







NHS PRACTITIONER HEALTH PROGRAMME

REPORT ON THE TWO YEAR PROTOTYPE SERVICE

OCTOBER 2008 – SEPTEMBER 2010

PRACTITIONER HEALTH PROGRAMME (PHP): DECEMBER 2010 1ST EDITION

Prepared by the Practitioner Health Programme and the London Specialised Commissioning Group

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1 Executive summary

1.1 Headlines (October 2008 – September 2010)

Figure 1: Headlines at 24 months

General

- 405 practitioner-patient presentations
- 54% men, 46% women
- 92% doctors, 5% dentists and 3% other health professionals
- Age range 24 68 years, more younger women and older men.

Employment

- 70.4% of practitioner-patients remained in or returned to work after contact with the service
- At presentation 217/405 (54%) working, 178/405 (44%) not working, 10 no information or N/A
- 27% at presentation involved in some form of regulatory or disciplinary process.

Problems diagnosed – all diagnoses

Practitioner patients have often presented with co-morbidities, most commonly mental health and alcohol problems

- 359 (69%) mental health diagnoses
- 134 (24%) addiction diagnoses
- 57 (10%) physical health diagnoses.

| Mental health | Addiction | Physical health |
|--|--|--|
| Depression 46% Anxiety and depression 9% Anxiety 7% Undiagnosed psychosis 9 patients Other 18% e.g. OCD, ADHD. | Alcohol problems/ dependence 68% of addiction diagnoses 61 men, 30 women Substance misuse , including ketamine, heroin, cocaine, amphetamine, cannabis | 41 patients: problems included cancer, deafness, MS, brain injury. |
| | • 30 men, 9 women. | |
| Curre | ent snapshot at 30"' Sept | 2010 |
| Mental health | Dependence on | alcohol or drugs |
| • 15 patients have needed inpatient admissions for affective disorders over 17 episodes of care. | 71% abstinent at current time and attending PHP regularly 6% on maintenance or detox 22% currently drinking/using drugs. | |

1.2 Outcomes

We are able to report favourable outcomes with respect to:

- improvement in mental health and social functioning
- numbers returning to work/training
- reduction in potential risk to patients and the public
- regulatory involvement; for example, amendments to GMC/GDC conditions
- cost effectiveness and financial benefits of the service.

1.2.1 Health status of patients

Outcome measures, using validated questionnaires both pre and post treatment, are being kept on all patients. Early analysis indicates significant, sustained improvements in all domains measured, details of which are provided in Chapter 6.

1.2.2 Numbers returning to work/training

At presentation around half of the practitioner-patients are currently working. After contact with the PHP service this number increases to around 70% of all practitioner patients. This figure is based on a snapshot of the caseload at 30th September 2010 and includes status on discharge.

1.2.3 Reduction in risk to practitioner-patients and their patients

- Over 20 practitioner-patients advised to self report to the GMC/GDC
- Over 25 practitioner-patients removed themselves from the workplace on advice from PHP
- Significant events analysed and resolved by the PHP team with learning shared as appropriate
- As at 30 September 2010, 42 practitioner-patients were classified as high risk (red), 43 as medium risk, (amber) and 220 as low risk (green) making a total of 305 (see Section 3.4 for explanation of risk assessment). 100 patients of the 405 seen through the PHP service been discharged as treatment was complete or had been referred back to routine NHS care.

1.2.4 Positive outcomes in relation to the regulators and other disciplinary or legal processes

Practitioner-patient involvement with PHP has been influential with the regulators and the legal system. For example, a patient who entered PHP through self-referral was given undertakings by the regulator, rather than conditions or a suspension, as a direct result of their involvement with PHP. The regulator saw their engagement with the service as evidence of insight into their condition and commitment to treatment. In three cases, judges made reference to PHP support and advocacy prior to handing out non-custodial sentences to practitioners who were attending PHP for treatment.

1.2.5 Cost effectiveness and financial benefits

Maintaining practitioner patients in work and enabling return to work in a timely way has been demonstrated to save organisations considerable sums in sickness pay and locum cover.

- Sickness absence costs the NHS £1.7 billion each year and presenteeism (coming to work and performing at less than full capacity) has been estimated to cost at least one and a half times this amount.
- The costs of London doctors and dentists who fall ill to the NHS is estimated at £23m a year in terms of sick leave, suspensions and cover for everyday duties:

- Suspensions owing to ill health cost £5.5m a year over and above salary
- $\circ~$ Dealing with cover for general practitioners on sick leave amounts to £900,000 a year
- Sick leave among hospital medical and dental staff is estimated to cost an annual £16.8m
- PHP was funded through a block contract of £1.6m in the first year. The estimated cost of mainstreaming this service for patients resident in London is about £1m per year (around £32,000 per PCT). The cost of excluding one doctor from work for seven weeks is £29,000.
- One Medical Director in London estimated that the PHP service has resulted in associated savings of half a million pounds in his organisation.

An independent survey carried out by Opinion Leader identified that positive impact of the service was seen to be high and the impact on trusts has been beneficial. It was also identified by some trusts that:

- the impact on Occupational Health is highly positive and could alleviate pressure on this sector in the future
- the cost of health professionals out of work is reduced and should continue to reduce in the future as more preventative care is carried out
- the improvement in patient safety is also significant.

1.2.6 Health and Social Care Awards 2010

This year PHP won the London Mental Health & Wellbeing category of the Health & Social Care awards and received special commendation at the national awards. There were over 1500 applicants for the awards. This represents a significant achievement for a localised service dealing with a small cohort of patients.

1.3 Patient satisfaction

The improvement and satisfaction rates of the practitioner–patients receiving care are consistently high and increase over time the longer the patients are involved with the service (See Chapter 7).

The Opinion Leader independent survey also identified that for service users overcoming their health concern was seen be the greatest benefit, as well as helping to increase confidence and allow independence to cope without the support of the PHP. Those with experience of the different stages of the service also identified a positive impact of the support which enabled them to return to work.

PHP consistently receives positive written and verbal feedback from practitioner-patients and their families.

2 Introduction

2.1 Report outline

This report has been prepared to give an overview of the two year prototype period of the PHP service and provides a review of the service's activity, patient profiles, patient satisfaction and commissioning data. It also includes a review of activity that took place over the two year period, from October 2008 through to September 2010. It is hoped that this report will demonstrate that a service like PHP is beneficial to patients and the public both in terms of health outcomes and financial benefits and will enable commissioners and planners to consider whether similar services could be provided in other parts of England and the United Kingdom. This report has been prepared by PHP and the London Specialised Commissioning Group (LSCG) for the Department of Health, London stakeholders and other parties interested in the progress of PHP.

The chapters in this report cover the following areas:

- the commissioning and governance of the service
- a description of the service
- the volume of services provided
- the demographic profiles of practitioner-patients, their morbidity and treatment
- the health status of patients
- patient satisfaction and experience of the service
- impact, cost and benefit analysis
- the costs of the service
- learning from the prototype and next steps.

2.2 Why do doctors and dentists need a specialist service?

Doctors make poor patients. For many reasons doctors and dentists do not seek help when unwell, this especially so where their problems are related to mental health or addiction.

The Chief Medical Officer report on medical regulation *Good doctors, safer patients* (2006) was the starting point for the development of PHP. Doctors and dentists (practitioners) can face a number of barriers when dealing with health difficulties, particularly mental health and addiction problems. For example:

- the insight of sick practitioners into their condition and the impact that it has upon their performance may be severely compromised
- illness in practitioners may be poorly managed and appropriate assistance may not be sought for a variety of reasons
- practitioners may be able to disguise their illness from others (perhaps through selfprescription)
- where illness is recognised to adversely affect performance, there may be a reluctance to refer a practitioner into a system that is perceived as "disciplinary", particularly where there is a lack of knowledge as to alternatives
- excessively stressful work environments may have a significant impact on a practitioner's health and wellbeing.

In addition, practitioners may not access mainstream services for a variety of reasons, including an unwillingness to admit to illness, concerns about confidentiality, opportunities for selfmedication and inappropriate treatment when they do access services (National Clinical Assessment Service (NCAS), 2007). Studies show high rates of depression, anxiety and substance misuse in healthcare professionals, especially doctors. Suicide is higher in doctors and dentists than in the general population (Harvey et al., 2009).

The prototype service demonstrates that doctors and dentists will make use of a specialised service, often after long periods of self care or without any professional input to their illness, sometimes at a crisis point. Over the two year prototype period PHP has seen health professionals contacting the service at increasingly earlier stages of their ill health, seeking confidential and practical support to get them well and back to work safely and effectively.

2.3 Commissioning and governance

2.3.1 **Procurement and selection of preferred providers**

During 2007 – 2008, NCAS worked with LSCG to commission the PHP1 prototype service, the first NHS practitioner health programme working to this model in the UK. Following a competitive tendering process, NCAS and LSCG selected the Hurley Group, an NHS GP practice, to run the prototype. Following the appointment of the Hurley Group to provide PHP1 services, a competitive process identified the PHP2 specialist providers to provide mental health and/or addiction services to PHP practitioner patients, with referrals to these providers made by PHP1 practitioners. The four preferred providers were identified as:

- South London & Maudsley NHS Foundation Trust
- Tavistock & Portman NHS Foundation Trust
- Capio Nightingale Hospital
- Clouds House, Action on Addiction.

This model proposed two services, working together but with distinct identities. PHP1 was to be first contact service providing initial assessment and brief intervention care, with referrals made to PHP2 "preferred providers" for more intensive psychological care and treatment. The bridge between the two services was to be maintained through case-management. As will be discussed later in this report, and in keeping with many successful primary care models, a more integrated service, with primary care and specialist practitioners working closely together was actually established.

2.3.2 Governance arrangements

The Medical Director of PHP1 is responsible for the service and for all patients seen by other PHP1 practitioners. Clearly, as with any multi-professional team, each member of the team conducts their practice according to their regulatory and clinical governance framework.

This includes

- Engaging in continuing professional development
- Engaging in clinical audit
- Engaging in appraisal and any requirements for revalidation/re-accreditation
- Undergoing clinical supervision as required
- Participating in multidisciplinary team meetings
- Adhering to Hurley Group policies and practices.

Given the confidential nature of the PHP service, early on it was important to develop a number of bespoke policies and practices. These included

- In-Case-Of-Emergency policy
- Did-not-attend policy
- Memorandum of Understanding with GMC and GDC

- Confidentiality agreement with practitioner patients to cover consultation processes with bodies such as GMC, GDC, Occupational health and general practitioner
- Information sharing guidance between PHP1 and PHP2 providers.

2.3.3 PHP1 reporting arrangements

PHP1 reports on operational and significant events (though not providing any identifiable patient information) through the Prototype Management Group, chaired by NCAS, to the Department of Health, and reports to the London Specialised Commissioning Group (LSCG) for contractual and financial matters. The Prototype Management Group meets monthly to discuss progress, risk and future developments. This group includes representatives of PHP1, LSCG and the Department of Health, and has access to independent clinical advisors. In addition, PHP service reports to the Hurley Group management Board on a monthly basis, with reports covering significant events, finance, staff and other operational issues.

A Stakeholder Advisory Group provides expert advice on the development of the PHP to ensure that the service meets the requirements of key stakeholders including regulators, professional bodies, potential users of the service, the public and the Department of Health.

Other contributions are sought according to need.

Figure 2: Commissioning/governance arrangements for the PHP Prototype



2.4 **PHP London prototype – features of the service**

2.4.1 Overview

PHP provides healthcare services to a population of around 30,000 doctors and dentists living or working in the London area and treats those with a mental health or addiction problem at any level of severity, or a physical health problem which may impact on performance. The service encourages effective use of occupational health, local primary care and other specialist services where these are available. It is designed to complement existing services and can be used as a specialist resource for clinicians treating doctors and dentists outside PHP, including occupational health physicians.

2.4.2 Accessing PHP

Practitioners with health concerns can contact the service directly for advice or for consultation and treatment. Patients are offered an appointment within two working days.

The PHP also provides advice to health care organisations employing or contracting with doctors and dentists, to Deaneries and Royal Colleges, also to colleagues, family and friends of practitioners with health problems. Employers or occupational health departments may make referrals with the knowledge and consent of the doctor or dentist concerned.

2.4.3 Confidentiality

Providing appropriate assurance to practitioners about confidentiality has been a key feature and contributed to the success of the prototype service. Practitioners accessing the service ("practitioner-patients") can expect the same or higher level of confidentiality as other patients accessing health services. Disclosure of information to another body is only made in those rare circumstances where there is a serious concern about the safety of the practitioner-patient, their patients or the public, or where there is concern about criminal activity. The prototype service has benefited from a designated GMC contact through the London GMC Affiliate pilot to talk, in principle, about health cases where there may be fitness to practise issues. The PHP has memoranda of understanding with the GMC and GDC and these, along with its confidentiality policy, are posted on its website.

From the outset of the service practitioner-patients were offered the opportunity to use a pseudonym if they preferred. This is often taken up at initial contact or for telephone triage although full details are provided at a later stage once treatment commences. On occasions it has been necessary to use a patient pseudonym internally when dealing with cases where a PHP clinician has prior knowledge of a practitioner-patient in a non PHP capacity.

Referrals processes and invoicing systems use only a patient number identifier and all electronic communications also rely on this reference number. The clinical records are stored on a separate IT system which is password protected for PHP staff.

A number of referrals arose from practitioner-patients referring their own practitioner-patients to the service, or where practitioner-patients advised practitioner friends/relatives to attend. These examples created complexity with respect to boundaries (for example, having to speak to patients about their own patients) as well as having to ensure that practitioner-patients who might know each other were not given appointments in close proximity to each other.

2.5 How the programme was developed

The Royal College of Psychiatrists and the London Deanery formed an expert working group assisted by NCAS to develop proposals for a Practitioner Health Programme during 2006 - 07. This was in response to CMO's 2006 report. Following the White Paper, *Trust, Assurance and Safety – the Regulation of Health Professionals in the* 21^{st} *Century* published in February 2007, the Department of Health tasked NCAS with overseeing the commissioning and implementation of a prototype PHP.

The commissioning process was carried out in two stages – initially to select the provider for the PHP1 service and then separately to select the preferred providers for onward specialist referral, known as PHP2.

After successfully winning the bid to provide the service in May 2008 the Hurley group began planning for the launch of the programme in September 2008, recruiting appropriate staffing, putting in place the policies, procedures and resources that would support the service. This included kitting out appropriate rooms within the GP surgery where PHP was to be housed, setting up a separate server and IT system to ensure complete confidentiality for the practitioner patients using the service, developing procedures for anonymised financial controls and preparing a range of promotional material to raise awareness of the PHP service, including a detailed website.

The promotional materials were developed with a common PHP brand and NHS logo and distributed to each hospital and Trust site (including the independent sector) across London and the PHP team gave a number of presentations and interviews across London to promote the service. The website was developed to include a range of information to prospective patients and employers and signposting was put in place to other supportive services.

Early discussions took place around the minimum data set that would be recorded for each patient and contact to enable a full evaluation and review of the prototype. This data included demographic and professional details including specialty. Each patient contact has been recorded on an integrated IT system providing a complete record of the care received and referral and financial control records were also put in place to allow analysis of costs against care received.

2.6 Evaluation

A comprehensive programme of evaluation has measured

- patterns of use self-referrals and referrals, demographics of those accessing the service and the range of health problems. The programme is using a dataset which should enable some comparison with physician health programmes in other countries
- service user satisfaction seeking the views of users with regard to how far the service has met their needs and how it can be improved
- practitioner-patient outcomes assessing impact and outcomes. This involves, for example, collection of information about health status through questionnaires at onset of treatment and intervals during treatment and follow-up. The possibility of some economic evaluation is being considered.

This evaluation report of the prototype service summarises the findings to date. The report will be available to commissioners and policy makers and will help inform decisions about possible extension of the service.

2.7 Funding and extension

Funding was provided by the Department of Health for a two year London prototype service, for both PHP1 and PHP2. Funding was provided for the period September 2008 to August 2010, although savings made during the two year prototype have been used to keep the service running for longer. Initial cost benefit analysis shows that treatment through PHP is both safer and cheaper than traditional ways of dealing with sick doctors and dentists – the latter often involves long periods of time off sick on full pay with associated management and locum costs for their organisation.

Significant savings were made by integrating the work of the PHP1 and PHP2 providers into one core team and service provision, "PHP Plus". This allowed for block contracts with PHP2 providers (in so much that PHP2 practitioners were seconded to PHP1 integrated team on a sessional basis).

The sharing of case records, regular review through multidisciplinary team discussions and joint consulting and care plans has reduced the need for onward referrals and saved money, allowing the prototype to be in place for longer than originally envisaged.

There has been a high level of interest in the PHP service, given the positive outcomes, cost benefits and feedback. The programme has the potential to be extended to other areas of the country, to undergraduates and to other health professionals. Discussions have been initiated with SHA areas around London over access to PHP in the longer term. Other areas of the UK have also been considering how similar services could be set up and the specification for the service has been shared with colleagues in England, Scotland, Wales and Northern Ireland.

A paper was submitted by NCAS to the Chief Medical Officer in 2009 setting out options for extension to other parts of England. These include one or two additional PHP hub services, with a network of suitably trained and experienced GPs and occupational physicians working across England, supported by and able to refer to a PHP. The proposal was well received but to date no

firm commitments have been made by commissioning bodies to funding additional PHP type services.

The London PHP identified particular difficulties that some practitioner patients were having in finding doctors willing or able to take them on as patients within the NHS and in 2009 funding was secured for the Royal College of General Practitioners, Royal College of Psychiatrists and Faculty of Occupational Medicine to develop a set of core competencies for their doctors providing care to fellow health professionals. These competencies have now been developed and all three professional bodies are developing training courses and accreditation programmes to ensure a network of suitably trained individuals to provide ongoing care to practitioner patients.

2.8 References

NCAS (2007). Proposal for a Practitioner Health Programme.

Harvey, S. B., Laird, B., Henderson, M., Hotopf, M. (2009). The mental health of healthcare professionals: A review for the Department of Health.

3 The service

Key Points:

An integrated multidisciplinary team crossing primary and secondary care services enables amore effective approach to patient care.

A clinical governance framework has enabled the team to discuss cases and events, reflect on user feedback, identify and manage potential risks and to learn from one another to develop the service.

Low cost, low input additional services such as group work and financial advice can make a big difference to health and wellbeing outcomes.

3.1 Introduction

The initial commissioning intentions were that PHP would comprise of two distinct services, PHP1 and PHP2, working closely together. PHP1 was intended to be a first contact service offering assessment and limited therapeutic intervention – and PHP2 a secondary care service, involving a number of preferred providers offering a range of specialist outpatient, inpatient and day care services.

From the outset, The Hurley Group preferred an integrated approach to service provision, such that the service included a core team of generalist and specialist practitioners working together, on the same site, using the same electronic record and meeting weekly to discuss all new cases and problems. This integrated team was known as PHP Plus. To complete the PHP service, a number of preferred PHP2 external preferred providers were identified through a competitive tendering process. The PHP integrated team and the PHP2 external providers were drawn from the same pool, such that there was a seamless service for patients, irrespective where they received their care.

3.2 A brief description of the integrated PHP service at Riverside Medical Centre

PHP is led by Dr Clare Gerada, a general practitioner with expertise in mental health and addiction. The service is embedded within a "normal" general practice, though has its own administrative, medical, nursing and management team, computer server and consulting areas.

PHP is a confidential service, except where the practitioner-patient poses a serious risk to themselves or to their patients: in these circumstances, PHP reserves the right to disclose to relevant third parties (see paragraph 2.4.3 for further details).

PHP provides an integrated approach to care, with primary, secondary and third sector practitioners working alongside each other, sharing electronic records, consulting rooms, and learning events. Once a week all team members meet to discuss new patients and review complex patients and discharges. This integrated multidisciplinary team meeting allows for sharing of information and treatment planning, with each member of the team complementing other team members' skills to bring about the best outcome for the practitioner-patient.

PHP is not an occupational health service, but does liaise with occupational health. The service provides assessments with respect to work place and supports return to work planning and implementation. PHP receives a number of referrals from occupational physicians.

PHP aims to be as accessible as possible, offering appointments within two days of first contact. Patients are offered an appointment time that best meets their needs (from 7.30 am - 6.30 pm

Monday to Friday and 9.00 am - 1.00 pm on Saturday), and with the health professional that best meets their condition (assessed during the first telephone triage contact). There is no waiting list to see a PHP integrated practitioner.

PHP offers the following:

- Confidential first contact by telephone or email including assessment and signposting
- first contact assessment, formulation and treatment planning
- multi-professional approach to care
- brief intervention, cognitive behaviour therapy, relapse prevention, psychodynamic psychotherapy, family therapy, couples-therapy, including NHS-Direct telephone Cognitive Behavioural Therapy (CBT)
- community based detoxification and access to inpatient alcohol detoxification
- substitute medication for opiate addiction
- therapeutic blood, urine and hair testing
- access to inpatient care
- access to inpatient rehabilitation
- massage and osteopathy
- work related CBT, with a focus on return to work strategies
- mentoring and specialist appraisal
- report writing
- case management
- contact with GMC / GDC supervisor
- support for attendance at GMC / GDC hearings
- attendance at employment tribunals or other work-related hearings
- direct liaison with defence organisations / Barristers / Solicitors / BMA representatives
- financial advice, via outreach from the Royal Medical Benevolent Fund
- contract and working partnership advice
- support to family, friends and carers.

3.3 PHP2

Patients may be referred from PHP1 to PHP2 services. PHP2 consists of specialist mental health and addiction services providing assessment and treatment for those who need outpatient, inpatient or rehabilitation care. These services are predominantly provided by South London and the Maudsley (SLAM) NHS Foundation Trust, the Tavistock and Portman NHS Foundation Trust, Capio Nightingale Hospital and Clouds House, Action on Addiction. Exceptions are made based on a number of factors, for example: when a practitioner-patient is already seeing a particular health professional for continuity of care; the practitioner-patient needs specialist treatment from a known expert; geographical access within working hours; or assessment and treatment for a physical health problem.

Figure 3: Movement through the PHP1/2 integrated service – first contact to treatment



3.4 Governance for quality of clinical care

The PHP service has considered clinical governance to be fundamental to its ability to deliver high quality services. All members of the PHP team have participated in a range of activities to ensure the care delivered is safe, of a consistently high quality, puts the patients first and is constantly improving. This has included opportunities to seek out and report back patient views and feedback, highlight concerns about standards of care, share and learn from their own and colleagues experiences and to monitor potential risks and learn from incidents.

| rship, Ind tion | The PHP team has operated on a fairly flat hierarchy meaning that every member has had a role to play in demonstrating the value placed on quality. |
|--|--|
| Culture: leade teamwork a communicat | Regular opportunities have been built in for team members to meet, communicate and tangibly support one another in issues around delivery of care and strategic delivery of the service. This has included regular multidisciplinary discussions and reviews, opportunities for shared learning and reflective practice and all team events for strategic development and training. |
| Risk management, patient safety and incident reporting: | A preliminary risk assessment was carried out at the start of the prototype period with contributions from within the PHP team and from wider stakeholders. This included the particular difficulties that may be encountered in delivering a service to particularly vulnerable patients and in treating patients outside of the main site such as visits to the home or workplace, as well as risks to the reputation of the service or to the organisations involved in delivery. A risk assessment process was put in place for all practitioner patients with the multidisciplinary team grading them as red, amber or green (RAG) dependent on their current health status and potential risk to themselves or others. Each patient has been allocated a case manager, together with a supporting clinician and their RAG rating informs the level of follow up and contact between scheduled appointments. Those patients assessed as high risk (red) are reviewed weekly, medium risk (amber) fortnightly and others (green) at least once a month. PHP has put in place reporting processes to identify and learn from any incident encountered across the range, such as human error, complexity or lack of uniformity in process design or record keeping or information deficiencies. All incidents will be assessed for cause and action agreed to either remedy or minimise the risk of a future occurrence. Incident reports, assessment and agreed actions have been shared with all team members and where appropriate have been available for external assessment. |
| Feedback and involvement from users and stakeholders | PHP has been active in seeking out the views of both patients and stakeholders. All patients have been assessed at the outset and their expectations defined using a range of questionnaires. At regular stages a user satisfaction assessment has been carried out to inform the external evaluation. PHP has a large log of positive feedback from patients, their families and their employers. The PHP team has participated in regular communications and networking events with stakeholders to seek feedback and to develop the service. A formal complaints process was put in place, however throughout the prototype period PHP has not received any formal complaints from patients. Some constructive feedback has come from both patients and healthcare organisations which have helped to inform the service development. |
| Clinical and service outcomes | The PHP team have a wide range of knowledge, derived from research, clinical expertise and experience of patient treatments on which care models have been based. In addition members of the team have been actively involved in ongoing research and assessment of further evidence and information as it is published and to implement and change clinical practice as a result. The external evaluation process is providing an ongoing assessment of the clinical and service outcomes and specific clinical audit topics have been identified as a result of the service delivery model e.g. prescribing |
| Education, training and supervision | All team members have participated in regular appraisal and continued professional development from a varied range of sources including personal research, training and networking events and by seeking input from colleagues in similar roles. All specialist staff have had supervision arrangements in place in order to develop supportive colleague relationships and to provide the opportunity for reflection on their own practice. The PHP service has joined the European networking group for practitioner health services (EAPH) to gain a wider understanding of service models and outcomes elsewhere. |

3.5 External advice and input

The PHP service has identified a range of external bodies and individuals who have been able to support the prototype throughout the two years of operation. Some of these include:

- The GMC and GDC constructive working relationships have been built up following the development of the memoranda of understanding which have allowed for anonymised case discussions and agreement over handling of individual cases. PHP has particularly benefited from the input of the pilot GMC affiliate role and from regular shared learning events with the regulators resulting in changes to operating principles for both parties. For example the GMC initiated a review of written communications to doctors suffering health problems undergoing investigations
- RCGP, RCPsych and FOM the three professional bodies have welcomed the need to identify and develop the core competencies for doctors who treat fellow health professionals and the training programmes for the first cohort of doctors have started
- Royal Medical Benevolent Fund the provision of a money advice service for patients with monetary difficulties or concerns offered by Jeff Brown has been hugely beneficial to individuals but has also identified areas of learning and development for both PHP and RMBF
- Witness and Gwen Adshead training and awareness raising both for PHP staff and for individual patients has enabled a better understanding of the difficulties involved in boundary transgressions and the blurred lines within this area
- Work advice by Jean Hassell this has provided an understanding of the employment and partnership difficulties and potential routes to resolution. Issues have centred around reapplications to the Performers list, financial entitlement during absence and "coaching" to resolve workplace difficulties
- Family group The wife of one of our practitioner-patients has set up and facilitated a
 regular support group for other family members and friends to offer advice, the benefit of
 experience and signposting to additional support
- The Stress of Medicine by David Rainham this book and the introduction by PHP has proved extremely useful to PHP patients and in raising awareness of PHP.

4 How many patients have used the service?

Key Points:

The PHP1 service has offered 405 practitioner-patients initial assessments up to end of September 2010. These initial assessments resulted in:

- 398 practitioner-patients undergoing detailed assessment
- 7 patients not attending their first face-to-face appointment. These patients were offered follow up appointments and contacted a minimum of three times.

At 30 September 2010, for the patients presenting in the first twenty four¹ months, PHP1 was providing 305 patients with ongoing treatment and case management / co-ordination – 100 patients were discharged.

4.1 Summary activity to the end of September 2010

A summary of the activity related to the service is shown in Table 2.

Table 2: Summary activity to the end of September 2010 – patient numbers

| Presenting Problems | | |
|---|-----|--|
| Offered initial assessment | 405 | |
| PHP1 in depth assessment | 398 | |
| PHP2 outpatient referrals including those within Integrated Team | 647 | |
| PHP2 inpatient referrals | 93 | |
| PHP1 ongoing treatment & case co-ordination as at the end of September 2010 | 305 | |
| Discharged | 100 | |

4.2 Initial assessments

A total of 405 initial contacts were made with the PHP1 service from mid September 2008 to 30 September 2010. 398 patients attended for initial assessments.

The monthly presentation pattern is shown in Figure 4.

The graph shows that:

- the number of assessments over the months is varied and has been as high as 23 and as low as 6 (in a partially operating month)
- there was a marked increase in presentations January March in both years due to recognised seasonal increases in mental health and addiction issues after Christmas and the New Year.



Figure 4: Initial assessments made by the PHP1 service





5 Patient and service profiles

Key Points:

The PHP service has seen more younger woman and older men although the overall profile for gender and ethnicity appears representative of the London practitioner workforce.

Practitioner-patients have been resident in 30/31 London boroughs and in every SHA in England.

Practitioner-patients have come from a cross section of specialties and grades, however psychiatrists are the highest category in proportion to workforce.

The PHP service has seen an increase in junior doctors over the two year period.

Around one third of all cases relate to addiction, two thirds to mental health issues.

5.1 **Demographics**

5.1.1 Age and sex

The age and sex of PHP patients is shown in Figure 6. The graphs show that:

- more men have attended than women; the split is 54% : 46% just over 40% of the London SHA medical and dental workforce are women, taking GP and Hospital and Community sectors and doctors and dentists together so this is not far from what might have been expected
- 13% are under 30, 32% fall into the 30 39 age bracket and 28% of patients are 40 or over – an age profile which approximately matches the medical and dental workforce in the London SHA area
- the service and associated awareness raising activities have reached a wide age range.

Figure 6: Age and sex distribution of patients





The age and sex distribution of the patients is broken down further in Figure 7. *Figure 7: Age distribution shown separately for female and male patients*



5.1.2 Ethnicity

The ethnicity for patients attending for initial assessments is shown in Figure 8. Since patient numbers are small the Office of National Statistics census categories for ethnicity have been grouped. The five groups shown in Figure 8 are those used by the NHS in classifying the Hospital and Community (though not yet GP) workforces. The graph shows that patients from a wide variety of ethnicities are attending the service. White or white British practitioners account for 61% of the 89% of patients who have stated their ethnicity (360). Lack of GP comparator data rules out precise matching with the London workforce and data incompleteness means that these data should be treated with caution. But with white practitioners known to account for 54 – 60% of Hospital and Community doctors and dentists in England in 2008 (NHS Information Centre) PHP patients are probably reasonably representative of the London practitioner workforce.

Figure 8: Initial assessments: patient ethnicity



5.1.3 Ensuring PHP and its procedures support equality and diversity

PHP has seen a mix of referrals in the twenty four months of operation across ethnicity, gender and age.

As noted above, the ethnicity mix of PHP contacts is very varied with representation from all sectors. Comparison to London population ethnicity data and evidence about the ethnicity of UK doctors shows that PHP is attracting patients from all ethnic backgrounds, and the patient split is in line with what might be expected. Similarly the gender mix is split fairly evenly between male and female. The age mix of PHP contacts appears to show a slightly higher distribution of younger women and older men. However, the younger woman category may also represent a positive finding of PHP accessibility and usage.

5.1.4 Geographical location

The PHP service is available to doctors and dentists who either live or work in the Greater London area. Of the 405 practitioner-patients 290 were resident in the Greater London area. This equates to 72% of the patients seen.

For the remaining 115 practitioner-patients 26% did not live in London, although they did work in the area. 2% did not disclose their address.

This has meant that based on residence the PHP service has seen practitioner patients from every SHA in England and also a small number from Scotland.

Figure 9 below shows the geographical spread of patients who are not resident in Greater London. The information is based on the postcode of the patient's registered address.



Figure 9: Number of patients by SHA of residence (excluding London)

Further analysis of patients resident in London is shown in Figure 10 on the next page.

London patient data shows that

- the geographical distribution of patients providing a postcode is fairly evenly spread across London, with slightly higher numbers appearing to come from South London
- 30 of 31 London PCTs have a practitioner-patient as a resident
- 31 of 31 London PCTs have a practitioner-patient working within the borough.



Figure 10: Number of patients by London PCT of residence

5.1.5 Professional profile

To the end of September 2010, PHP1 undertook 398 initial assessments of doctors, dentists and nurses. The breakdown by profession is shown in Figure 11.

The doctor to dentist ratio in London is around 11 - 1 and dentists were slightly underrepresented in the numbers attending PHP.

Doctors make up by the far the highest number of practitioner-patients in line with expectations but make up more than their proportionate number of professionals working in London. Over the 2 years of operation the proportion of dentists has gradually fallen. The number of dentists as a proportion of initial assessments at 1 year was 8%; across the whole 2 years this proportion has fallen to 5%. Additional awareness raising among dentists was initiated as a result of this drop in presentation. PHP1 agreed to see senior nurses and other practitioners allied to medicine on a

strictly case-by-case basis as the service is not formally open to (and not set up to accommodate referrals from) these professions.

Figure 11: Patients shown by profession



To the end of September 2010 the professional split was:

- 32% GPs
- 5% dentists
- 12% psychiatrists
- 10% foundation trainees.

A further breakdown showing key professional categories is shown in Figure 12.

Figure 12: Initial assessments: breakdown by professional category



NHS Information Centre statistics show that the London target population for doctors and dentists is around 30,000. Around one third of this population is made up of GPs and dentists; the other two thirds being Hospital and Community practitioners. Therefore the proportion of GPs and dentists attending PHP is greater than might be expected given the workforce population. This may suggest that Hospital and Community practitioners have better access to occupational health services.

In addition, it is interesting to note that over the two years of the prototype:

- the proportion of GPs seems to have remained fairly constant at 32% (compared to 37% in year 1)
- the proportion of dentists fell from 8% to 5%
- the proportion of junior doctors presenting has increased from 5% to 10% over the 2 years
- the proportion of psychiatrists was higher than any other secondary care professional category.





5.2 Morbidity and treatment

5.2.1 Presenting problem

 Table 3: PHP1 presenting problems (all diagnoses)

| Presenting Problems | Total | % Total |
|---------------------|-------|---------|
| Mental Health | 359 | 65.3% |
| Addictions | 134 | 24.4% |
| Physical Health | 57 | 10.4% |
| Total | 550 | |

Table 3 shows the number of patients presenting with mental health, addiction or physical health problems. More than half PHP patients present with a mental health problem and 24% present with addiction problems. Please note that practitioner-patients may present with more than one category of problem hence a total of 550 diagnoses for 405 practitioner-patients. This is shown graphically in Figure 14: Patients by diagnoses

Figure 14: Patients by diagnoses



A further breakdown of the two main presenting problems is shown in Figure 15 below.

The results are based on the initial screening cohort of 398 patients where the relevant information was known.

Figure 15: A breakdown of mental health and addiction diagnoses



Figure 15 shows that:

- anxiety and depression account for 62% suffering mental health problems
- alcohol accounts for 68% of all addiction problems.

Under both diagnoses there are considerable percentages shown as 'Various' (18% of mental health diagnoses and 13% of addiction diagnoses). These diagnoses have been grouped together for purposes of anonymity.

PHP has seen a number of doctors and dentists presenting with health problems relating to alcohol and substance misuse.

In addition to psychoactive substances, we have assessed and treated practitioner-patient who have experienced addictive behaviours in other areas which have included: internet gaming and gambling.

PHP has been able to access specialised treatment for these problems, some of which have resulted in the practitioner patient experiencing problems with the Regulator and his/her employer, as often these behaviours have been treated as conduct issues, rather than a health or behavioural problem. Through talking therapies and health advocacy, these patients have been have successfully returned to work, and have either ceased or moderated their problem behaviours.

5.2.2 PHP treatment at Riverside Medical Centre

As shown in Section 3.2, both primary care (general practitioners with special interest in mental health/addiction; nurse practitioners; specialist addiction nurses) and secondary care practitioners (consultant psychiatrists; consultant psychologists) are located at Riverside Medical Centre. Consultations are used to provide:

- first contact assessment, formulation and treatment planning
- brief intervention, CBT, relapse prevention, psychodynamic psychotherapy, family therapy, couples-therapy
- community based alcohol detoxification
- assessment of mental state
- psychotherapy
- motivational interviewing
- ICD-10 diagnosis
- work related CBT, with a focus on return to work strategies
- mentoring
- case management and care planning.

The number of consultations, broken down by quarter, is shown in Table 4 below.

Table 4: Number of PHP1 consultations provided by all GPs and nurses/at 6 month intervals

| PHP1 Consultations | 6 Months | 12 Months | 18 Months | 24 Months | Total |
|--------------------------|-------------|--------------|--------------|--------------|-------|
| Consultations with GPs | 392 | 776 | 750 | 680 | 2598 |
| Consultations with Nurse | 633 | 549 | 899 | 1228 | 3309 |

These numbers are shown graphically in Figure 16 below.

As at the end of September 2010, PHP1 was case managing 305 patients. Case management/case co-ordination includes organising referrals to PHP2 external services, follow-up consultations, attendance at hearings, and liaising with professional bodies and professional carers. The case manager is essentially the co-coordinator of care and the lead clinical contact

for the patient and will undertake regular reviews based on the risk assessment process explained in Chapter 3.



Figure 16: PHP1 Consultations at Riverside Medical Centre

5.2.3 PHP Plus and PHP2 Treatment

A referral is categorised as a distinct appointment being set up between the patient and the provider, and excludes brief discussions, joint assessments, multidisciplinary team meetings and telephone/email contacts.

PHP1 made 740 referrals for 319 patients to PHP Plus and PHP2 services to the end of September 2010; 50% of these referrals were to the integrated PHP Plus provision on site at PHP1. The split between outpatient and inpatient, episodes and individuals is shown below:

The vast majority of referrals (87%) were for out-patient treatment. The average number of episodes of PHP Plus and PHP2 treatment for all practitioner patients is 1.82.

| Table 5: | Referrals to | PHP2 – | showing s | plit between c | outpatient and in | patient |
|----------|--------------|--------|-----------|----------------|-------------------|---------|
|----------|--------------|--------|-----------|----------------|-------------------|---------|

| PHP2 referrals | Provision at 24 months | | |
|-------------------------------|------------------------|--|--|
| Total Outpatient referrals: | 647 | | |
| Outpatient referrals PHP Plus | 370 | | |
| Outpatient referrals PHP2 | 277 | | |
| Inpatient referrals | 93 | | |
| Total (Referrals) | 740 | | |
| Total (Individuals) | 319 | | |

Figure 17 shows the breakdown of PHP Plus and PHP2 referrals by treatment type:

- 26% of all referrals were made to psychiatric specialists for assessment of mental state, advice about medication, diagnosis (ICD-10) or in-depth assessment
- 22% of referrals have been for cognitive behavioural therapy and 8% for traditional psychotherapy
- In-patient referrals account for 12.2% (addiction 9.9% and affective disorders 2.3%)
- PHP developed a fortnightly support group for doctors and dentists with addiction problems

- Referrals for massage and osteopathy were part of a separate pilot initially funded by the Hurley Group. These treatments were separately evaluated and were found to improve wellbeing, reduce stress levels and contributed to improvements in mental health
- A money advice service was provided on a monthly basis, funded by the Royal Medical Benevolent Fund to provide advice to doctors in financial difficulties
- A workplace and employment advice service was provided on site at PHP.

Figure 17 Referrals to PHP Plus and PHP2:



This is further broken down to show referral made to each setting: both on-site PHP Plus provision in Figure 18, and external PHP2 provision in Figure 19.

Figure 18: PHP Plus on site provision:







5.3 Awareness

5.3.1 Awareness of PHP

Where appropriate-practitioner-patients are asked how they heard of PHP and Figure 20 shows what was recorded for patients who provided an answer.



Figure 20: How those making initial contact heard of PHP

5.3.2 Awareness raising activities

During its two years of operation PHP has engaged in a number of awareness raising activities. This has included:

The development of the initial promotional material and a targeted distribution to medical directors and human resources teams,

Creation of the PHP website <u>www.php.nhs.uk</u> with a range of information, signposting and links resulted in more than 40,000 unique visits during the prototype period. The top ten website areas accessed in the last six months were:

- 1. About Us
- 2. Resources
- 3. What does PHP provide?
- 4. If I am dependent on alcohol and approach PHP1 do you have to tell the GMC/GDC?
- 5. London Practitioner Health Programme report on the first 12 months
- 6. How to find us?
- 7. Does PHP replace normal GP services?
- 8. What happens when I come to the appointment?
- 9. Confidentiality.

A range of articles and interviews in medical journals and publications such as BMJ and Medical Council on Alcohol, articles in London press and interviews with the media including Radio 4 and The Times newspaper

Regular meetings and discussion with key stakeholder groups including :

- hosting a session at the RCGP annual conference in 2009 and 2010
- hosting a session at the International Physicians' Health Conference in November 2008 and attending the annual conference of European Association for Physician Health in October 2009 and 2010
- regular meetings with the Primary Care Medical Directors (BAMM) network
- providing articles for Chief Medical and Dental Officer updates
- meeting London Workforce Leads
- meeting London Dental advisors
- meeting SHA Medical Directors and regional networks of medical directors
- meeting with the Royal Medical Benevolent Fund to produce guidance for sick practitioners in financial difficulty
- attending the Medical Council on Alcohol AGM
- attending the GP registrars' event
- attending London Wide Associate In Training events
- meeting representatives from the MDU/MPS/GMC/GDC
- publishing articles, papers in academic and other journals
- participating in ongoing discussions with the Deaneries in London and surrounding areas e.g. Kingston, Surrey and Sussex
- input into the Suicide Prevention Strategy Advisory Group.

Speaking engagements at local, national and international events including:

- NCAS national conference
- BMA Joint Medical Consultants Committee
- The British Doctors and Dentist Group annual conference and academic away day
- Annual LMC conference
- Regular slots on Health care events conferences nationally
- Trent Occupational Medicine forum
- Work and Mental Health conference

- Royal College of General Practitioners annual conference
- 2nd annual London trainee conference
- Staff wellbeing and Medical student awareness sessions at St Georges Hospital
- 14th national conference working with drug and alcohol users in primary care.

5.4 GMC or GDC issues

By the nature of the PHP service, many of the practitioner-patients had been referred to or were about to be referred to their Regulator (GMC, GDC). At the outset, PHP had discussions with the GMC and GDC and developed a memorandum of understanding to cover issues such as confidentiality, information sharing and other issues. This provided PHP clinicians with the ability to discuss cases in confidence with GMC/GDC and provide written reports rather than full disclosure of medical records.

Figure 21 shows the percentages of practitioner-patients who have involvement with the regulator.

Of note, as the service progressed, the numbers of practitioners involved with the regulator at presentation dropped.





5.5 References

NCAS (2006). National Clinical Assessment Service: analysis of the first four years' referral data. *National Patient Safety Agency*.

6 Monitoring the health status of practitionerpatients¹

Key Points:

Patients are improving on the majority of questionnaires and sub-scales at each interval; 52-week follow-up scores show vast improvements compared to baseline scores i.e. patients are experiencing less distress and less impairment of work and social functioning after treatment.

At baseline and 8-week follow-up patients show, on average, greater levels of distress than a non-clinical group but lower distress levels than a clinical sample.

By 26-week follow-up patients are scoring the same as a non-clinical sample on the risk sub-scale.

6.1 Introduction: clinical questionnaires and analysis

All PHP patients complete a number of self-report questionnaires during their engagement with the service (see section 6.2: Method for further details). The PHP research team have used the results of these questionnaires to form a clinical audit of the first two years of the service. Highlights of the findings are included here. A more in-depth review of questionnaire results at assessment is currently being prepared for submission to an academic journal; a further in-depth review of how patients have improved over time is also being undertaken.

At initial assessment, patients complete several questionnaires: the Work and Social Adjustment Scale, the CORE-OM and the FAST. These are then repeated at 8-week, 26-week and 52-week intervals, along with a global improvement questionnaire to assess if the patients themselves feel they have improved as well as their satisfaction with the service. Where there are particular concerns about alcohol/drug use or cognitive functioning, additional questionnaires may be given out, but these are not included in this review due to the small number of patients requiring them.

The clinical questionnaires form an integral part of the clinical consultation, by giving practitioners an idea of how well the patient is functioning in everyday life helping to assess the level of their distress. The follow-up questionnaires provide a helpful measure of how patients are progressing with the service, and whether their ability to function is improving.

This section summarises the clinical characteristics of patients at baseline and at follow-up intervals, exploring whether patients' health is improving during their treatment with PHP.

All data shown and discussed here is presented purely as a review of the service.

¹ Please note that data for this section was collated on October 26th 2010, at which point 420 patients had been registered with the service. Any patients registered after this date and any questionnaires received after this date were not included.

6.2 Method

6.2.1 Data collection

During the initial face-to-face assessment, each patient's age, gender, profession and identified problem(s) are recorded by the practitioner. In addition, patients are asked to complete simple self-report questionnaires (described below) which measure the severity of their distress and their ability to participate in everyday life. All patients are also asked to complete a short alcohol screening test. Where there are further concerns about substance use or cognitive functioning, some patients are asked to fill out a substance misuse questionnaire or a cognitive screening test.

All of the measures employed by PHP have been used before both within academic research and by the clinicians involved in PHP1. The measures used were chosen because they are simple to use; quick to complete; their reliability and validity has been tested in other settings; and they are clinically relevant to the health professional carrying out the assessment.

6.2.2 Measures

Distress

The Clinical Outcomes for Routine Evaluation – Outcome Measure (CORE-OM) (Evans et al., 2002) is a general measure of distress consisting of 34 items scored on a five-point scale. The total score for the CORE-OM gives a measure of 'global distress', and responses are then split into four sub-scales to separately measure well-being, psychological problems, functioning and risk. Higher scores indicate greater levels of distress. Average CORE-OM scores can be compared to a non-clinical group and a clinical group (as presented in the CORE system user manual). The clinical group come from 21 different treatment sites and the non-clinical group is a combination of opportunity sample participants and university students.

Social Adjustment

The Social Adjustment Scale (Mundt et al., 2002) is a simple five-question measure of impairment in day-to-day functioning. Patients respond to the questions about different aspects of impairment by selecting a number between 0 ('not at all') and 8 ('severely impaired'). Higher scores indicate a higher level of impairment.

Screening for Alcohol Misuse

The Fast Alcohol Screen Test (FAST) (Hodgson et al., 2002) consists of four questions designed to screen for hazardous/harmful drinking and alcohol dependence. Participants answer the questions about their drinking using a five-point scale ranging from 'never' to 'daily or almost daily'.

Follow-ups

During initial assessments, clinicians decide with patients an individual treatment plan, which may include cognitive behavioural therapy (CBT), inpatient detox, medical massage, psychotherapy or telephone CBT, for example. It is important to carry out the measures again during and after treatment in order to assess whether patients are improving. Therefore, the CORE-OM and the Social Adjustment Scale are repeated at 8-week, 26-week and 52-week follow-ups. The FAST is not included as a follow-up measure as it is primarily a screening tool, and hazardous drinking is therefore monitored by getting feedback from clinicians about whether patients are abstaining from alcohol, rather than a questionnaire score.

Global Outcome

In addition to repeating the baseline questionnaires, patients fill out a brief measure of global outcome and satisfaction with treatment – the self-rated Clinical Global Improvement (CGI) questionnaire which has been used in randomised controlled trials to evaluate treatment outcome (see Fulcher & White, 1997). The first question asks patients to rate how much better they feel, on a scale of 1 (very satisfied) to 7 (very dissatisfied).

Satisfaction with Treatment

The second question on the CGI asks patients to rate how satisfied they are with their contact with PHP, on the same scale of 1-7 (very satisfied – very dissatisfied).

Analysis

Data was entered into SPSS ver. 17.0 for analysis.

6.3 Results

326 patients (77.6%) handed in at least two complete questionnaires at baseline. Several patients handed in incomplete questionnaires which have been discounted for the purpose of this report. Other reasons for not completing questionnaires at baseline include the patient being a telephone-only contact; the patient deciding not to engage with the service; the patient being inappropriate to collect data from (e.g. out of the London area); or the patient being newly-registered and not yet returning their forms. At the time of this report:

- 165 patients have completed 8-week follow-up questionnaires; approximately 99 more patients have been sent questionnaires but not yet returned them
- 111 patients have completed 26-week follow-up questionnaires, and at the time of writing, we are awaiting a further 79
- 44 patients have completed 52-week follow-up questionnaires, and we are awaiting a further 63.

Table 6 gives a summary of the average (mean) scores for PHP patients for the CORE-OM, the Social Adjustment Scale and the FAST at each interval. The results for the core global improvement (CGI) are discussed in section 7.1.

As described in the table, for each questionnaire, a higher score indicates a more severe problem. Therefore, we would hope to see scores getting consistently lower at each follow-up interval.

The table shows that we are seeing lower scores on the questionnaires at almost every interval. All follow-up scores are lower than baseline scores indicating that patients are improving in all areas during their treatment at PHP. Global distress, subjective wellbeing, and problems/symptoms are improving at every interval. Risk improved at 8-week and 26-week follow-up, while 26-week and 52-week scores were identical. Life functioning and social adjustment were slightly higher at 52-week than 26-week but remained vastly improved from baseline scores. Overall it appears that treatment within PHP is successful and effective across a range of measures, and that patients are showing improved functioning and less distress as they progress with their treatment.

Each questionnaire will now be discussed in more detail.

CORE-OM

As shown in the table, the clinical cut-off scores for the CORE-OM are 1.19 for men and 1.29 for women.

At baseline, 215 patients (65.95%) scored above this clinical cut-off (117 male, 98 female). When compared to other samples (provided in the CORE system user manual), PHP patients scored on average higher than a non-clinical group but lower than a clinical group [table available on request].

At 8-week follow-up, 79 (48.17% of patients) scored above the cut-off (46 male, 33 female).

At 26-week follow-up, 41 patients (36.94%) scored above the cut-off (20 male, 21 female). By this point PHP patients were scoring, on average, identical scores on risk to the non-clinical group.

At 52-week follow-up, 15 patients (34.88%) scored above the cut-off (9 male, 6 female). Again, PHP risk scores matched those of the non-clinical group.

Table 6 Summary of average questionnaire scores

| Questionnaire | Maximum possible score | Clinical cut-off score* | Mean score – baseline (n=326) | Mean score - 8 weeks (n=165) | Mean score – 26 weeks (n=111) | Mean score – 52 weeks (n=44) |
|---|--|----------------------------------|--|--|--|--|
| CORE-OM (global distress) | 136, indicating the highest level of distress | An average per question | Overall: 53.92 (SD= 25.15) | Overall: 41.59 (SD= 26.08) | Overall: 36.03 (SD= 25.18) | Overall: 35.70 (SD= 22.71) |
| | | for men; 1.29 for women | Per question 1.59 (SD= 0.74) | Per question 1.23 (SD= 0.77) | Per question 1.06 (SD= 0.74) | Per question 1.06 (SD= 0.68) |
| Subjective well- being (sub- scale) | 16 | | 2.15 (SD= 1.02) | 1.63 (SD= 1.09) | 1.41 (SD= 1.11) | 1.35 (SD= 0.95) |
| Problems / symptoms (sub- scale) | 48 | | 1.98 (SD= 0.91) | 1.51 (SD= 0.94) | 1.32 (SD= 0.88) | 1.30 (SD= 0.83) |
| Life functioning (sub-scale) | 48 | | 1.63 (SD= 0.82) | 1.30 (SD= 0.82) | 1.12 (SD= 0.82) | 1.13 (SD= 0.70) |
| Risk/harm (sub- scale) | 24 | | 0.36 (SD= 0.49) | 0.26 (SD= 0.44) | 0.20 (SD= 0.33) | 0.20 (SD= 0.33) |
| Social Adjustment | 40, indicating high level of impairment | - | 16.47 (SD= 9.70) | 14.82 (SD= 10.36) | 11.90 (SD= 9.21) | 12.23 (SD= 9.60) |
| FAST | 16, indicating hazardous drinking | 3 | 2.27 (SD= 3.87) | - | - | - |

Clinical cut-off scores' refer to whether or not a score represents a clinical case. They have been established by asking a large sample of the UK population to complete questionnaires and comparing their scores with those for large samples of clients in therapy. We can examine the extent to which a patient's score represents a 'clinical population' by comparing their score with the national cut-off score.

SD - Standard deviation

At baseline, 8-week and 26-week intervals, female patients scored significantly higher than males on subjective wellbeing (p=0.010, p=0.001, p=0.034 respectively). At the 8-week interval, females also scored significantly higher on global distress (p=0.007), functioning (p=0.047), problems (p=0.007) and risk (p=0.001). However, by 52-week follow-up, no significant gender differences were found.

No significant age or diagnostic category differences were found at any interval.

Social Adjustment

No significant age, gender or diagnostic category differences were found between male and female patients on the Social Adjustment Scale at any interval.

FAST

81 patients (27%) scored above the clinical cut-off point for the FAST at presentation, indicating hazardous drinking behaviour. Male patients scored significantly higher than female patients (p=0.044). There were no significant age differences in FAST scores, though patients with comorbid disorders scored significantly higher than those with just one diagnosis (p=0.005).

Further research

We continue to seek feedback from practitioner-patients, and those with overdue questionnaires have recently been contacted again in order to try and get greater response rates.

Overall we are seeing excellent progress in the PHP patients, including those with co-morbid disorders and those presenting with severe levels of distress. By twenty six weeks, in particular, patients are tending to score similarly to a non-clinical sample of people. It appears that PHP is providing an extremely valuable service to the practitioner-patients, significantly helping to decrease levels of distress and improve work and social functioning.

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7 Determining self reported improvement, user satisfaction and experience of PHP services

Key Points:

Improvement and satisfaction rates are consistently high.

The majority of patients have said that they feel better since beginning their treatment with PHP, and a great majority are also satisfied with the service.

Comments are optional, but many patients want to express their views.

Comments overall extremely positive.

Of importance to patients: confidentiality, staff who understand the specific needs of doctors, a supportive atmosphere.

PHP has been a 'lifesaver' to many patients.

Much praise for PHP as well as comments about difficulty finding help elsewhere.

A more in-depth report currently in progress will further explore patient satisfaction.

7.1 Method

Patients are asked to fill in Core Global Improvement (CGI) 'follow-up' questionnaires 8 weeks, 26 weeks and 52 weeks into treatment (see section 6 for explanation of CGI). At each follow-up interval, patients are given a brief questionnaire designed to assess both satisfaction with the service and global improvement. This questionnaire involves rating how they feel since engaging with service (very much better, much better, a little better, the same, a little worse, much worse or very much worse) and also how satisfied they feel with their contact with PHP (again, a seven-point scale, this time ranging from very satisfied to very dissatisfied).

7.2 Results

The following graphs show the frequency of responses for the improvement and satisfaction questions at each interval.

In Figure 22 below showing improvement, it can be seen that:

- At the 8-week interval, 84% of patients felt at least "a little better", with the most frequent response (35.4% of patients) being "much better"
- At the 26-week interval, 90.8% of patients felt at least "a little better", with most feeling either "very much better" (34.7%) or "much better" (38.8%)
- At the 52-week interval, 85.4% of patients felt at least "a little better", and no patients felt "much worse" or "very much worse".





In Figure 23 below showing satisfaction, it can be seen that

- At 8-week follow-up, 92.4% of patients were either "very" or "moderately" satisfied with their PHP treatment. The majority (82.1%) were "very satisfied"
- At the 26-week interval, 100% of patients were either "very" or "moderately" satisfied. The most common response at the twenty-six-week interval was "very satisfied" (86.9% of patients)
- At the 52-week interval, 97.6% of patients were either "very" or "moderately" satisfied. One patient was "slightly dissatisfied".



Figure 23: Satisfaction

We can see from the graphs that both self-rated improvement and satisfaction scores are extremely high, indicating that a vast majority of patients are feeling better than they did when they first contacted PHP, and that they also feel satisfied with their treatment.

The percentage of patients feeling "very much better" rose slightly from the 8-week interval and the 26-week interval, and the percentage of patients feeling "very satisfied" with their treatment improved between 8-week and 26-week intervals, suggesting that improvement and satisfaction with the service get better over time.

In late 2009 (approximately 10 months into the evaluation) we added a 'work questionnaire' to the measures given to patients at every interval. This questionnaire asks patients about their current work situation, time off, reasons for time off, and GMC/GDC involvement. It is hoped that the responses to this questionnaire will provide valuable insight into how mental health and addiction problems affect ability to work, and will enable us to monitor the work-related progress of patients.

7.3 Patient feedback comments

We added an optional 'comments' section to the global improvement questionnaire, in order to gain further insights into patient opinions. Feedback has overall been extremely positive and despite this section being optional, many patients are keen to express their views. Table 7 below shows examples of patient feedback received by PHP, divided into six main 'themes' emerging from a basic thematic analysis. The feedback has been anonymised and content has been omitted where this could allow identification of patients.

| | Comments |
|------------------------|--|
| ۲ خ ۲ | "Extremely impressed by professionalism, access to other services, confidentiality, the feeling of being under a safe 'umbrella' during my illness." |
| ce c ialit | "Fast access to help. Excellent confidential nature of service invaluable. Keep it up!" |
| ortano fidenti | "I have found the treatment has been excellent. Very sympathetic and professional approach with confidentiality." |
| lmp con | "Life-saving accessible service for ill doctors. Impressive network of professionals. Should be a nationwide service. Confidential nature ensures more will use PHP if it continues to be supported. Surely cost effective?" |
| aff who rs' needs | "I think PHP is a great service and I wouldn't have recovered nearly as well without the support of the whole team. You treat patients as professionals and take into account patients' ideas, concerns and expectations, involving us in decision-making for treatment options." |
| ince of st nd docto | "I have found the help from PHP invaluable. As soon as they were involved, treatment began immediately and their understanding of external circumstances made all the difference." |
| Importa understaı | "I found all the health professionals very professional. I'm just very grateful to have been helped by people who understand the NHS system, and so therefore already know so much, without having to explain it to them. I thought PHP had been around for much longer as I found everything ran very smoothly and efficiently." |
| ortive | "I believe this is the best part of the NHS. The service provided should be extended to all parts of the NHS. To have people, staff and an environment that cares about what happens to the staff is marvellous. It runs efficiently and people are helpful. I am very happy I was referred here." |
| a supp here | "I have felt <u>extremely</u> well looked after and cared for by all the professionals and staff I have had contact with. A very containing and supportive atmosphere." |
| ance of a atmosp | "Excellent service to contact if worries/new developments. Have felt very supported emotionally and in terms of career outlook. It feels after three years from the onset of my period of illness that somebody is listening and willing to help." |
| Import | "People at PHP have been more than helpful and supportive. I consider them crusaders for the cause of helping people out in very bad times in their lives and I feel blessed that I encountered them." |
| | "I feel I can turn to PHP for support." |

Table 7: Patient comments

| | Comments |
|--------------------------------------|--|
| PHP as a 'lifesaver' | "Without the unfailing support and kindness of PHP I would not be here." "Dr Gerada and the team at PHP have been a life saver – I am now looking forward to carrying on with my career with the support of PHP. Thank you." "PHP has been a lifeline. Thank you." "PHP has saved my life – literally and metaphorically." "My whole experience of PHP has been fantastic. Four months ago, I was depressed, suicidal and felt my life had fallen apart. Now, I am back at work full time, enjoying life again and feel I have a very sturdy support network. PHP and Jane Haywood are first class, and have likely saved my life. I am very grateful." "A fantastic service that has quite literally saved my life, rebuilt my self respect and my family life." |
| Difficulty finding help elsewhere | "This really is a brilliant service for doctors. The staff know how to deal with fellow professionals, and the strains that are imposed on us by the NHS, especially when we are in crisis in our personal lives. Without PHP I could not have sorted out my difficulties, CMHT does not have the expertise to deal with me, especially throughout my investigation. I hope its funding continues, so other doctors can access its help." "I am very happy with the support PHP has given to me which I was unable to get from the Trust Management despite my requests. It would be very beneficial to doctors and dentists if this programme is accessible to all regions. I hope there will be a rolling programme to open or set up clinics in other parts of UK." "The PHP provide an excellent service. It is impossible to get this quality of help elsewhere. Very impressed!" |
| Praise for the service | "PHP has been a vital part of my recovery and return to a contented life. Please pass on the truth of this to those who control the funding. It would be disastrous if this service were to discontinue. I couldn't have asked for better care." "This has been an invaluable service – without it I do not think I would have made the transition back to work successfully or possibly at all. I am truly grateful!" "Long may PHP continue – I hope you get your funding! It has been a Godsend and have referred several friends here too. The presence of PHP goes a long way to ease the guilt of being off work in the medical profession and makes it acceptable to be off work and take time to even recognise that you are unwell and need help." "This is the best thing that ever happened to me. This week particularly I am in a very good place." "Excellent treatment, far beyond my expectations. A first-class service provided by first-class health professionals." "I am overwhelmingly grateful to PHP for everything they have done for me. I feel blessed beyond words that I came into contact with PHP when I did, and feel that I owe them my life! Thank you." |

7.4 Patient stories in their own words

We have also begun carrying out semi-structured interviews with a small sample of patients, using a combination of discourse analysis and thematic analysis on the interview data in order to gain greater insights into patient opinions. Initial feedback from the qualitative study is consistent with this report.

7.4.1 A doctor

"I am a 46 year old medical practitioner, who referred myself to the Practitioner Health Programme at the beginning of 2009. I had been unable to get any meaningful on-going therapy for an addiction to opiate medication which I had been tackling in a haphazard fashion for many years.

The service provided has been invaluable, and has enabled me to re-structure my life, become established in recovery from my addiction, and continue to treat patients safely.

For many reasons, 'normal' mental health and addiction provision within the NHS is hardly ever appropriate for health practitioners as patients. Private treatment, particularly for addictive illness, is also fraught with difficulty. The PHP fills a gap in the care of health professionals which has been until now unfilled, with often desperate and tragic consequences.

I am sure that the outstanding level of therapeutic care which PHP provides could and should be offered to health practitioners throughout the country. Without their services I cannot say for certain that I would not have survived my illness, but I would certainly still be very unwell. To lose this unique facility would be in my mind unthinkable."

7.4.2 A dentist

"I would like to express how wonderful the above institute has been for me as a patient, a dentist dependent on tranquillisers. I was lucky enough to be referred to the above medical centre and even luckier that I found a therapist, a specialist nurse, who is very successfully helping me overcome my addiction on a weekly basis by appointment in counselling and monitoring my progress as I progressively reduce the dosage of Valium that I am reliant upon. Nothing is rushed or coerced in this reduction, yet the combined therapy is one of a gradual, gentle persuasion to reduce dosage when I feel I am able to. The specialist nurse instils confidence both in myself and in her as she does not restrict herself to treatment only at the Centre but can be called upon in between visits for advice, help and support as I have had to do many times. As well as treating me, she has managed to find time to make mandatory written reports about my progress when called upon by other professional bodies and people. The Centre is also associated with a regular group meeting of doctors and dentists to discuss their problems, addictions, treatments and recovery which I attend, all at the behest of the PHP.

An integral part of the PHP programme involves being sent to a Rehabilitation Centre in Wiltshire called "Clouds House" done by mutual agreement between patient and therapist when a certain level of reduction of dosage has been reached. "Clouds" will admit me for 6 – 8 weeks where I will continue to be treated until I am completely off Valium, while at the same time being counselled and taught coping skills like Cognitive Behavioural Therapy, relaxation techniques and exercises. The facility also allows visits from relatives and friends and in my case, visits from the specialist nurse herself to monitor my progress.

I have had the misfortune to be admitted for similar tranquilliser addiction in the past to ordinary hospitals, often with harsh time limits set for abstinence from addictive substances, including alcohol. In one case after my father died, I turned to Valium again and after admittance to a private hospital, I was forced to go 'cold turkey' and made to stop taking everything I was on which led me to having post traumatic stress disorder for which I had to be treated with antidepressants. In stark contrast to these barbaric techniques, the PHP programme epitomises how addictions should be treated in the 21st Century and more funds should be made available for such modern Centres. I am very, very fortunate to be included in the PHP programme.

Yours sincerely,

A Dentist"

7.4.3 A General Practitioner

"I would like to take this opportunity to say how extremely helpful the PHP programme has been.

It is extremely useful to be able to access confidential help when you are a doctor. It can be a daunting task trying to access help through the usual NHS system, you often worry who will see your referral letter, who will be seeing you and how quickly you can get help.

It was great to be able to be assessed and have therapy provided so quickly.

I feel this has greatly improved my overall wellbeing which I no doubt has had a positive impact on my work, treating my patients.

I feel it is important to continue this service for future doctors in need of help. The fact that it is independent of other organisations is extremely helpful.

Many Thanks

A General Practitioner"

7.4.4 A Partner

PHP Family Group

I started my journey into recovery, as a family member of a doctor with addiction problems. As soon as he was in treatment and got all the 'tools' to get better, I was left with the mess and the reality. I am so grateful for the support and help of others in the same position as me, as I found it very difficult to talk to close friends or family members about something that I tried so hard to cover up myself.

Therefore, I see the importance in having a family-support group available at PHP. Once the health professional gets help the family members are left with lots of questions and a desperate need to be heard, or just to listen. The PHP Family group is now been running for about 1 year and we have a regular number of members.

7.4.5 A Psychiatrist

I am writing to express my heartfelt thanks to the team at the Practitioners Healthcare Programme at Vauxhall in London.

Six months ago I was very unwell with problems with my mood and addiction. I was also at this time physically unwell and unable to attend work. I felt as a medical professional ashamed of my condition and that I had nowhere to turn to. I felt helpless and genuinely suicidal.

I contacted the Sick Doctors Helpline who put me in contact with PHP. Within days I was offered an appointment in Vauxhall with Jane Haywood who very speedily organized that I would be admitted into a rehabilitation unit. Following this the team at Vauxhall have provided superb aftercare and I am now six months into recovery and back at work full time, healthy and happy.

In short, I feel that the team at PHP has certainly not only saved my career but also my life. With the interventions and help that they have provided I am now finally living a healthy, content life and working effectively in a job I enjoy.

I sincerely hope that the PHP service can somehow find funding to continue their essential work. My experience is there is a huge level of stigma and fear surrounding addiction in doctors and this is certainly a barrier to accessing care. Without the existence of PHP, I think there is a very strong possibility that I would not be here to write this letter today.

Once again I would like to thank Jane, Clare, Martin and everyone else who has helped get my life back on track. I hope having provided such an outstanding service and level of care will allow you to share in some of the happiness I finally feel today.

8 Evidence for mainstreaming the service - need, impact, costs of ill health and benefits of the service

Key Points:

Research and evidence highlights the need for a specialised, confidential service for health professionals with significant numbers concerned over stigma or effect on their career.

The costs of ill health are considerable and estimated at around £23m per year in London.

The PHP service has impacted positively on practitioner-patients and their employers enabling return to work and reducing costs of absence.

8.1 Health problems in doctors and dentists

Doctors and dentists are more likely than the average person to suffer from one or more of 'the three Ds' – depression, drink and drugs.

- Current evidence indicates that there are higher rates of depression and anxiety in health professionals than in other groups of workers. Several studies indicate that health professionals feel more stressed than other workers and stress has been linked to mental ill health
- Rates of suicidal thoughts and completed suicides are significantly higher in doctors and dentists
- The British Medical Association has estimated that one doctor in 15 (7%) could have some form of drug/alcohol dependence in their career
- A questionnaire study of UK dental professionals revealed that 6% of the 545 respondents had a 'drink problem' while 9% had alcoholic tendencies.

8.2 Need for the service in London

8.2.1 Incidence

Estimating the incidence of ill health amongst doctors and dentists in London that requires a PHP service is difficult. Estimates from PHP and other services, one previously operational in Scotland and a current service in Spain, indicate a prevalence of between 0.5% and 1%. This would indicate a patient base of 150 – 300 doctors and dentists in London at any point in time.

8.2.2 Stigma attached to mental health and addiction issues

Practitioners (here meaning doctors and dentists) are reluctant to disclose mental health or addiction issues to a GP or other health professional. A survey of 2,500 doctors in Birmingham²

² A postal survey of doctors' attitudes to becoming mentally ill, Clinical Medicine, Journal of the Royal College of Physicians, Volume 9, Number 4, August 2009, pp. 327-332(6)

showed that only 13% would seek help, 87% choosing alternative paths such as self medication or informal medical help.

In research recently undertaken by Ipsos MORI Social Research Institute on behalf of the Department of Health, it is reported that the majority of stakeholders (all health professionals) said they would fear being stigmatised or labelled if their colleagues knew they were suffering from either an addiction (73%) or mental ill health (63%)³. For doctors alone, these percentages rise to 81% and 73% respectively; for doctors who are also managers these percentages rise to 84% and 74% respectively.

Figure 24: Stigma attached to mental health or addiction

To what extent do you agree or disagree with the following statements?



8.2.3 Support for a specialist service

*Invisible patients*⁴ makes a strong link between the health of health professionals and the quality and safety of patient care. It makes firm recommendations to improve the health of health professionals. The report states:

"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."

The researchers from the Ipsos MORI Social Research Institute confirmed that it can be more difficult for a senior health professional to seek health advice and that they are more inclined to think that they should be able to solve their own health issues. Furthermore they believe specialised health services should be made available for healthcare professionals. When the public was asked to consider whether specialist services should be available to health care professionals, most believed these services should be made available, since they understood it can be difficult for healthcare professionals to use mainstream services due to issues surrounding stigma and embarrassment. They did, however, emphasise that while this service should be tailored toward healthcare professionals it should not be seen to be 'better' than the mainstream service.

³ Fitness to Practice: the Health of Healthcare Professionals, Ipsos MORI, 2009

⁴ *Invisible Patients*, Report of the Working Group on the health of health professionals, Department of Health, 5 March 2010

Overall effective health care for health professionals should:

- reduce sickness absence in NHS staff and its associated costs
- protect the safety of patients and the public
- maintain the quality and efficiency of the NHS.

8.3 Costs of ill-health in London

The costs of London doctors and dentists who fall ill to the NHS is estimated at £23m a year in terms of sick leave, suspensions and cover for everyday duties.

Evidence on the costs of ill-health to the NHS in London is largely restricted to doctors. It is therefore reasonable to assume to that the figures below could be greater if similar evidence for dentists existed (particularly as the PHP 12-month report⁵ and the DH report on the health of health professionals, *Invisible Patients*⁶, detail similar health concerns for doctors and dentists).

8.3.1 Doctors suspended on ill health grounds

Using a variety of sources LSCG estimated that the cost of doctors suspended on ill-health grounds *could amount to £5.5m per annum across London's NHS*. This is based on an estimated 38 doctors (out of a total of 27,640⁷) with an associated cost of £144,000 each⁸. The latter cost is made up of locum cover, management costs and legal costs, but does not cover salary costs, which would be incurred whether the clinician were suspended or not. This estimate is in line with evidence from PCTs in London currently utilising the service.

The following quotation indicates the potential benefit at PCT level:

"Over the past year, I have found a small number of doctors have made use of the service with significant benefit. They have accessed PHP, made a recovery and returned to work to provide safe clinical care to patients. Never before have we had such a service that helps doctors in great need and protects patients.

"The PHP has saved us from incurring steep costs associated with suspensions which would have totalled around a quarter of a million pounds. If you add costs associated with hiring locum staff to cover the work of a suspended clinician, legal costs, hearings and appeals we could have been faced with costs spiralling beyond half a million pounds. This huge saving, made as a result of the PHP, has meant we were able to spend this money on where it was intended – patient care." Dr Doug Russell, Medical Director Tower Hamlets PCT.

8.3.2 Sick leave

The DH provided details of the average sickness absence rates for April 2009 to March 2010, for each NHS Trust & Foundation Trust in London (except for Moorfields Eye Hospital) for medical and dental staff⁹. Sickness rates are recorded as a percentage of the Full Time

⁵ NHS Practitioner Health Programme: Report on the First Year of Operation, January 2010

⁶ *Invisible Patients*, Report of the Working Group on the health of health professionals, Department of Health, 5 March 2010

⁷ NHS Information Centre for Health & Social Care, data as at 30 September 2009: Table 3: Hospital and Community Health Services (HCHS): Medical and dental staff by Strategic Health Authority and grade; Table 1a: All General Medical Practitioners : Headcount by type

⁸ Based on costings from the National Audit Office report, *The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England*, 6 November 2003, updated for inflation

⁹ The source data has been extracted from the NHS Electronic Staff Record (ESR), the national HR & Payroll system for the NHS.

Equivalents (FTEs) employed. LSCG applied these percentages to the total FTE doctors employed in each organisation, suggesting an annual sickness rate across London hospitals equivalent to 170.73 FTEs. Using an average salary of £80,000 and including the superannuation and employer costs at a conservative level of 23% *the annual cost of this sickness is estimated at £16.8m.*

The Health Service Journal submitted FOI Act requests to more than 20 PCTs asking for details of payments for sickness and maternity leave cover made to GP practices in 2007-08 - approximately 20% related to sick leave¹⁰. The 16 PCTs that released information revealed that they had paid practices $\pounds 2.3m$ – extrapolating this to 31 PCTs to reflect London and then isolating the sick leave element suggests that PCTs *in London are paying in the region of* $\pounds 927,000$ per annum to cover GPs sick leave.

8.3.3 Treatment costs currently incurred

In interviews with Medical Directors of both Hospital Trusts and PCTs, it has become clear that when a doctor is ill and needs treatment for mental health or addiction issues, they are often treated privately or out-of-area. Employers and PCTs often pick up the bill for this. Trusts and PCTs are paying for health care for doctors and dentists at present on an ad hoc, case-by-case basis. If this funding was redirected to PHP, the care it supports would be provided by *experts in treating doctors* - PHP or one of its network of preferred providers.

8.4 A successful service

PHP has been cited as an excellent example of a specialist service and as a flagship for other areas of the UK. The PHP prototype has demonstrated that a specialist healthcare service for health care professionals is needed, will be used and is allowing practitioners to receive appropriate care, return to safe effective practice and most importantly provide quality care to patients.

Key statistics for the service include:

- 405 patients during the first 23 months
- 70.4% remained in or returned to work whilst a patient (based on 30th September 2010 snapshot including status at discharge)
- 71% abstinence rate for those treated for alcohol or drug addiction (compares to 10% -20% of those treated in the general population)
- evaluation through a range of recognised, validated questionnaires demonstrates improvements on all measures including, mental health and social and work functioning.

8.5 What impact has PHP had?

One year into the pilot, an independent review of user satisfaction and impact of the PHP service was commissioned by PMG which includes commissioners of the service¹¹. This involved those with experience of the service, those who may use the service in the future, as well as stakeholders who may have a view on its impact on service users. The Opinion Leader report states: "The service is seen overwhelmingly to be very successful by all audience groups and it is important that the momentum of the programme is continued. Many stakeholders identify that the pilot is a 'good starting point' and should be used as a learning process to build future programmes."

¹⁰ GPs paid £20m for sickness and maternity leave cover, HSJ, May 2008

¹¹ Practitioner Health Programme - Seeking views on the pilot one year on – Interim results. Opinion Leader on behalf of the PHP Prototype Management Group, November 2009

8.5.1 Satisfaction

The Opinion Leader report identified that overall satisfaction with the PHP service was high across all audience groups taking part in the review. There were several reasons identified for this with the key being that PHP provides a holistic, confidential service which covers a previously unmet need. The staff and service were also praised by all audience groups (including practitioner-patients, medical workforce managers and clinical service providers) as high quality and well trained in the field of mental health and addiction. This feedback from a wider group of stakeholders supports the findings outlined in Chapter 7.





8.5.2 Impact on service users

Overcoming their health concern was seen to be the greatest benefit, 89% of service users in the survey rated the impact positively (between 1 and 5 on a scale of –5 to +5). Impact was also significant in helping to increase confidence and allowing independence to cope without the support of the PHP:

"It boosted my confidence, the fact that people really cared that I got better, and that is really something that is crucial if you're going to get off of whatever you're taking, whether it's booze or hard drugs or tranquilisers."

"I'm probably the best I have been for years now and I think the therapy and medication has helped a lot... It ultimately reflects in your family and personal life as well."

Those with experience of the different stages of the service identified a positive impact of the support which enabled them to return to work or supported them through the regulatory process. As a direct result, 65% of service users in the quantitative survey stating that the programme had a positive impact on this their career prospects:

"It's been a very positive experience and had a very positive effect on me in that they've helped me get back to work when my registration was suspended and I wasn't able to work."

When asked about the impact on their performance at work, 44% responded that the service had had a positive impact, (11% responded identified that there was neither a positive nor negative impact, and 42% replied that this as not applicable).

8.5.3 Impact on Trusts

The positive impact on those using the service was seen to be high and the impact on Trusts has been beneficial. It was also identified by some Trusts that:

- the impact on Occupational Health is highly positive and could alleviate pressure on this sector in the future
- the cost of health professionals out of work is reduced and should continue to reduce in the future as more preventative care is carried out
- the improvement in patient safety is also significant.

8.6 How does PHP save money?

- It provides appropriate care and support enabling practitioner patients to *get back to work*. One patient, on incapacity benefit for four years prior to help from PHP, is now back at work.
- It supports patients appropriately so that when there is involvement with the regulator, PHP patients are allowed to continue working wherever possible.
- It's a one-stop-shop for practitioners with mental health or addiction problems an umbrella from admission to discharge. Traditionally sick practitioners are passed from pillar to post, or do not seek treatment with resulting risks to themselves and their patients.
- It is able to refer patients to preferred providers quickly and appropriately.
- The longer the service exists, the more people know about it and trust it, leading to earlier, less costly interventions.

Some initial work comparing the costs and benefits of patient treatment and outcome in PHP, to their situation prior to PHP has been undertaken, *initial findings* are shown in Table 8.

Table 8: Indicative patient pathways

| | | Practitioner C | |
|---|--|---|--|
| A 42 year old hospital consultant. Dr A had not been working since he/she was suspended by the GMC in 2004. Suspension was for drug & alcohol use. When Dr A approached PHP1 he/she had been living on incapacity benefit for 4 years and was seeing a GMC supervisor, another health professional & a GP Dr A had found out about PHP from a voluntary sector organization. | PHP1's lead clinician attended a voluntary group on New Years Day. She met a 36 year old hospital doctor. He/she was not working & was both depressed and alcoholic. Dr B was suspended on full pay pending the outcome of a disciplinary process. Dr B thought nothing would ever change. Our lead clinician managed to engage Dr B and he/she presented at PHP. | A 54 year old PCT PMS salaried GP, Dr C was alcoholic & working. Dr C was regularly inappropriately contacting out-of-hours care and other public sector services. Dr C had been in & out of hospital under section for short periods. Dr C's partner was also a doctor but was unable to work full time due to Dr C's problems. On admission to PHP, Dr C had been sectioned 5 times in 12 months. | |
| On admission to the PHP Dr A was treated as an: outpatient for 4 wks for drug detox inpatient for 4 weeks to continue detox & rehab Dr A was then supported by PHP professionals through meetings that were weekly at first and then became fortnightly. | Dr B was supported through outpatient alcohol detox & in discussions with his/her Occupational Health service. Dr B was suspended under threat of dismissal but intervention meant that Dr B was reinstated. Dr B's had also been reported to the GMC – he/she was allowed to return to work under the condition of remaining abstinent. In total Dr B was suspended on full pay for 6 months. | On engaging with PHP, Dr C was told that he/she would be reported to the GMC if he/she did not stop working while under the influence of alcohol. Dr C did not stop working and the PHP reported him/her to the GMC. After weeks of meetings with Dr C, PHP got him//her admitted to a preferred provider for inpatient detox and supporting day care. | |
| Dr A is abstinent from all drugs & alcohol, is not depressed & is taking an opiate blocker. Dr A was helped back to work by the London Deanery & his/her Royal College. PHP supported Dr A through the GMC process & he/she is now back at work. | Dr B is back at work & remains abstinent. | Dr C has been engaged in treatment through PHP and has remained abstinent for 2 months. He/she is returning to part time work in the near future. | |
| 4 years incapacity benefit £18,000 Cost of trust suspension and dismissal process, average cost £144,000* Cost of GMC Supervision, GMC regulatory process – not known Cost of potential litigation – not known Basic cost of training doctors who are then not working - £250,000 | Estimated cost of suspension for 6 months – £72,000* Cost of GMC regulatory process – not known Basic cost of training doctors who are then not working - £250,000 | Estimated cost of locum for 6 months (paid by PCT) £75,600 Cost of potential litigation – not known Estimated cost to other NHS & public sector organisations at least £2,500 Cost of section and accompanying high cost inpatient stays £6,700 Basic cost of training doctors who are then not working - £250,000 | |
| PHP costs: £12,300 | PHP costs: £6,720 | PHP costs: circ £20,000 | |
| Patient safety and effective care | Patient safety and effective care | Patient safety and effective care | |
| Trained doctor back at work, contributing to patient care, paying taxes etc Contribution to the training of junior | Trained doctor back at work, contributing to patient care, paying taxes etc Contribution to the training of junior | Trained doctor back at work, contributing to patient care, paying taxes etc | |
| | A 42 year old hospital consultant. Dr A had not been working since he/she was suspended by the GMC in 2004. Suspension was for drug & alcohol use. When Dr A approached PHP1 he/she had been living on incapacity benefit for 4 years and was seeing a GMC supervisor, another health professional & a GP Dr A had found out about PHP from a voluntary sector organization. On admission to the PHP Dr A was treated as an: outpatient for 4 wks for drug detox inpatient for 4 wks for drug detox inpatient for 4 weeks to continue detox & rehab Dr A was then supported by PHP professionals through meetings that were weekly at first and then became fortnightly. Dr A is abstinent from all drugs & alcohol, is not depressed & is taking an opiate blocker. Dr A was helped back to work by the London Deanery & his/her Royal College. PHP supported Dr A through the GMC process & he/she is now back at work. 4 years incapacity benefit £18,000 Cost of trust suspension and dismissal process, average cost £144,000* Cost of GMC Supervision, GMC regulatory process – not known Cost of potential litigation – not known Basic cost of training doctors who are then not working - £250,000 PHP costs: £12,300 PHP costs: £12,300 | A 42 year old hospital consultant. Dr A had not been working since he/she was suspended by the GMC in 2004. Suspension was for drug alcohol use. When Dr A approached PHP1 he/she had been living on incapacity benefit for 4 years and was seeing a GMC supervisor, another health professional & a GP Dr A had found out about PHP from a voluntary sector organization.PHP1's lead clinician attended a voluntary group on New Years Day. She met a 36 year old hospital doctor. He/she was not working & was both depressed and alcoholic. Dr B was suspended on full pay pending the outcome of a disciplinant process. Dr B thought nothing would ever change. Our lead clinician managed to engage Dr A had found out about PHP from a voluntary sector organization.PHP was suspended on full pay pending the outcome of a disciplinant process. Dr B thought nothing would ever change. Our lead clinician managed to engage Dr B was supported through outpatient alcohol detox & in discussions with his/her Occupational Health service. Dr B was suspended un full pay for 6 months.Dr A is abstinent from all drugs & alcohol, is not depressed & is taking an opiate blocker. Dr A was helped back to work by the London Deanery & his/her Royal College. PHP supported Dr A through the GMC process & he/she is now back at work.Dr B is back at work & remains abstinent.4 years incapacity benefit £18,000 Cost of GMC Supervision, GMC regulatory process – not knownEstimated cost of suspension for 6 months – £72,000*PHP costs: £12,300PHP costs: £6,720PHP costs: £12,300PHP costs: £6,720PHP costs: £12,300PHP costs: £6,720PHP costs: £12,300PHP costs: £6,720PHP costs: £10,010, to the training of junior <br< td=""></br<> | |

* Figures estimated using findings from the National Audit Office report, The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England, 6 November 2003, updated for inflation. They are the additional costs of suspension, and do not include the clinician's salary

9 The cost of PHP services

Key Points:

The PHP service was funded at £1.6m per year. Actual costs for specialist referrals were less than anticipated, allowing the service to extend beyond the two year period.

Detailed analysis has enabled robust costings to be developed to support future service provision.

Practitioner-patients with multiple diagnoses are the most costly, followed by those with major mental health and addiction issues,

9.1 PHP1 cost

PHP1 was financed through a block contract throughout the two years of the prototype service. The contract year ran from September 2008 to August 2010 and built in a transitional period from June 2008 to August 2008 to allow for service setup. The service specification allowed £800,000 for PHP1 in each contract year. PHP1 spent according to budget in the first contract year, having provided for three months set-up and transitional costs. During the second year PHP1 services cost £750,000.

9.2 Costing PHP1 services

In order to attribute the costs of PHP1 and the integrated team to patients, clinicians were asked to group patients together according to diagnosis. This lead to the development of 5 patient categories: Major Mental Health, Minor Mental Health, Addiction, Multiple Diagnoses and Physical Health. Costs were then attributed to these categories based on the time input of the treating clinicians. The standard NHS method of costing was used – a combination of a top down and bottom up approach and then judgment used to determine an appropriate approach where any discrepancies existed. The results are shown in Table 9 below:

| | Addictions | Major Mental Health | Minor Mental Health | Multiple Diagnoses | Physical Health |
|--------------|------------|------------------------|------------------------|-----------------------|--------------------|
| Cost / Price | £5,000 | £5,000 | £3,500 | £7,500 | £2,500 |

 Table 9: Cost of PHP1 and the integrated team – per patient by patient category

It should be noted that these prices are valid for the two year period of the prototype. They include initial assessment, treatment provided by the integrated team and ongoing case management. The costs do not include external specialist assessment or treatment provided under PHP2. As some patients will remain in treatment with PHP for many years (if the service continues beyond the prototype phase) these prices may increase over time.

9.3 PHP2 costs by provider

The service specification allowed £800,000 a year for the purchase of PHP2 services. The total spend for completed patient episodes during the first year of the service was £423,900 and £750,000 in the second year. Details of percentage spend for both years combined by supplier are shown in Figure 26 below.

This spending includes the costs of the clinicians that support PHP1 as permanent members of the integrated team, through outreach sessions at Riverside Medical Centre. Additionally:

- outpatient, inpatient and day care services for mental health are provided at the Capio Nightingale Hospital in central London
- Action on Addiction runs Clouds House in Wiltshire which provides nearly all the service's inpatient treatment for addiction
- Tavistock and Portman NHS Trust provide consultant led psychotherapy
- South London and Maudsley NHS Trust provide outpatient mental health treatment for conditions such as chronic fatigue, affective disorders and neuropsychiatry

Figure 26: PHP2 spend - by provider



9.4 PHP2 costs by patient and patient category

Figure 27 shows spending on PHP2 services by patient. The graph shows only direct spending on services and excludes the £100,000 PHP spend on permanent PHP2 members within the PHP Plus integrated team. Figure 27 shows that approximately 40% of patients requiring PHP2 treatment have cost more than £5,000, the remaining 60% required very little PHP2 input.

A number of patients have required considerable treatment with PHP2 providers as shown by the high peaks on Figure 27. In order to understand the type of patients requiring these services, the twenty highest cost patients are shown Figure 28 by patient category. The graph shows that the highest cost patients have suffered from major mental health issues, addiction or multiple diagnoses (usually a combination of mental health and addiction issues).



Figure 27: Range of spend per patient on PHP2 services

Figure 28: PHP2 spend - top twenty patients



The cost of PHP2 services by patient category is shown in Figure 29 below. The graph shows that the PHP2 care provided for patients with multiple diagnoses takes up one third of the PHP2 budget, followed closely by that provided for patients with major mental health problems (30%) and addiction (29%).

Figure 29: PHP2 spend - by patient category



9.5 Overall financial position

Overall PHP1 has performed financially as expected whilst PHP2 has been considerably underspent – in particular during the first year. At the end of the two year contract the prototype was approximately £450,000 underspent due to:

- an underspend on PHP2 of £350,000 in Year 1
- an underspend of £100,000 in Year 2, due to savings on both the PHP1 and PHP2 budgets.

The underspend each year has been carried forward to allow the service to continue for longer.

9.6 Using the under-spend

The underspend described in 9.5 above has been used to provide services beyond August 2010. Together with a further £300,000 from the Department of Health, PHP is able to provide care for existing and new patients to end of December 2010. From January 2011 all new contacts with a London residence will be assessed by PHP clinicians and accepted for treatment only where there is an immediate need. The London sector commissioning leads have agreed to underwrite the costs relating to this cohort of patients until commissioning arrangements can be agreed for 2011/12.

10 Conclusion

10.1 Summary

The NHS Practitioner Health Programme has now completed its prototype period of operation and this report provides a detailed description of the practitioner-patients who have been seen, their demographics, presenting complaints and treatment outcomes.

The service has demonstrated in simple terms that:

- Health professionals will use a specialist, confidential service
- When they do come for treatment, they get better
- When they get better, they get back to work safely and effectively.

PHP saves money allowing this to be invested back into patient care and improves patient safely overall.

PHP improves the health and wellbeing of the practitioner-patients who are treated and, most importantly according to patient testimony, the service can save lives.

The team involved in the delivery of the PHP service wish to acknowledge the support and assistance they have been given throughout the two year period and in particular thank all the practitioner-patients and their families for their inspiring messages and feedback. The entire team believe that it has been an honour and a privilege to be part of this service.

10.2 Learning

Over the last two years a number of emerging themes are becoming clear, for example;

- some professional and demographic groups have been identified as more likely to present as practitioner-patients and a range of risk factors are becoming apparent. PHP have had discussions with Royal Colleges and support organisations such as the London Deanery to ensure preventative measures can be taken for these at risk groups
- disproportionate numbers of psychiatrists are presenting and the PHP service believes that this reflects both the difficult position psychiatrists find themselves in with respect to accessing confidential treatment and that the nature of offering treatment to patients with mental health problems on a daily basis adds particular pressures to psychiatrists
- relatively large numbers of paediatricians are presenting and this may reflect the added pressures for this speciality group
- PHP has also identified a number of stressors that add to the mental health burden on doctors. This includes the current shift pattern of junior doctor training which means that young doctors rarely work with the same team and do not have the support that team working provides. The number of younger doctors presenting to the PHP service has increased over the two year prototype period.

On a positive note, the working relationship with the GMC and GDC has enabled a smoother passage through the regulatory process for doctors that are engaged with PHP and more positive outcomes for some.

PHP has demonstrated in the two year period that doctors and dentists do have difficulties accessing routine NHS care for a range of reasons and for many their contact with PHP is the first time they have sought help for longstanding ill health issues.

10.3 Next steps

The task ahead for PHP is to build on the positive outcomes and identify the added value and benefits a service of this nature can bring to individual doctors and dentists, the organisations and teams in which they work and to ensuring safe, effective care to patients and the public.

The next stages of data collection and service evaluation will assist in this process building on the evidence base and current research in this area, but perhaps the most valuable evidence is the experience of the practitioner-patients and healthcare organisations that have accessed and experienced the service offered.

Discussions are still underway over the future commissioning of the London service and the potential for expansion to surrounding areas.

Learning from the prototype will feed into the cohort of GPs, Psychiatrists and Occupational Health Physicians across England who have begun their training in the specialist competencies and skills needed to be a doctor to a fellow health professional. By the end of 2011 this first cohort will have completed their training, meaning that across the country there will be doctors with the necessary attitude and aptitude to care for their colleagues on a long term basis.

Acronyms

| ADHD | Attention Deficit Hyperactivity Disorder |
|---------|---|
| AGM | Annual General Meeting |
| BAMM | British Association of Medical Managers |
| BMA | British Medical Association |
| CBT | Cognitive Behavioural Therapy |
| CGI | Core Global Improvement |
| СМО | Chief Medical Officer |
| CORE-OM | Clinical Outcomes for Routine Evaluation - Outcome Measures |
| DH | Department of Health (England) |
| EAPH | European Association of Physician Health |
| FAST | The Fast Alcohol Screening Test |
| FOI | Freedom of Information |
| FOM | Faculty of Occupational Medicine |
| FTE | Full time equivalent |
| GDC | General Dental Council |
| GMC | General Medical Council |
| GP | General Practitioner |
| HHP | Health of Health Professionals |
| LMC | Local Medical Committee |
| LSCG | London Specialised Commissioning Group |
| MDU | Medical Defence Union |
| MPS | Medical Protection Society |
| MS | Multiple Sclerosis |
| NCAS | National Clinical Assessment Service |
| NHS | National Health Service |
| OCD | Obsessive Compulsive Disorder |
| ОН | Occupational Health |
| PCT | Primary Care Trust |
| PHP | Practitioner Health Programme |
| PHP2 | Practitioner Health Programme specialist providers |
| PMG | Prototype Management Group |
| RAG | Red, Amber, Green Risk Status |
| RCGP | Royal College of General Practitioners |

| RCPsych | Royal College of Psychiatrists |
|---------|--------------------------------|
| RMBF | Royal Medical Benevolent Fund |
| SD | Standard deviation |
| SHA | Strategic Health Authority |
| WTE | Whole Time Equivalent |