

Supporting health and wellbeing at work

October 2018



Executive summary

At a time when the NHS is under-resourced, over-stretched and is facing recruitment and retention problems, it is vital that the health and wellbeing of staff is prioritised. NHS staff are more likely to incur a work-related illness or injury than staff in other sectors, yet access to support is variable and inconsistent.

Keeping doctors healthy will have important benefits for the NHS by improving staff engagement, reducing costs associated with absence and turnover, and improving patient outcomes. An employer focus on the health and wellbeing of staff will have a long lasting and positive impact in terms of patient care and value for public investment. This is important in a system that is under severe pressure. In order to ensure that the NHS is able to deliver the highest quality care to patients, the NHS has to ensure that the health and wellbeing of the workforce is supported on an individual and systemic level.

Dr Steve Boorman's landmark report in 2009 highlighted many of the issues that are still faced today. The lack of credible joined-up action since then is unsustainable. NHS staff sickness absence is double the national average. This places major burdens on the NHS in terms of cost, continuity of care and overwork in an environment where long working hours are endemic. On top of this doctors frequently feel the necessity of attending work in ill health. Absence and ill health of staff is not a good combination in any workforce, but particularly not for doctors who are trying to maintain the health of the nation.

We are facing major systemic problems and the responses up to now have not been effective. Only half of all doctors we surveyed were aware of any services that support them with physical and mental health problems. Early intervention is critical to support doctors' health and wellbeing, particularly considering the very particular pressures they are under. But not only are the current services often not known, they are disjointed, different in different nations, and any good practice and learning is rarely shared. In summary, there is an inequality of access to health and wellbeing services that must end.

This can change. Employers can do more to prioritise doctors mental and physical support, build a supportive culture, tackle the stigma around accessing support services, and ensure that services are holistic and comprehensive. The very real dangers for doctors and patients from the current situation can be remedied but we have to start a conversation on how to achieve this and must support those doctors' voices struggling today and, in the future, so they can receive the care they need. This report sets out our initial recommendations about how we might get there.

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Overview of our recommendations

Occupational health services

- NHS staff should have **access to a specialist-led occupational health service**
- Occupational health services should be **free, comprehensive and meet the individual needs and requirements of doctors** working across all settings.
- Access to OH services should be **consistent and easily accessible** for all doctors. Staff need to have timely access to assessments to prevent absence or delays in training.
- OH services need to be **adequately funded** in order to deliver high-quality services.
- It is vital that OH services are **confidential** to avoid discouraging staff from seeking early help and advice.
- There needs to be **better funding and support for doctors with disabilities** who need specialist equipment to do their jobs. For example, doctors using specialised or personalised equipment (which is owned by the employer) should be able to keep this equipment throughout their training, even if they move between placements.

Health and wellbeing support services

- Trusts/health boards should review current **funding and commissioning of health and wellbeing services** to ensure that these meet the needs of the medical workforce.
- There is an inequality of access to health and wellbeing services. There needs to be scope for sufficient **flexibility in any service** to accommodate doctors' working patterns and rest times (for example, access to gym, canteen, 24 hour access to food).
- Fatigue and sleep deprivation, associated with long working hours and shift work, impacts on doctors' personal safety, increasing the likelihood of occupational accidents, road traffic crashes and needlestick injuries. In order to **reduce the risk of fatigue** employers should implement the [BMA fatigue and facilities charter](#).
- Health and wellbeing **support services must be more widely promoted by NHS organisations**. Obstacles to obtaining support for mental and physical issues can include lack of knowledge of where to access it. This is particularly important for junior doctors who rotate. Inductions would be a good opportunity to inform new recruits about the availability of health and wellbeing services.
- There are pockets of good practice where trusts have worked with staff to develop and implement successful health and wellbeing strategies. **This learning should be disseminated** across all NHS organisations.

Line managers

- Line managers should be supported to **support the health and wellbeing of staff under their care**, through training and education opportunities.

Culture of care

- Trusts/health boards should have **appropriate health and wellbeing policies in place**, including NICE guidance, and ensure that these are implemented consistently.
- Staff health and wellbeing improvement strategies need to be **holistic** and bring together the provision of OH services, wider non-OH health and wellbeing support services, and initiatives that will have a positive impact on staff health, including for example, staff benefit and recognition schemes or opportunities for personal development.
- In order to ensure that health and wellbeing strategies work, **staff should be encouraged to be involved in their design and implementation**.
In order to encourage staff to access services at an early stage of their condition, employers should **tackle the stigma that surrounds accessing support services**. This should include regularly raising awareness of mental health and suicide risk amongst healthcare workers with information on how to get help.
- **Employers must give priority to staff health and wellbeing and provide leadership on the subject**. In order to ensure that a culture of health and wellbeing is developed board members need to show engagement and leadership on the issue.

- Employers need to take steps to **mitigate the effects of understaffing and rota gaps** in order to improve wellbeing and reduce unnecessary pressure on staff. The [BMA medical rota gaps report](#) highlights steps that can be taken.
- There needs to be greater emphasis on **preventing and tackling the causes of ill-health early** and creating a no-blame culture that fosters continuous learning and development.
- Finally, NHS organisations would benefit from **collecting and analysing information about the extent and causes of staff ill-health** in order to monitor improvement.

1. Introduction

Doctors are working in a system which is under pressure due to chronic underfunding, workforce shortages, and rising patient demand, which is affecting their mental and physical wellbeing. Intense workloads, understaffed rotas, and long hours are leaving doctors at risk of illness and burn-out. With a significant number of doctors citing concerns about health and wellbeing as being a major driver in breaks in training it is vital that issues around workload, stress, and burnout are addressed urgently.

Placing staff health and well-being at the heart of the NHS benefits patients, staff and the NHS as a whole – through improved patient outcomes, better staff morale, reduced staff turnover and sickness absence.¹

NHS staff are more likely to incur a work-related illness or injury than staff in other sectors.² NHS staff have a higher rate of sickness absence compared to the UK average worker across the public and private sector. Provision of health and wellbeing services, however, is inconsistent across the UK with considerable variation in the type of health and wellbeing services provided across trusts and health boards, which could be due to resourcing constraints and/or the benefits of these services not being fully recognised.

Having access to a workplace occupational health (OH) service ensures that managers and staff have access to specialist advice on improving and maintaining health in the workplace, as well as preventing and managing any work-related ill health. Comprehensive OH services play a key role in preventing ill health, ensuring health-related risks in the workplace are managed, and staff are able to return to work following absence due to ill health. Those with chronic disabilities will be reliant on effective OH services to support them throughout their careers.

The provision of non-OH health and wellbeing services (such as counselling, smoking cessation services) have an important role to play in improving staff health. A proactive approach to staff health and wellbeing requires investment in these support services alongside investment in OH services.

However, providing support services on their own does not achieve a comprehensive approach to staff health and wellbeing, it requires NHS leaders and managers to embed a culture of care. In order to develop a culture of care, the board and senior management need to recognise the contribution that staff health and wellbeing bring to delivering the organisation's core objectives.

This report looks at the state of health and wellbeing of NHS medical staff, the benefits to be reaped from improving it and sets out practical recommendations for change. It has a particular focus on the issues that junior doctors are facing in this area. While the focus of this report is on the NHS, many of the recommendations in this report can also be applied to employers in non-NHS settings.

2. Health and wellbeing challenges for NHS staff

“Health and wellbeing of NHS staff should no longer be a secondary consideration but needs to be at the heart of the NHS mission and operational approach”

Dr Steve Boorman
The Boorman Review 2009

When Dr Steve Boorman produced his report on the state of the UK NHS workforce’s health and wellbeing he hoped that it would “serve as a catalyst to prompt change – a change that makes the health of its workers of key importance to the NHS.”³ His report highlighted that NHS organisations worked in ways that were “incompatible with delivering high-quality health and wellbeing services and support for staff.” He commissioned a major staff survey which found that many staff reported significant levels of stress, and that staff did not believe that senior managers took a positive interest in their health and wellbeing.⁴ He argued that staff health was not just the responsibility of occupational health departments or wellbeing advisers but the responsibility of every single member of staff.⁵ Health and wellbeing was central at board level as much as at ward level.

Mental health

Doctors have a high risk of developing mental health problems. It has been estimated that between 10-20% of doctors will suffer from depression at some point in their career, although this is likely to be an under-representation.⁶

Poor mental health is also estimated to account for more than 25% of staff sickness absence in the NHS.⁷ A BMA investigation into sickness absence rates for doctors found that there was a wide variation across different acute trusts – in some, the absence rates for depression, stress and anxiety were four times the average.⁸

The perceived stigma surrounding mental health prevents many doctors from seeking help. Some studies show that it is usually younger doctors who approach support services. A 2007 study found that the largest group attending MedNet, a confidential consultation service for doctors and dentists in London, were between 30-39 years old.⁹ Similarly, the average age of doctors accessing the NHS Practitioner Health Programme, a confidential service for doctors that offers support for mental health issues, has dropped from 51.6 to 38.9 in 10 years.¹⁰ During this time more than 5,000 doctors accessed this service, around two-thirds of whom were women.

Female health professionals have an elevated risk of suicide.¹¹ Between 2011 to 2015 the risk of suicide among female health professionals was 24% higher than the national average. This is in contrast to the general population where men have a higher risk.¹²

Physical health

– Musculoskeletal

Musculoskeletal disorders are a major cause of illness and injury among the NHS workforce.¹³ Without timely diagnosis and intervention they can result in long-term absence or ill-health retirement. OH services cover a wide range of support for musculoskeletal conditions, including assessments, treatments, referral to physiotherapy/specialist services, and advice on self-management. For employees with lower back pain, interventions by OH services have been shown not only to return employees to work up to 5 weeks earlier than under normal care, but also to reduce the recurrence of back pain in the following year by up to 40%.¹⁴ A comprehensive OH service will ensure good clinical outcomes and significant reduction in time spent off work.

– Harassment and assault

Working on the frontline can bring with it a range of hazards including risk of physical violence. The 2017 NHS staff survey, which is completed by staff working in NHS organisations in England, found that 15.2% of staff experienced physical violence from patients, their relatives or the public.¹⁵ In addition, 2.1% of staff have experienced physical violence from staff.¹⁶ Incidences of harassment, bullying and abuse are even higher at 28% from patients and 24% from their colleagues. Employers are by law required to identify potential hazards in the workplace and take steps to minimise these as much as possible. Staff need to feel empowered to report these incidences while employers should ensure that any complaints are taken seriously and appropriate action is taken.

– Lifestyle

Several studies have shown a link between lifestyle choices, such as smoking, and sick leave. Dr Boorman's staff survey found that those who smoke 6 cigarettes or more a day have a 34% higher incidence of being absent than do non-smokers, and a 10% higher incidence of being absent for longer.¹⁷ Staff with poor physical health report more absence and for longer periods of time than those in good health.¹⁸ To reduce sickness absence staff need to have access to healthy food, rest facilities and opportunities/activities to improve their physical health. This is why the BMA have produced a [Fatigue and Facilities Charter](#) which sets out steps for employers to improve rest and catering facilities for the wellbeing of staff.

Working in a system under pressure

Doctors are not just at an increased risk of developing mental health or physical problems, they are also bearing the brunt of workforce pressures and chronic underfunding of services, as the BMA report [Working in a system that is under pressure](#) explores. Heavy workloads, long shifts and unpredictable hours are increasingly affecting doctors' physical and mental health.

The latest GMC (General Medical Council) national training survey, for example, found that nearly half of UK doctors in training worked beyond their rostered hours, while one in five said that their working pattern had left them short of sleep.¹⁹ Fatigue and sleep deprivation, associated with long working hours and shift work, impacts on doctors' personal safety, increasing the likelihood of occupational accidents and needle-stick injuries.²⁰ Work periods of over eight hours carry an increased risk of accidents that cumulates, with twice the risk of an accident at around 12 hours compared to eight hours.²¹ Fatigue also increases the risk of patient safety.²²

The situation in the NHS is now so bad, that the GMC survey found that nearly one in every four UK doctors in training say they were burnt out because of their work. Stress can manifest itself in physical effects, encouraging unhealthy behaviours such as smoking, drinking, substance abuse, and poor diet²³ or resulting in mental health problems.²⁴ Concerns about health and wellbeing (including risk of burn-out) is now a major driver in breaks in training according to BMA research.²⁵ The impact of rota gaps on training, morale, work-life balance and quality of care is further explored in the BMA report [Medical rota gaps in England](#).

3. Why improving health and wellbeing is important

Healthy staff benefit patients, colleagues and employers by improving staff and patient satisfaction, improving patient outcomes, reducing costs and increasing staff productivity.

Improved patient safety and outcomes

Dr Boorman found that patient satisfaction in acute trusts was higher in trusts where staff health and wellbeing (measured by injury rates, stress levels, job satisfaction and turnover intentions) was higher.²⁶ Conversely, where staff are unhappy and unhealthy, where there are high sickness rates, high turnover and high levels of stress, there are likely to be poorer outcomes and patient experience. Over 80% of staff who contributed to Dr Boorman's review said that their state of health affected patient care.

Improved retention

With ongoing staff shortages, it is vital that doctors are supported to stay in work and/or return to work following recovery from a period of ill-health swiftly. Staff retention rates improve when they feel their employer cares about their health and wellbeing. Employees who feel well cared for are 27% more likely to stay with their current employer for more than five years, compared with employees who feel only adequately or poorly looked after.²⁷

Good occupational health services also play a significant role in helping to keep an increasingly ageing workforce in work. As the average age of NHS employees is increasing²⁸ the number of doctors retiring on ill health grounds is rising too.²⁹ In 2008 the proportion of hospital doctors retiring on ill health grounds accounted for 1% of retirements, in 2018 it was 5.4%. The same trend can be observed for GPs where 5.4% retired on grounds of ill health in 2017.³⁰

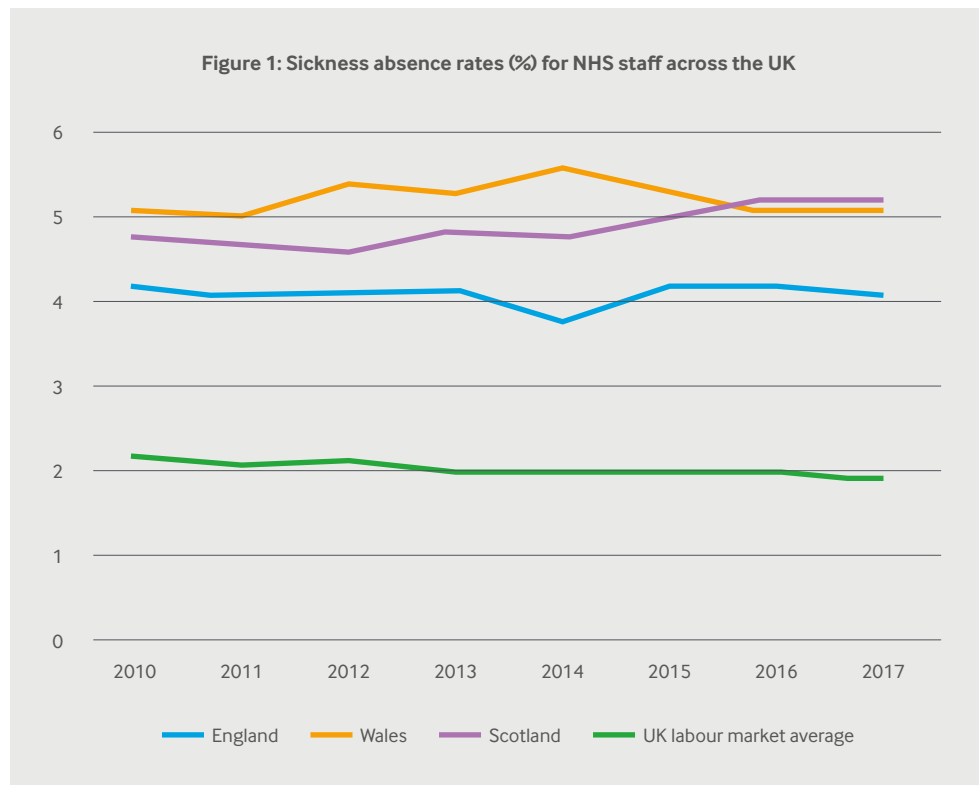
Reduced cost

Improving employee health and well-being will help to reduce the cost of sickness absence and ill-health retirement, increase productivity and lower spending related to staff turnover.³¹

Organisations that invest in health and wellbeing services have achieved major reductions in absence rates.³²

4. What sickness absence tells us

Sickness absence is a key indicator of the health and wellbeing of staff. Sickness absence rates (the proportion of working hours lost due to sickness or injury) in the NHS are more than double the UK labour market average, where there has been a general decline as shown in figure 1.



[StatsWales](#); [NHS Scotland](#); [ONS](#); [NHS Digital](#) (data from electronic staff record)

While doctors (in particular trainees) are less likely than other healthcare workers to take time off due to sickness³³, attending work while unwell (presenteeism) may be more of a threat. In Wales, for example, 70% of NHS staff report having recently attended work despite not feeling well enough to perform their duties.³⁴ Staff attending while sick may not be able to perform efficiently, passing on their illness to colleagues, or already immunocompromised patients. Doctors often come into work because they feel they have a responsibility to their patients or do not wish to burden colleagues who will pick up the work. Missing out on learning opportunities is another consideration for junior doctors in particular. The will to be at work may also be linked to organisational culture and pressure from managers. The most recent NHS staff survey found that 52.9% of staff attended work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves.³⁵

5. National strategies and policies for improving health and wellbeing

The below provides an overview of the various national policies, strategies and initiatives in place around improving health and wellbeing of NHS staff across the UK since the publication of the Boorman review. There are policies and strategies that can be built on but significantly more needs to be done to support doctors' physical and mental health and wellbeing.

England

The [NHS Constitution for England](#) includes a pledge to provide support and opportunities for staff to maintain their health, wellbeing and safety. The government has also stated its commitment to improving the health and wellbeing of NHS staff in the White Paper [Healthy Lives, Healthy People](#) (2010) including the need for NHS organisations to improve access to occupational health services and strengthening board-level accountability for the management of sickness and absence. [Healthy Staff, Better Care for Patients](#) (2011) provides proposals for improving the provision of OH services and the accompanying [Improvement Framework for Health and Well-being](#) (2011) was meant to help managers to establish a culture that promotes staff health and wellbeing.

NHS England have launched a number of initiatives to encourage trusts to prioritise health and wellbeing since. NHS England has for example been encouraging providers via the 2017-19 Commissioning for Quality and Innovation incentive scheme to implement changes that will improve the health and wellbeing of their workforce.³⁶ The scheme covers: improving the health and wellbeing of all staff, healthy food for NHS staff, visitors and patients, and improving the update of flu vaccinations for front line clinical staff. We should get a better understanding of whether the scheme has been successful next year. NHS England have also undertaken national work to reduce the amount of sugar on NHS sites.

In May 2018 NHS England developed a framework for all NHS organisations to use to help them improve their support for staff – the [NHS Workforce Health and Wellbeing Framework](#). They also developed a [diagnostic tool](#) to help employers assess their organisation against the Health and Wellbeing Framework.

NHS England announced in October 2018 that the NHS Practitioner Health Programme, which provides mental health support for doctors and dentists and currently only operates in London, would be made available across England.

Wales

One of the NHS Wales Core Principles is that all staff who work for the NHS are valued. In 2012, the Welsh government published [Working Differently, Working Together](#) setting out a framework that aims to support the health and wellbeing of staff. All health boards and trusts were asked to adopt the [NHS Wales Staff and Wellbeing Charter](#) (2013) and achieve the objectives outlined within it. In addition to this, the Welsh Government announced in its [Primary Care Workforce Plan](#) (2015) that an occupational health service would be made available for primary care staff, beginning with GPs. A OH service for GPs was rolled-out in 2016.

Scotland

The Scottish government has been addressing staff health and wellbeing through a number of strategies. The [Quality Strategy for NHS Scotland](#) (2010) recognises the importance of staff health and wellbeing in improving patient outcomes. [Everyone Matters: 2020 Workforce Vision](#) (2013) and the associated [implementation plans](#) ask NHS boards to take action to promote the health and wellbeing of the workforce and ensure staff are aware of the support available to them. [Safe and Well at Work](#) (2011) promotes occupational health and safety of NHS Scotland staff. In 2016, the Scottish Government also launched the GP occupational health service for primary care staff including GPs, GP locums, administration, nursing and other practice staff.

Northern Ireland

The [Health and Social Care Workforce Strategy 2026](#) recognises the benefits of occupational health service to the health and social care sector and recommends further work to improve the delivery of OH services.

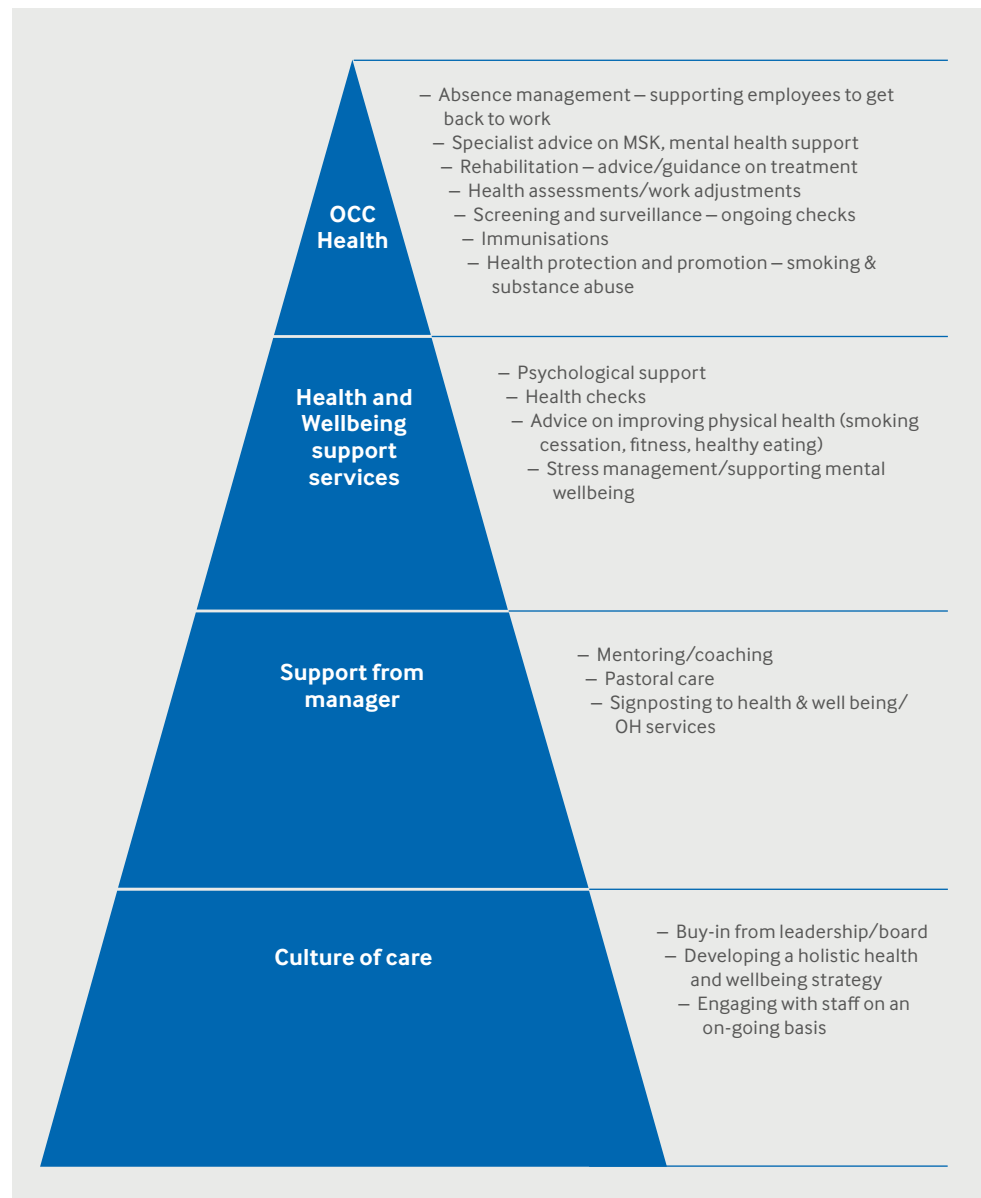
6. Improving the health and wellbeing of doctors

The above sections have focussed on the mental and physical needs of healthcare staff, how sickness absence in the NHS differs from the wider labour market, what the benefits of improving workforce health are for patients and the NHS, and what national policies are in place across the UK.

The current situation is not working for the proper health and wellbeing of doctors in the UK. Many doctors do not know that services do exist but even where they do the coverage of the existing services varies across the country with outcomes that are not supporting staff at a time of severe pressure in the NHS.

The focus of this section is how to change this. It explores what needs to be done at all levels (see figure 2 below) – from organisational culture to the delivery of OH services – in order to ensure that staff are well supported. In order to be successful, health and wellbeing strategies need to be driven at all levels – by the board, senior management, individual departments (HR/OH departments), line managers and individual staff.

Figure 2 – Levels of support



Occupational health services

Dr Boorman's staff survey raised a number of concerns about the provision and accessibility of occupational health services including considerable variation in the level and extent of services provided, uncertainty over the role and function of OH services, and inadequate funding and resourcing.³⁷ He believed that some of those commissioning services took a narrow view on their role and function (i.e. that it is concerned solely with pre-employment screening, immunisation).³⁸ Although this report was published nearly ten years ago we see a similar picture today.

Role of OH services

Occupational health services play a key role in ensuring that staff are well and supported when they are at work or when they return to work following injury or ill health. An OH service is a confidential advisory service that has a dual role to provide advice and support to both managers and employees about health in the workplace. As experts in physical and mental wellbeing of employees, OH physicians have detailed knowledge of relevant health & safety legislation, provide strategic advice to employers on issues affecting health in the workplace and provide individual support.³⁹ They can work as part of a wider multidisciplinary team to provide advice and support. Figure 2 provides examples of the types of services that are provided by OH teams. Many large organisations have their own in-house OH service or they buy these services from a third-party occupational health provider. Dame Carol Black's review *Working for a healthier tomorrow* advocated for formal accreditation of all OH providers which was endorsed by the government.⁴⁰ As a response, the Faculty of Occupational Medicine developed standards and accreditation of OH services.⁴¹ The Royal College of Physicians were commissioned by FOM to develop and manage the accreditation scheme.

OH services play an important role in supporting staff, however, it is worth noting that the OH medical workforce is facing a supply crisis due to number of specialists set to retire in the next 10 years and the time it takes to train new OH physicians, as has been highlighted by a report from the APPG on Occupational Safety and Health.⁴²

Support for staff with a disability

Those with chronic disabilities, in particular, are reliant on effective OH services to support them throughout their training.

The Equality Act 2010 requires employers and providers of medical education to make reasonable adjustments to ensure that people with a disability do not face disadvantages compared to a colleague who is not disabled. What is considered 'reasonable' will depend on the individual circumstances. Once an individual declares an impairment or medical condition the process varies depending on the providers, in many cases reasonable adjustments are dealt with on a local level with the employers and occupational health teams.

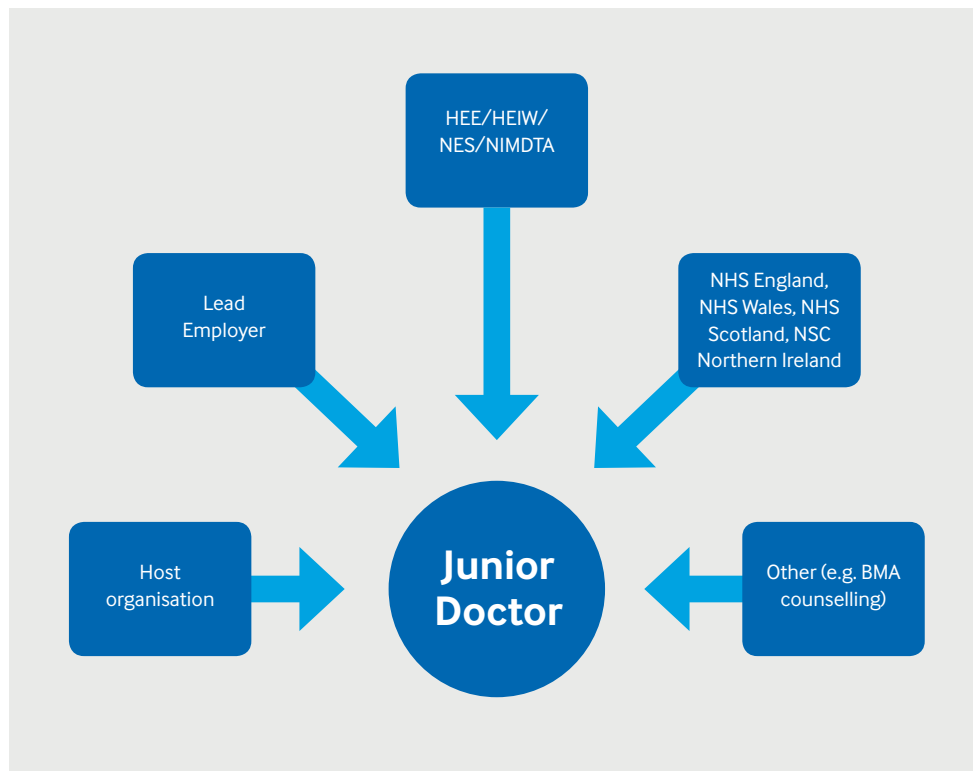
Depending on their employer arrangement some trainees may be re-assessed and have to re-apply for equipment every time they move setting. In some cases a lack of appointments for OH assessments have even meant that trainees have had to delay to the start of their training.

Support from employers/post-graduate education providers

Junior doctors receive support from numerous sources throughout their training such as through their lead employer, host organisation (GP practice, trust/health board) or their postgraduate education provider (Health Education England, Health Education and Improvement Wales, NHS Education for Scotland, Northern Ireland Medical and Dental Training Agency). Most postgraduate education providers have professional support units which offer holistic support services. There are nationally and regionally commissioned occupational health services junior doctors have access to.

Figure 3 – Roles and responsibilities of the lead employer, postgraduate education provider, and host organisation

Lead Employer (if there is one)	Legal employer and responsible for employment matters (e.g. payroll, occupational health and other HR services).
Health Education England/Health Education and Improvement Wales/NHS Education for Scotland/Northern Ireland Medical and Dental Training Agency	Oversees education & training (sets the framework that will determine trainees health and wellbeing).
Host organisation	Responsible for providing training placement, local supervision and management – and the ‘local culture of care’ (this may include provision of OH services)



Each trust/health board or GP practice is a separate employing organisation and responsibility for providing OH services to staff rests with them unless there is a ‘lead employer’ arrangement in place.

The picture of OH provision and configuration differs across the UK. In secondary care, trusts/health boards are responsible for providing health and wellbeing services, including OH services to their staff. In England, trusts provide an occupational health service for its own staff or commission it from another provider. This has led to the development of a large number of OH services with different sizes and structures. There are also geographical variations when it comes to the number of separate providers. One report published shortly after the publication of the Boorman review highlighted that in some places fragmentation was so extensive that multiple services would be provided in very close proximity (especially in major urban areas) and many Trusts, based on the same site, would be supported by

different providers.⁴³ In some cases NHS staff on one site where a OH unit was based received their OH support from a completely different location.⁴⁴

The provision and funding of occupational health services for NHS staff is inconsistent, particularly, when it comes to provision in primary care. For example, in Scotland the government launched an OH scheme which is available to all staff working in primary care, in England only very basic OH services are funded and any additional services have to be paid for by the GP practice or self-funded. In Wales, where healthcare structures work on a more integrated primary/secondary care basis, the remit of local health board occupational health services was extended to cover some staff in primary care (e.g. GPs).

Support for staff working in primary care

In 2016, NHS England launched a nationally-specified occupational health service for primary care staff. While some services are commissioned by NHS England, others are self-funded by applicants to the national performers list or paid for by GPs in support of their employees. Some services cover all healthcare workers, including trainees (for example, management of blood borne viruses) while access to additional OH services (for example, OH screenings/assessments, virology testing & immunisations) have to be paid for by the GP practice or self-funded. Since 2017, GPs and trainees also have access to the nationally funded NHS GP Health Service. The service is targeted at GPs and GP trainees who are suffering from mental ill-health (stress or depression) and addiction. BMA GPC has been calling for all GP practice staff to be covered by a funded and comprehensive OH service.

In 2016, the Scottish government launched an OH service for all staff working in primary care (including GP trainees and locums). These OH services can be accessed free of charge from the local health board. This service is backed by £920,000 per year.

The Welsh Government announced in its [Primary Care Workforce Plan](#) back in November 2015 that “an occupational health service would be made available for primary care staff, beginning with GPs.” An OH service for GPs (including partners, salaried GP, and any other GP employed directly by the practice) was launched in 2016. This service is backed by £200,000 per year. GPs are able to access these services from their respective local health board, however, any other practice staff are not covered. BMA GPC Wales has been calling for the extension of this service to cover all GP practice staff. GP trainees are able to access OH services via a single employer (NHS Wales Shared Services Partnership).

In Northern Ireland, there are arrangements in place for the provision of occupational health services to GPs on the medical performers list and their staff (including locums) through HSC-based services (i.e. Trust based) at no cost.

The above paragraphs show that NHS staff, and in particular junior doctors, face a lack of consistency in OH provision during their training. The level of OH support differs according to where they are based, which can make it hard for them to know where to turn.

Recommendations:

- NHS staff should have **access to a specialist-led occupational health service**.
- Occupational health services should be **free, comprehensive and meet the individual needs and requirements of doctors** working across all settings.
- Access to OH services should be **consistent and easily accessible** for all doctors. Staff need to have timely access to assessments to prevent absence or delays in training.
- OH services need to be **adequately funded** in order to deliver high-quality services.
- It is vital that OH services are **confidential** to avoid discouraging staff from seeking early help and advice.
- There needs to be **better funding and support for doctors with disabilities** who need specialist equipment to do their jobs. For example, doctors using specialised or personalised equipment (which is owned by the employer) should be able to keep this equipment throughout their training, even if they move between placements.

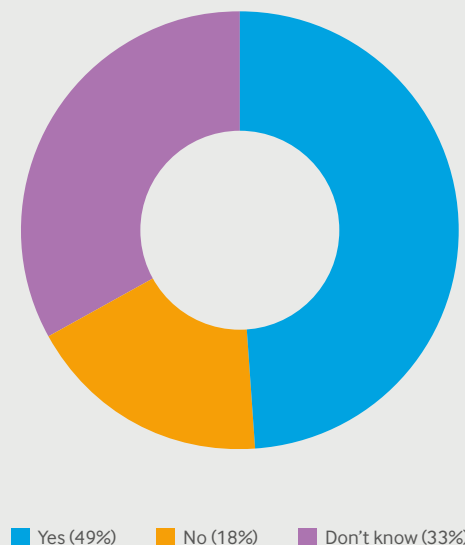
Health and wellbeing support services

In order to prevent staff sickness and improve mental health and wellbeing staff require services that go beyond those that are traditionally provided by OH units, including health trainers, screening services, psychological support, funding for gym membership, health checks, smoking cessation services and anti-obesity advice.⁴⁵

Dr Boorman found that investment in these services had been patchy and arranged on an ad hoc basis (at time commissioned by different departments of the same organisation) without regard of how services should fit together.

Many doctors now are not aware of the support services available in the workplace. According to the BMA quarterly survey from April 2018 only half of doctors in the UK were aware of any services that support doctors with physical or mental health problems in their place of work (see figure 4) while 18% stated that no such services were available (33% were unaware that these were provided).⁴⁶

Figure 4: Are there any services that are provided to support doctors who have physical or mental health problems where you work?



Recommendations:

- Trusts/health boards should review current **funding and commissioning of health and wellbeing services** to ensure that these meet the needs of the medical workforce.
- There is an inequality of access to health and wellbeing services. There needs to be scope for sufficient **flexibility in any service** to accommodate doctors' working patterns and rest times (for example, access to gym, canteen, 24 hour access to food).
- Fatigue and sleep deprivation, associated with long working hours and shift work, impacts on doctors' personal safety, increasing the likelihood of occupational accidents, road traffic crashes and needlestick injuries. In order to **reduce the risk of fatigue** employers should implement the [BMA fatigue and facilities charter](#).
- Health and wellbeing **support services must be more widely promoted by NHS organisations**. Obstacles to obtaining support for mental and physical issues can include lack of knowledge of where to access it. This is particularly important for junior doctors who rotate. Inductions would be a good opportunity to inform new recruits about the availability of health and wellbeing services.
- There are pockets of good practice where trusts have worked with staff to develop and implement successful health and wellbeing strategies. **This learning should be disseminated** across all NHS organisations.

Support from line manager

Often employees are worried to tell their manager about a mental health issue they are experiencing. It is important that managers are confident about mental health to help normalise conversations and encourage an open dialogue.⁴⁷ Line managers need to be empowered to take a proactive approach to wellbeing, this includes having the support and training to recognise health and wellbeing issues early and encouraging a member of staff to seek help.

Recommendations:

- Line managers should be supported to **support the health and wellbeing of staff under their care**, through training and education opportunities.

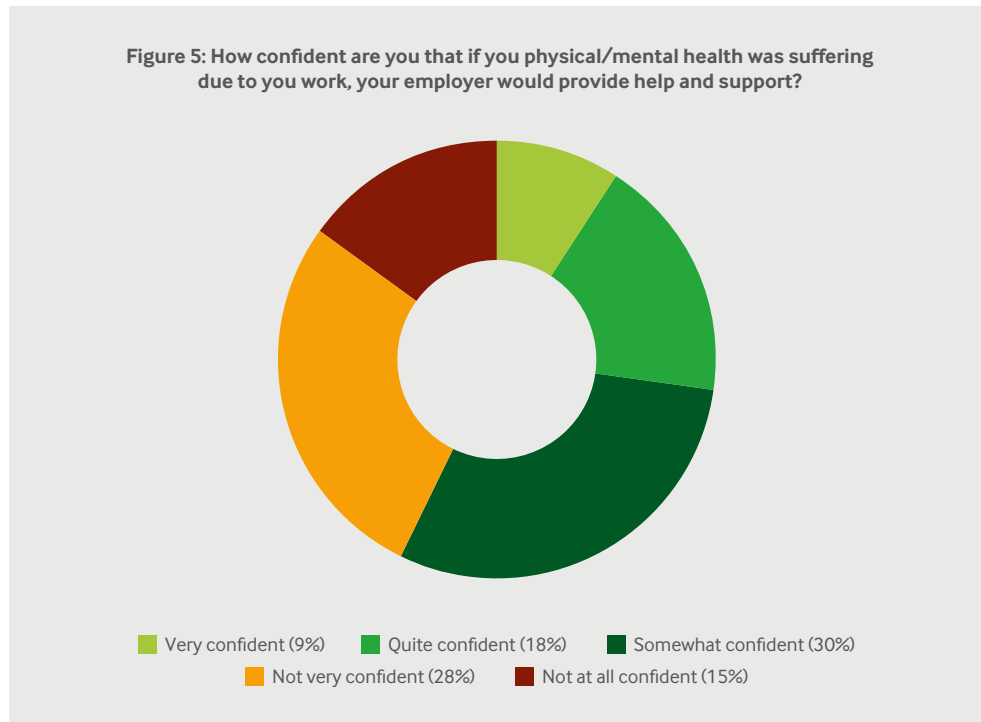
Culture of care

The Boorman review recognised that optimising health and wellbeing was only possible through an organisational culture that promoted care and support. He believed that "a comprehensive approach to staff health and wellbeing require[d] good leadership and management as much as good support services." Without this, health and wellbeing initiatives, although well intentioned, would not be effective. Staff and wellbeing approaches must not be seen as a series of one-off initiatives but a joined-up strategy which is integral to the organisation's business plan.⁴⁸

An organisational culture that listens to employees' concerns and encourages staff to access health and wellbeing services (including occupational health services) would help reduce absence rates. A review by Dame Carol Black and David Frost into sickness absence highlighted that where absence had been tackled and reduced "one consistent factor was the willingness of senior managers, starting at Board level, to acknowledge the problem and take action" by spreading a good working culture and changing habits.⁴⁹

Stress and mental health issues are a big cause of sickness absence, however, mental health disorders are still poorly understood by employers and the public at large. They are still regarded a taboo subject and research shows that employees are reluctant to disclose these issues at work.⁵⁰ Senior leaders have a responsibility to create an open culture, help employees recognise wellbeing as a vital issue, and empower line managers to make this a priority.⁵¹ This would involve promoting awareness of mental health issues, thereby reducing the stigma, and encouraging early access to support services.

The BMA's own research shows that NHS organisations need to do more to support and promote health and mental wellbeing of their staff. According to the BMA quarterly survey from April 2018 only 27% of doctors were very or quite confident that if their physical/mental health was suffering due to work, their employer would provide help and support (see figure 5).⁵²



Support strategies need to be backed up by appropriate policies and processes. In 2014 an audit of NICE workplace guidance found that only 57% of trusts in England had a mental wellbeing policy in place, just 44% of trusts had a policy in place for physical activity and only 28% had a plan to tackle obesity. In addition, 24% of trusts did not monitor the mental wellbeing of staff.⁵³ Staff health and wellbeing is a key enabler to delivering the wider service goals and needs to be recognised as such (see section 3 on the benefits of improving workforce health).

More widely, the findings from the BMA's caring, supporting, and collaborative report highlight that a culture of fear and blame in the NHS persists. Therefore, it is vital to have a shift in culture in the NHS, involving the creation of a genuinely supportive learning environment for staff. **Appendix 1** includes case studies where trusts have taken proactive steps to create a 'culture of care' and improve staff health and wellbeing by raising awareness around bullying, mental health, and stress management.

Initiatives such as 'hot' debriefs following clinical incidents play an important role in reducing the risk of doctors developing mental health problems later on. Balint groups and Schwartz round also play an important role in providing emotional support for doctors and supporting collaborative working.

Recommendations:

- Trusts/health boards should have **appropriate health and wellbeing policies in place**, including NICE guidance, and ensure that these are implemented consistently.
- Staff health and wellbeing improvement strategies need to be **holistic** and bring together the provision of OH services, wider non-OH health and wellbeing support services, and initiatives that will have a positive impact on staff health, including for example, staff benefit and recognition schemes or opportunities for personal development.
- In order to ensure that health and wellbeing strategies work, **staff should be encouraged to be involved in their design and implementation**.
- In order to encourage staff to access services at an early stage of their condition, employers should **tackle the stigma that surrounds accessing support services**. This should include regularly raising awareness of mental health and suicide risk amongst healthcare workers with information on how to get help.
- **Employers must give priority to staff health and wellbeing and provide leadership on the subject**. In order to ensure that a culture of health and wellbeing is developed board members need to show engagement and leadership on the issue.
- Employers need to take steps to **mitigate the effects of understaffing and rota gaps** in order to improve wellbeing and reduce unnecessary pressure on staff. The [BMA medical rota gaps report](#) highlights steps that can be taken.
- There needs to be greater emphasis on **preventing and tackling the causes of ill-health early** and creating a no-blame culture that fosters continuous learning and development.
- Finally, NHS organisations would benefit from **collecting and analysing information about the extent and causes of staff ill-health** in order to monitor improvement.

Emotional support – examples of good practice

- **Schwartz rounds** provide a forum for all healthcare staff to come together at regular times to talk about emotional and social challenges of their work.⁵⁴ Research into Schwartz Rounds have shown that they have a positive impact on staff including an increase in confidence, decreased stress and feeling supported. There are over [100 NHS organisations](#) that have signed up to run these.
- **Balint groups** provide a safe space for clinicians to meet and present cases to each other. The focus is on the emotional component of a consultation rather than the clinical context. Balint groups help trainees deal with workplace pressures but also improve their relationships with patients and colleagues.
- **'Hot debriefs'** following a critical incident allows those present to identify learning points and acknowledge the emotional impact it has had.

Appendix 1: Guidance for employers to improve health, wellbeing and mental health

England

NHS Employers

[Health and Wellbeing website](#) section provides practical resources, guidance and support to help NHS organisations implement effective health and wellbeing programmes for the workforce.

Case studies where trusts have developed successful health & wellbeing strategies:

- [Choosing a healthy lifestyle](#)
- [Staff engagement](#)
- [Reducing stress](#)
- [Weight management](#)
- [Supporting staff to deliver leadership & management behaviours](#)
- [Supporting mental health wellbeing](#)
- [Tackling bullying and harassment](#)
- [Tackling physical inactivity](#)
- [Reducing sickness absence](#)
- [Quitting smoking](#)
- [Improving staff morale](#)
- [Peer-to-peer coaching & mentoring](#)
- [Pastoral lead for junior doctors](#)
- [Stress management, mindfulness and trauma debriefing](#)
- [Leading with authority and resilience](#)
- [Flexible e-rostering to reduce fatigue](#)

Wales

- [Medical Trauma & Resilience Training \(MedTRiM\)](#)
- [Guidance for Trust and LHB Health and Wellbeing](#)
- [NHS Wales Staff Health and Well Being Charter](#)
- [Caring for staff: The NHS Wales Staff Psychological Health and Well-being](#)

Scotland

Case studies where health boards have implemented good practice:

- [Abstinence programme \(LEAP\)](#)
- [Alcohol Awareness](#)
- [Cycle Training and Light Therapy for Staff](#)
- [Employee Placement](#)
- [Dealing with verbal and non-verbal abuse](#)
- [Managing Violence and Aggression](#)
- [Effective Communication for V&A Reduction](#)
- [Litepods](#)

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