not always have access to advice about what work health professionals are capable of doing⁶. For example, an individual may no longer be able to work in emergency care, but could work in other departments. It is good practice for the regulators to arrange an independent medical assessment when there is concern about whether health is affecting fitness to practise. Some regulators include two independent medical reports.⁶
- 6.29. Medical assessors advising fitness to practise panels may need additional information to understand the health professional's particular area of expertise or the context of their practice. For example, the job specification of a hospital pharmacist will differ from that of a community pharmacist.
- 6.30. Addressing these issues will ensure that health professionals with health issues are dealt with fairly and it is likely to increase health professionals' faith in their regulatory systems. Almost half of health professionals questioned in the staff and public perception survey do not have confidence in the current regulatory system⁷.
- 6.31. From 2011 a new independent body, the Office of the Health Professions Adjudicator (OHPA) will adjudicate on fitness to practise cases brought before it by the GMC and subsequently the GOC, investigation of complaints will remain with the regulators. The fitness to practise panels will be strengthened if they include suitably qualified health professionals to advise the panel on cases where fitness to practise is affected by a health professional's ill health.

‘Good health’

- 6.32. Most regulators have ‘good health’ as a requirement for registration in their respective legislative frameworks and some include this in fitness to practise descriptors. CHRE points out that ‘good health’ suggests that there is some general state of health that is required for registration and implies there are standards set for the individual’s health rather than health only being of relevance in relation to its impact on competence and conduct⁴.
- 6.33. CHRE believes that the only legitimate consideration for the regulatory body is whether a person is fit to practise and that access to information about health should be sought only in relation to the impact it has on a health professional’s competence and conduct⁴.
- 6.34. Regulators may use the term ‘good health’ in a non-discriminatory manner, but a report from the former Disability Rights Commission indicates that the ‘good health’ requirement may be open to misunderstanding or misrepresentation by other parties and so lead to discrimination⁵.

Health declaration

- 6.35. The GMC requires a health declaration from the individual on graduation and a declaration from the medical school, followed by a statement at the end of foundation training, but does not require any further health declaration during the course of a doctor’s career².
- 6.36. If they have not already done so, pharmacists and pharmacy technicians must inform the Royal Pharmaceutical Society of Great Britain if they have any mental and/or physical health problems that may impair their fitness to practise when they complete their annual retention fee forms.

Checking on health issues: the Scottish Social Services Council (SSSC)

The SSSC regulates social workers in Scotland and does not have formal requirements regarding health. It requires applicants to have their suitability to practise endorsed by their employer, including notification of any issue about management of their health/practice. If the employer raises issues in the endorsement, the SSSC will seek information from the individual about how they manage their condition and practice. The SSSC may also ask for access to medical records and request the individual has a medical assessment.

Health reference

- 6.37. As noted previously, the CHRE report on the health conditions imposed by health professional regulators advises that regulatory bodies do not need formal stand-alone health requirements either at registration or during fitness to practise procedures, because health is important only in so far as it relates to an individual’s ability to meet the necessary competence and conduct standards⁴.
- 6.38. Most regulators, however, currently require a health reference from a doctor about a potential registrant. This indicates a person’s ability to meet the regulator’s standards, in the form of a declaration or statement. The HPC guidance for doctors providing health references includes the need for them to take into account the

duties of employers under the Disability Discrimination Act 1995³. These duties include providing an accessible workplace for those with disabilities and making reasonable adjustments to the physical environment to ensure that no one who is capable of working is barred from employment or disadvantaged because of their disability.

HPC examples of what should be included in the health reference

An applicant has had diabetes for several years. She manages her condition with insulin, which she injects herself. Her doctor looks at her notes and discusses with her how she is currently managing her condition. The doctor has a great deal of detail about the history of this patient's condition, but does not feel that any of it has any bearing on the applicant's ability to practise her profession. He therefore signs the HPC health reference without mentioning his patient's diabetes.

A student has had clinical depression for more than five years, for which he has been taking various antidepressants. He discusses with his doctor how the current medication is helping to control his depression and that he has been taking it for almost a year. He also discusses how he has managed his depression while studying, by managing stressful situations, recognising the early signs of stress and going for counselling. He has found out how he can continue to do this when he is working. His doctor is confident that although the depression is long-term, his patient is attending the necessary follow up appointments and presents no risk to the public. So, he signs his patient's health reference, giving no further information about the clinical depression.

An applicant to the Register has been receiving treatment for alcoholism for several years. The applicant is honest about her alcoholism and thinks that she will be able to maintain her sobriety. After talking to his patient, the doctor is reassured that the alcoholism will not affect her fitness to practise, but is still concerned that this could affect public safety in the future. So, he signs the HPC health reference but, with the patient's permission, mentions the alcoholism treatment.

Revalidation

- 6.39. The proposals for the revalidation of doctors include the need for annual appraisals to cover some discussion of a doctor's health, but the GMC has not specified a requirement for a health declaration for revalidation. However, those responsible for recommending doctors for revalidation will need to consider the individual's health where this may be impairing their performance and access appropriate advice before making a recommendation to revalidate.
- 6.40. Revalidation for dentists has been piloted and options for revalidation of other health professionals are being considered. As these are taken forward, procedures for revalidation of each health professional will need to set out clearly how concerns about health matters should be handled when these may impact on fitness to practise.

Role of employers/contracting bodies

6.41. Employers and contracting organisations, such as primary care organisations, have a duty to safeguard patients and the public when the health of a health professional may be adversely affecting their work.

6.42. Some of the measures required are set out in the chapter on managing health concerns. They are summarised here and include:

- Ensuring that all staff know when and where to raise concerns about the competence, conduct or health of a colleague.
- When concerns are raised about the performance of a health professional, the manager dealing with the case adopts a low threshold for seeking an opinion from an occupational health physician about whether there is an underlying health concern.
- A consultant-led occupational health department, which meets the standards set by the Faculty of Occupational Medicine and has suitably skilled staff to handle referrals for specialist opinion—particularly mental health and addiction—as well as knowledge of the requirements for referral to the professional regulators.
- Fast-track access to confidential assessment and treatment services, particularly for musculoskeletal problems and mental health.
- Vocational rehabilitation schemes to help sick health professionals stay safely in work or manage their return to work.
- Human resources expertise to advise on flexible working, cover arrangements, reduced out of hours /shift work, the employer's statutory duty in respect of compliance with the Disability Discrimination Act and the responsibility of a health professional to cooperate with the design of reasonable adjustments made.
- Clear policies regarding those rare occasions when referral of a sick health professional to the regulator may be required, including confidentiality and the limits of disclosure to third parties.
- Compliance with the Disability Discrimination Act to ensure reasonable adjustments are made to allow staff with physical or mental disabilities to stay in/return to work safely.
- The discharge of responsibilities under the Statement of Financial Entitlement for primary care professionals.

6.43. The roles of all those involved in fitness to work can be clearly defined:

- Responsibility for managing the illness and its treatment lies with the health professional, his/her family, GP and the treating specialist, if any
- Responsibility for managing the effects of the illness on the health professional's work lies with that individual, his/her manager and his/her clinical colleagues
- The occupational physician's role is to provide an independent assessment of the health professional's health, taking into account specialist advice where

required and advising both the employer and the employee on aspects relating to fitness for work. They can also manage the case, provide support to the health professional and liaise with the GP to facilitate appropriate ongoing care

- In the case of doctors, dentists and pharmacists, NCAS can advise managers on how to handle concerns about the impact of health on performance and where to seek advice on health issues.

Return to work

6.44. When a health professional returns to work after a period of sickness absence attention to the follow points will help support that individual and protect the safety of patients:

- ensuring the individual has access to appropriate treatment, mentoring and receives follow up care for their condition
- risk management — monitoring for signs of recurrent ill health
- re-skilling of the health professional in his/her field of practice
- rebuilding of the health professional's career — mentoring and support
- reintegration into the workplace — phased return and modifications to prevent relapse
- re-establishing continuing professional development (CPD) — to include recent developments or address identified deficiencies.

6.45. A clearly defined action plan, which covers each of these components, can be helpful for setting out performance objectives, training requirements, health monitoring and supervisory arrangements, as well as the action to be taken if progress is unsatisfactory.

6.46. Health professionals returning to work after a period of sick leave, particularly if it concerns mental ill health, may face negative attitudes from colleagues. In view of this it is helpful if managers are particularly vigilant and advise that bullying or harassment would give rise to disciplinary action.

6.47. There will be times when it is not possible for a health professional to return to work and employers and contractor organisations need clear and well publicised policies in place for the circumstances in which a contract will be terminated or not renewed.

Health professionals with a disability

6.48. Sometimes an individual's scope of practice may need to be restricted as a result of illness or disability, for the protection of patients and in the interests of the individual health professional. It would normally be the responsibility of the individual to agree the changes in job description/environment with his/her employer that would enable him/her to meet the fitness to practise standards set by the regulator.

6.49. If an employer does not provide the necessary adjustments, an individual may be deemed unfit to work. A review of the published evidence carried out by the Nursing and Midwifery Council (NMC) found a mixed picture in terms of the provision of guidance on reasonable adjustments in training and employment.⁸

6.50. Examples of health professionals who have adapted to physical disabilities include a paramedic with a leg mobility problem who takes a job in research, or a biomedical

scientist, who needs to use British Sign Language (BSL), ensuring that a BSL interpreter works with her so that she can communicate with her colleagues.

- 6.51. Health professionals who have enduring mental illness need to continue with ongoing treatment and monitoring. They may also be helped by a reduction in workload, such as working part time, avoiding on-call duties, or reducing the level of their responsibilities.

Tracking health during the transition from undergraduate to postgraduate practice

- 6.52. The small number of undergraduates whose progress has been complicated by illness will need additional help to enable them to make the transition from undergraduate training to postgraduate practice. These are students with illnesses that would normally attract the imposition of undertakings, conditions and supervision if these had come to light after full registration — most frequently, addictions, enduring mental illness and other disability.
- 6.53. Problems can arise for doctors in the years following graduation when the employer, deanery and medical school may each assume that the other has taken responsibility for monitoring a doctor's ill health and its impact on his/her practice. Sometimes, while consistent with fitness to practise, the health problem or disability may require an individual to deviate from a standard working schedule, but this is not communicated to workplace supervisors, rota organisers, trainers and employers. No matter how confident or assertive, the doctor may then drift into isolated working arrangements and so miss out on training, personal support and access ongoing monitoring and treatment of their health.
- 6.54. A clear procedure for handling health issues during this transition period would set out who is responsible for ongoing monitoring of the individual's health, implementing workplace adaptations and for ensuring that arrangements are workable, particularly when an individual is moving into another area. One option would be for university fitness to practise arrangements to have an identified health component equivalent to the medical supervision arrangements required by the regulator for postgraduate health professionals. This medical supervision would continue during the first years of employment. With the agreement of the individual, the medical supervisor would provide reports to the employer's occupational health department and those responsible for postgraduate training. These responsibilities would be replicated at each change of employment during postgraduate training.
- 6.55. The key is to safeguard continuity of clinical care for the individual health professional by recognising that assertive action may be required to ensure confidential transmission of clinical information and in this regard, the medical supervisor's role is crucial. The medical supervisor will also ensure that the individual is accessing suitable on-going treatment for their condition, helping to prevent relapse and worsening of their condition, as was the case for Daksha Emson.

References to Chapter 6

1 The Shipman Inquiry. The Fifth Report of the Shipman Inquiry. Safeguarding patients. Lessons from the past; proposals for the future. Crown, 2004.

- 2 General Medical Council. The meaning of fitness to practise. GMC, 2004.
- 3 Health Professions Council. Information for prospective registrants and doctors. Information about the health reference. HPC, 2007. <http://www.hpc-uk.org/apply/uk/health/index.asp>
- 4 Council for Healthcare Regulatory Excellence (CHRE). Health condition: report to the UK health departments 11/2008. CHRE, 2009.
- 5 Disability Rights Commission. Maintaining standards, promoting equality. Professional regulation within nursing, teaching and social work, and disabled people's access to these professions. DRC, 2007.
- 6 Crawford JO, Shafir A, Graveling R, Dixon K, Cowie H. A systematic review of the health of health practitioners: strategic consulting report. Institute of Occupational Medicine. 2009. www.dh.gov.uk
- 7 Ipsos MORI. Fitness to practise. The health of health care professionals. 2009
www.dh.gov.uk
- 8 Kane A, Gooding C. Literature review: reasonable adjustments in nursing and midwifery. NMC, 2009.

Chapter 7 Further resources

This chapter covers some useful publications and websites that are not included in the references at the end of each chapter.

Publications

Department of Health www.dh.gov.uk

Religion or belief: a practical guide to the NHS. 2009.

Health care workers and blood-borne viruses. Background note. April 2009. (Infectious Diseases and Blood Policy Branch)

Improving health and work: changing lives. 2008 (government's response to Dame Carol Black's review).

Health Professions Council www.hpc-uk.org

A disabled person's guide to becoming a health practitioner. 2006.

Health and Safety Executive www.hse.gov.uk

The costs to employers in Britain of workplace injuries and work-related ill health in 2006/6 2008

Improving efficiency and productivity by managing attendance and work-related stress 2007

Ipsos MORI www.ipsos-mori.com

What matters to staff in the NHS: Research conducted for the Department of Health. Ipsos MORI 2008

National Institute for Health and Clinical Excellence www.nice.nhs.org

Promoting mental wellbeing at work 2009

Alcohol dependence and harmful alcohol use 2009

Promoting mental wellbeing through productive and healthy working conditions: guidance for employers 2009

NHS Employers www.nhsemployers.org

Line Managers' Resource: A practical guide to managing and supporting people with mental health problems in the workplace 2007.

The health workplace agenda (Briefing 56). Guidance for employers. 2008

The management of health, safety and welfare for NHS staff. 2005.

Mental health and employment in the NHS. 2008. (Update of DH guidance from 2002)

The healthy workplaces handbook. The NHS reference guide to staff wellbeing.

www.healthyworkplaces.org.uk

Occupational Health and Clinical Effectiveness Unit www.rcplondon.ac.uk

Back Pain Executive Summary 2009.

Depression Screening Executive Summary. 2009.

Peninsula Medical School www.pms.ac.uk

Avoiding long-term incapacity for work: Developing an early intervention in primary care 2007

Price WaterhouseCoopers www.pwc.co.uk

Building the case for wellness (economic and business case) 2008.

Royal College of Physicians www.rcplondon.ac.uk

Working the night shift: preparation, survival and recovery. A guide for junior doctors. 2006

Royal College of Psychiatrists. www.rcpsych.ac.uk

Mental Health and Work. 2008

Other relevant published research

Watson R, et al. Nurses over 50: options, decisions and outcomes. Policy Press, 2003.

Iversen A, Bruno Rushforth, Forrest K. The competent novice How to handle stress and look after your mental health. British Medical Journal 2009; 338: 1139-42.

Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the health care provider “second victim” after adverse patient events. Quality and Safety in Health Care 2009; 18: 325-30.

Websites

Association of Anaesthetists of Great Britain and Ireland

www.aagbi.org/memberswellbeing.htm

Association of National Health Occupational Physicians

www.anhops.com

British Doctors and Dentists Group

www.bddg.org

Docs for Docs BMA Counselling and Doctor Advisor Service

www.bma.org.uk/doctorsfordoctors 08459 200 169

Doctors Support Network

www.dsn.org.uk ; contacts: chair@dsn.org.uk or info@dsn.org.uk

Expert Patients Programme

www.expertpatients.co.uk

Faculty of Occupational Medicine

www.facocmed.ac.uk

House Concern for Doctors and Dentists (Northern Deanery)

mypimd.ncl.ac.uk/PIMDDev/pimd-home/lead-employer-trust/house-concern

Individual Placement and Support (IPS): support for NHS managers to employ staff with mental health problems

www.scmh.org.uk/employment/supported_employment.aspx

Listening Friends for pharmacists

www.pharmacistsupport.org/listeningfriends.asp

MedNet for doctors and dentists (London)

www.londondeanery.ac.uk/var/career-planning-personal-development/MedNet

Mindful Employment Practice Resource List. 2008.

www.mindfulemployer.net

National Clinical Assessment Service (NCAS)

www.ncas.npsa.nhs.uk

NHS Plus

www.nhsplus.nhs.uk/

Pharmacist Support

www.pharmacistsupport.org

Practitioner Health Programme for doctors and dentists (London)

www.php.nhs.uk/

Royal College of Nursing, support services for members

www.rcn.org.uk/support/services

Royal College of Psychiatrists, Psychiatrists Support Service

www.rcpsych.ac.uk/member/psychiatristssupportservice.aspx

Royal College of Surgeons Confidential Support and Advice Service (CSAS)

www.rcseng.ac.uk/support/csas

Royal Medical Benevolent Fund

www.rmbf.org

Sick Doctors Trust

www.sick-doctors-trust.co.uk

The Medical Council on Alcohol

www.m-c-a.org.uk

The Individual Support Programme for doctors (Wales)

www.cardiff.ac.uk/psych/cpdr/isp/index.html

Unison

www.unison.org.uk/benefits/index.asp

Annex A - Group Membership

National Working Group (known as the Reference Group)

Professor Alastair Scotland (Chair)	National Clinical Assessment Service
Ms Gail Adams	UNISON
Professor Louis Appleby	Department of Health
Professor Dame Carol Black	Department of Work and Pensions
Ms Frances Blunden	WHICH?
Ms Sheelagh Brewer	Royal College of Nursing
Mr Ian Brownhill	The Prince's Foundation for Integrated Health
Dr Harry Burns	Scottish Executive Health Directorate
Dr Peter Carter	Royal College Nursing
Ms Margaret Coats	General Chiropractic Council
Mr Peter Coe	General Optical Council
Dame Catherine Elcoat	NHS East Midlands
Dr Rosemary Field	National Clinical Assessment Service
Dr Helen Flacon	Oxford Deanery
Ms Kathryn Fodey	Northern Ireland Department of Health, Social Services and Public Safety
Dr Anthony Garelick	MedNet, London Deanery
Ms Kellie Green	General Osteopathic Council
Mr Anthony Halperin	Patients' Association
Professor David Haslam	Care Quality Commission
Professor Sheila Hollins	Royal College of Psychiatrists (UK)
Professor Elizabeth Kay	Peninsula College of Medicine and Dentistry
Ms Mandie Lavin	The Royal Pharmaceutical Society
Ms Rosemary MacAlister-Smith	Council for Healthcare Regulatory

	Excellence
Dr Ewan Macdonald	SALUS Occupational Health
Mr Hew Mathewson	General Dental Council
Ms Karen Middleton	Department of Health
Dr Vivienne Nathanson	British Medical Association
Professor Elisabeth Paice	Conference of Postgraduate Medical Deans
Dr Mike Peters	Doctors for Doctors Unit, British Medical Association
Mr Paul Philip	General Medical Council
Dr Sian Rees	Department of Health
Ms Susie Sanderson	British Dental Association
Dr David Snashall	Faculty of Occupational Medicine of the Royal College of Physicians
Ms Elaine Stevenson	National Clinical Assessment Service
Mr David Stout	NHS Confederation
Professor John Strang	Institute of Psychiatry
Ms Sally Taber	Independent Healthcare Advisory Services
Mr Julian Topping	NHS Employers
Ms Martine Tune	Nursing and Midwifery Council
Dr Anna van der Gaag	Health Professions Council
Mr Peter Ward	British Dental Association
Dr Jean White	Welsh Assembly Government
Dr Patricia Wilkie	Academy of Medical Royal Colleges
Ms Sonja Wolfskehl	Nursing and Midwifery Council

Technical Group for the Health of Health Professionals

Professor Alastair Scotland (Chair)	National Clinical Assessment Service
Ms Maree Barnett	Department of Health
Dr Rosemary Field	National Clinical Assessment Service
Mr Karl Norwood	Department of Health
Ms Florence Starr	National Clinical Assessment Service
Ms Elaine Stevenson	National Clinical Assessment Service
Ms Caroline White	Medical Journalist

Annex B – Contact Details for Health Professions Regulators

Regulator	Telephone Advice Line /e-mail	Relevant Website Pages
Nursing and Midwifery Council	Triage Team 020 7462 5800 or Email: fitness.to.practise@nmc-uk.org .	http://www.nmc-uk.org/aArticle.aspx?ArticleID=3023
Health Professions Council	Fitness to Practise Directorate 020 7840 9814 Email: ftp@hpc-uk.org	http://www.hpc-uk.org/complaints/making/
General Chiropractic Council	0207 713 5155 Email: enquiries@gcc-uk.org	GCC: The General Chiropractic Council
General Medical Council	Registration Enquiries Team 0161 923 6602 Email: mailto:registrationhelp@gmc-uk.org	http://www.gmc-uk.org/guidance/index.asp
General Dental Council	Registration Team 0207 344 3740 or Email: mailto:ProfessionalStandards@gdc-uk.org	http://www.gdc-uk.org/General+public/Reporting+unfitness+to+practise/Who+can+help.htm
General Optical Council	Registration Team 0207 357 6655 or Email: mailto:goc@optical.org	http://www.optical.org/en/our_work/Investigating_complaints/index.cfm
General Osteopathic Council	Help Line Advisors 0207 357 6655 or Email: mailto:info@osteopathy.org.uk	http://www.osteopathy.org.uk/information/complaints/
Royal Pharmaceutical Society of Great Britain	Information Advisory Services 0207 572 2302 or Email: mailto:infopharm@rpsgb.org	http://www.rpsgb.org/informationresources/advisoryservices/
Pharmaceutical Society of Northern Ireland	Registrar 028 903 26927 or Email: mailto:brendan.kerr@psni.org.uk	http://www.psni.org.uk/professionals/fitness-to-practise-hearings/fitness-to-practise.php#Health

Note on Impact Assessment

The Department of Health welcomes the report from the Health of Health Professionals Reference Group and will give careful consideration to the recommendations contained within.

The Department has decided that an Impact Assessment or an Equality Impact Assessment, is unnecessary on the basis that the report is advisory and Ministers are not committed to supporting any of the recommendations at this time.

If Ministers decide to take forward some or all of the recommendations from the report, then the Department will ensure any policy decisions are robustly impact assessed from both a financial and equality perspective.