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Psychiatry in NHS OH and wellbeing service

A liaison, assessment and treatment service that evolved into a 'one-stop shop'

An innovative new service from the Occupational Health and Wellbeing Department at Buckinghamshire Healthcare NHS Trust will provide joined-up care for the trust's staff, as explained by Kathryn Campion, consultant occupational health physician and Danny Allen, consultant psychiatrist.

OCCUPATIONAL health (OH) services in the NHS traditionally help employees of NHS trusts (and quite often other groups of employees from the public sector). They support individuals and organisations on all aspects of health at work, such as advising on the health of individuals, workplace health risks and the occupational implications of risks to health.

In 2011, the basic functions of OH and wellbeing services were described and formalised in the NHS Health and Wellbeing Improvement Framework[1]. This included a description of OH clinical quality indicators (QIs) for use in the NHS. The need for such QIs had been recognised by NHS Employers, NHS Health at Work (the network of NHS OH teams) and its predecessor NHS Plus in order to be able to evaluate the provision of NHS OH and wellbeing services in a more robust and comparative manner. These QIs were incorporated into the National SEQOHS (Safe, Effective, Quality Occupational Health Service) standards[2]. The six core NHS services were recognised as:

- **prevention** – the prevention of ill health caused or exacerbated by work, eg occupational immunisations (hepatitis B, measles, mumps, rubella, tuberculosis etc), health surveillance and the management of needlestick and other accidental occupational exposures to blood and body fluids
- **timely intervention** – easy and early treatment of the main causes of sickness absence in the NHS, eg physiotherapy and counselling
- **rehabilitation** – processes to help staff stay at or return to work after illness, eg phased return to work
- **health assessments for work** – supporting organisations to manage attendance, retirement and related matters, eg on-commencement assessment, pre-placement screening, in-service referrals and ill-health retirement applications
- **promotion of health and wellbeing** – using work as a means of improving health and wellbeing, and using the workplace to promote health, eg stress control, weight management and smoking cessation
- **teaching and training** – promoting health and wellbeing among staff and managers, eg induction programmes, and providing advice and guidance on the hospital intranet.

As the world of work changes, the types of illnesses presenting to OH services also change, especially in a hospital environment where, in addition to manual work, the workplace is characterised by complex human relationships. The case of *Walker v Northumberland County Council*[3], in which a social worker successfully sued his employers for psychiatric illness caused by his work, and many subsequent cases, have made clear that employers have a duty of care for the psychological health of their employees, as well as their physical health. Similarly, the *Health and Safety at Work etc Act 1974* and the *Management of Health and Safety at Work Regulations 1999* impose statutory obligations to assess and control risks to mental as well as physical health. Failure to manage mental health at work also risks higher sickness absence, loss of experienced staff through illness and ill-health retirement and potentially the high costs of defending cases taken to courts and employment tribunals.

At the Buckinghamshire Healthcare NHS Trust Occupational Health and Wellbeing Department, we have been undertaking the core services outlined above for many years. In addition, to deal with the mental issues presented to us, the service also employs counsellors and has access to cognitive behavioural therapy (CBT) services. However, with an increasing number of employees presenting with mental ill health, we needed to explore additional support options, and how psychiatric services and OH services could be joined up. The idea of this way of working is not to replicate the work already done by NHS mental health services, but to capture those caught between primary and secondary mental health services[4].

In summer 2009, we decided to employ a psychiatrist for one session a month to advise on complex mental health cases amongst our patients – predominantly trust employees. The model adopted was one of liaison, assessment and treatment (LAT). More recently, the service changed from a regular clinic to seeing employees referred on an ad hoc basis, but it

has continued to the present day. Here we describe the model, discuss its development into a 'one-stop shop' and look at the challenges that were encountered.

REFERRAL AND TRIAGE

For many years the OH department has directly employed counsellors; latterly a psychotherapist has also joined the service. The OH physician or OH nurse decides whom to refer to in-house staff and who to send to the psychiatrist. The OH physician is experienced at recognising where work-associated health disorders are caused, at least in part, by psychological problems[5].

Cases referred to the psychiatrist usually fall into one of three categories – liaison, assessment or treatment – although there are instances where there is a post-assessment discussion as to whether or not treatment is required outside the usual channels. It is the OH physician who usually makes the decision about which arm of the LAT model to proceed along.

LIAISON

There is evidence that psychiatrists can have a useful role in OH practice[6]. At our trust, this role was perceived to be one of closing the widening gap between general and mental health trusts. This gap has meant that it is difficult for doctors in general trusts to know whom to speak to, as they no longer mix with psychiatrists in the clinical and academic environments. In addition, as well as dividing patients by age, they are also now divided by sub-specialty, such as drug and alcohol, rehabilitation, forensic and learning disability. It is important therefore that the psychiatrist working in OH still has one foot in the local mental health trust, so that they are familiar with the various teams, for example early intervention, assertive outreach and crisis.

The liaison arm is effective as the OH team is aware of the pressures on the patient's job – people with depression in the workplace, for example, are less productive and are more at risk of losing their job[7], and the fact that it is difficult to sustain sick leave for more than one year – so they are likely to ask the psychiatrist to review certain employees to advise on impediments to recovery.

Typical cases in the liaison arm concern employees who may only be being treated by their general practitioner (GP); those who have been referred to primary care mental health services; or those only receiving partial treatment, for example seeing a frontline clinician when they also need a psychiatrist, or seeing a psychiatrist when they also need psychological therapy. In the latter case, it is almost always necessary for there to be some communication between the OH psychiatrist and the psychiatrist at the mental health trust in order to progress matters through standard psychiatric services. In other cases, it is a matter of liaising with OH to see whether an employee who is referred for CBT might be better directed back into NHS services for a more appropriate therapeutic intervention, for example cognitive analytical therapy.

ASSESSMENT

While every case that is seen is assessed, this arm of the LAT model refers particularly to those cases that are causing a diagnostic or management problem to the OH service because of a lack of information being available. This occasionally may be due to poor communication from treating clinicians, but in the majority of cases the employee has not been referred to secondary care and is being treated by their GP. This can create problems for OH because GPs do not always have a good understanding of either the illness or, particularly, the effect it is having on the workplace.

In other cases employees are referred to primary care mental health services – under the NHS Improving Access to Psychological Therapy (IAPT) programme – and are on a waiting list, but their problems are actually more severe and this has not been appreciated either by the GP or by IAPT services. And on other occasions there are concerns about conditions which appear to have the potential to disrupt the workplace – such as psychosis – but where a psychiatrist can assess whether the condition is adequately managed by the existing care plan and may not therefore require any further input.

TREATMENT

Our service sees a variety of staff who need treatment; many are doctors. This pattern is consistent with previous studies on the mental health of doctors[8]. Keeping doctors well so that they can treat their patients requires a tailored approach.

Of the doctors referred with problems at work thought to be due to mental health issues, the majority are recommended for direct treatment though a psychiatrist. The majority of these have a depressive disorder and in most cases this requires both medication and CBT. In these patients this is provided directly by the psychiatrist and CBT therapist (who both work in the private sector and are commissioned by the trust). Specific consideration needs to be made for junior doctors on rotations as they need to be treated while they are still with the trust – waiting lists can be a problem when they have to move hospitals every four to six months.

Another problematic area is treating employees who refuse permission for their own GP to be involved. This poses a dilemma for long-term care, as the OH service may not be able to fund ongoing treatment, and the doctor may leave the trust while still requiring

CONCLUSIONS

- **Increasing** numbers of NHS employees are presenting to OH with mental health issues
- **Psychiatric** services are joined up with OH services in Buckinghamshire Healthcare NHS Trust to capture those employees caught between primary and secondary mental health services
- **Doctors,** as patients, have special health needs and responsibilities to protect their patients
- **A** 'one-stop-shop' approach allows OH practitioners, GPs and psychiatrists to work together in the interests of the patients
- **Including** psychiatric services within OH complements recently announced plans for a nationally specified service to support GPs suffering from stress and burnout

treatment. Where employees with complex multi-specialty presentations are not being proactively managed by their GP, if they also have medical problems, these may not get addressed.

The types of issues discussed above led us to look at how we could go one step further and offer joined-up services for our trust's employees.

ONE-STOP SHOP

We were concerned that employees, in particular doctors, did not always receive a joined-up approach to care. This was often because of the way in which 'confidentiality firewalls' are located. The OH–manager firewall is necessary for patient confidentiality, but OH practitioners, GPs and psychiatrists should be able to work together, in medical confidentiality, in the interests of the patients. There is a precedent for a limited form of this model with the Practitioner Health Programme (PHP) in London[9]. However, the PHP programme does not include OH services and advice sometimes needs to be 'bought in'.

Our vision was to use OH understanding of the limitations of the workplace to drive the treatment forward. Timely intervention can prevent job losses, and a joint approach between a focused and well-connected local GP can ensure that physical interventions are carried out in parallel to the mental health ones. We therefore decided that a joint private-public enterprise between our OH department, a local GP and the same mental health service, which provided ad hoc input to OH, should be set up.

The service aims to fill any voids in care, and referral will be open to all trust employees. An employee who does not have a GP, or who is unwilling to see their own GP, is seen by the service's GP. Similarly, an employee who is not engaged with NHS psychiatric services is treated by the in-house psychiatric team. Almost all employees are seen by the OH practitioner. The service has been set up with the agreement of the trust, and will start seeing its first patients as soon as appropriate funding pathways can be agreed. We then hope to assess the effectiveness of the service.

The service will complement the forthcoming nationally specified OH service for GPs suffering from work-related health conditions such as burnout and stress[10]. This initiative was announced in September 2015 by the NHS England chief executive, Simon Stevens, who said: 'At a time when the pressures on GPs have never been greater, we need to extend the local practitioner health programmes that have been shown to help GPs stay healthy and get back to work when sick'. We think that our model, which is similar to that of the PHP but available to all staff and not just GPs, could have a useful role to play beyond this national initiative. ■

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Notes

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