Department of Health

The Provision of *Occupational Health and Safety Services for General Medical Practitioners and their Staff*

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Foreword

The primary care work force represents a substantial part of total NHS staffing. It has long been an aspiration to make occupational health services universally available to all who are engaged in NHS health care, including general practitioners and their staff, as well as those in hospital and community trusts.

The provision of these services will, by improving the health and environment of the primary care workforce, ensure that General Practitioners and their staff make the best possible contribution, both individually and collectively, to improving health and patient care in primary care.

That is why the Government announced in the NHS Plan that Occupational Health services would be extended to General Practitioners and their Staff from 1st April 2001.

We are therefore delighted to bring you this guidance which gives details on what Health Authorities need to commission, funded through additional allocations to their budgets to provide these services.

This guidance is the culmination of many months of work by the Department of Health, the British Medical Association's Occupational Health and General Practitioners Committees, the Faculty of Occupational Medicine, the Society of Occupational Medicine, the Royal College of General Practitioners, the Association of National Health Occupational Physicians and the Royal College of Nursing. It recognises in the most practical way the commitment of the NHS to its staff and through them to the people it serves.

No doubt lessons will be learnt as this most important project goes forward and occupational health services in primary care are developed. We welcome this beginning and look forward to the future.

John Denham
Minister of State for Health

Howard Vaile
Chairman, BMA
Occupational Health Committee

Introduction

1. Good occupational health and safety is an essential part of the effective management of the health of people at work. It can reduce work related ill health and accidents and should improve employee morale and performance.

2. The NHS Plan, published by the Secretary of State for Health in July 2000, announced that:

> *Occupational Health services, already a requirement in Hospitals and Community Trusts, would be extended to General Practitioners1 and their Staff from 1st April 2001.*

The current situation

3. There is currently no national occupational health service available for GPs or their employees, although such a service is available to staff who work in and for NHS Trusts and Health Authorities. Some NHS Trusts and Health Authorities already make their OH services available to Primary Care staff through locally financed initiatives but these services are, at best, patchy.

4. Reports by the Nuffield Hospitals Provincial Trust, the medical Royal Colleges and the British Medical Association have raised concerns about the health of General Practitioners (GPs). These reports have also highlighted the fact that GPs in need of medical assistance may choose to self diagnose and medicate rather than seek help from an appropriate independent source. In some cases, staff who work for GPs choose to register with their employer, rather than an external practice, causing possible conflicts over management and confidentiality.

[1] All references in this document to general practitioners or GPs refer to general *medical* practitioners.

Evidence of the need for occupational health services

5. As well as the problems of self diagnosis, self prescribing and staff being enrolled with their own employer as GP there is other evidence of the need to provide access to occupational health services to GPs and their staff. Recent studies have found raised levels of mental ill-health scores in GPs[2]. In doctors, the mental health problems range from anxiety, through emotional exhaustion to clinical depression and suicide. In some cases problems are associated with unhealthy lifestyles e.g. excessive alcohol consumption[3].

6. The aim of extending access to occupational health services to GPs and their staff is to ensure that all people who work in and for the NHS are able to make the best possible contribution, individually and collectively, to improving health and patient care.

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[2] Improving the Health of the NHS Workforce – Michie,Williams, Pattani, - Nuffield Trust 1998

[3] as above

Chapter One

What are Occupational health and Safety Services

1. The new NHS has a number of key principles: fairness, excellence, equity of access, working in partnership and the need for positive health gains. These principles are shared by occupational health and safety services.

2. Traditionally occupational health and health and safety services in the NHS have been delivered separately, although there is an increasing move towards better integration and closer working between the specialties. Health Authorities in commissioning these services for GPs and their staff may wish to purchase services either separately or together depending upon local circumstances.

   An Occupational Health and Safety Service (OHSS):

   - Addresses the impact of work on health and of health on work
   - In an NHS context, seeks to reduce the incidence of illness and injury caused by work in the NHS
   - Has the objectives of ensuring that work in and for the NHS fits the worker and that all staff are able to achieve their full capabilities at work

3. These objectives are important because the NHS (including GPs) has a statutory and ethical duty as an employer, and as the holder of contracts with primary care contractors, to safeguard, so far as is reasonably practicable, the health and safety of staff at work. There is a parallel duty to prevent harm to patients and the wider public arising from work activities. These duties are placed firmly upon those who manage or enter into contracts with primary care contractors – in the case of PCGs or PCTs – or employ – in the case of GP practices or PCTs – and an occupational health service should provide competent advice and support to help secure these aims.

4. In enabling those who work in Primary Care, including PCGs and PCTs, to have access to a comprehensive OH service, it is important that such a service should be designed to meet the needs of Primary Care: both as a community and an organisation. It should not simply be a scaled down model of the service available to those working in NHS Trusts. Primary Care is a very different organisation and will require a different style of delivery and provision, more appropriate to the needs of small and medium sized enterprises.

Chapter Two
The Range of Functions and Services Included in Occupational Health and Safety Services

1. An occupational health and safety service (OHSS) does not work in isolation, it responds to assessment of need, including hazard identification and risk assessment and though services may vary from area to area, there is a common commitment to competence and excellence.

2. Health Authorities commissioning OHSSs for GPs and their staff will be expected to ensure that the following criteria, considered the minimum essential requirements for staff working in both the primary and secondary care sectors, are met.

   - all GPs and their staff, including locums and casual employees, have access to a competent confidential OHSS;

   - the OHSS is geared appropriately to the needs of the organisation and the health and safety risks identified, and is staffed by competent and appropriately trained medical, nursing and other staff;

   - staff representatives and Local Medical Committees are consulted over setting up and reviewing the running of the OHSS. Arrangements should also be made for continuing discussions, e.g. a user's committee.

3. The range of services and functions of an OHSS should include as a minimum:

General guidance and advice

The development of OH policies and standards in collaboration with all stakeholders and staff representatives, personnel, health and safety services and infection control.

Monitoring the health of employees and primary care contractors including work-related stress, hazard identification, risk assessment, elimination or control followed by an audit of effectiveness.

Ensuring that the employers take into consideration the requirements of the Disability Discrimination Act 1995 (DDA) and that adjustments are made, where reasonable, to ensure that people can work in the Primary Care Sector regardless of physical or mental impairment.

Health issues

Immediate access to advice and treatment for blood exposures, including HIV post exposure prophylaxis when appropriate, and available outside normal working hours.

Health assessment in employment e.g. following sickness absence, in connection with fitness to work or practice, for work related ill health issues or for ill health retirement purposes. There should be a facility for both self-referral (see Chapter 5) to enable employees to obtain confidential advice and also for employer referral.

Pre employment health assessment of all new staff carried out fairly, objectively and in accordance with equal opportunities legislation and good OH practice.

Facilitate rehabilitation after a period of sickness and the provision for staff to return to work on a staged basis only carrying out part of their normal duties until they are able to fulfil their full range of duties.

Employers should ensure that appropriate immunisations are carried out on employees and should satisfy themselves of the immunisation status of any locum staff. The diseases of particular concern are polio, HBV and HIV, rubella, tuberculosis. GPs and their staff are required to comply with DH guidance on HIV and HBV which may require access to advice from a consultant OH physician. The OH department will keep accurate records.

Access for all GPs and their staff to the confidential counselling services already provided for staff working elsewhere in the NHS.

Safety issues

Assessment and reduction of risk.

Assistance with job design to allow for application of ergonomic principles and appropriate strategies for risk elimination, reduction or control.

Production of comprehensive workplace assessments.

Monitoring of ill health and accident statistics - contributing to the understanding of the working environment, management of sickness absence and the reduction of risk.

Training and good practice on the usage and disposal of needles and sharps and the procedures for the management of blood exposure incidents.

Advice on the correct aids and training for use in manual handling

Health promotion

Education of staff in, and promotion of adherence to, health and safety legislation and objectives in association with health and safety, personnel, line managers and other relevant professionals.

Health promotion and education in the workplace in collaboration with health and safety, health promotion, personnel and other relevant professionals.

Chapter Three

Occupational Health and Safety Services Delivery Standards

1. The NHS Plan announced that standards for occupational health services for NHS staff would be included in the Improving Working Lives standard. These standards will also apply to the provision of occupational health services to all GPs, and eventually to all primary care contractors, and their staff working in the NHS. Whenever practicable the same standards should also apply to services provided to all other GPs and their staff.

2. The standards set out below are intended to be auditable to ensure compliance and suggestions are given for audit protocols to facilitate this. It is assumed that both the occupational health department and those providing health and safety services, if separate, will keep accurate and auditable records of work carried out to allow managers to meet legal requirements and assess the volume and type of work being carried out.

Risk Management

Standard: Comprehensive risk assessment should be carried out on a regular basis to identify workplace hazards, assess the risks to staff and suggest appropriate action to remove, minimise or control them.

Audit protocol: A written risk management policy should be available together with details of risk assessments carried out, recommendations made and actions undertaken to deal with the identified risks.

Pre-Employment

(i) Standard: Pre-employment health questionnaire to be dealt with within 48 hours of receipt.

Audit protocol: Date of receipt of questionnaire and issue of fitness to work advice to be logged and available on staff record or PC.

(ii) Standard: (a) Manager notified within 2 working days of the need for potential new member of staff to attend for health assessment.

(b) Individual concerned to be offered appointment within 7 working days.

Audit protocol: Data questionnaire received is logged as is date of notification to manager, date of appointment and confirmation that appointment was attended.

(iii) Standard: All new starters to be sent a letter via their manager, prior to commencement, requiring their attendance in the occupational health department within two weeks of starting for vaccinations.

Audit Protocol: Date letter sent and appointment attended recorded on staff OH record or PC.

In Service Referral

Standard: Following referral by the client or their manager, an appointment will be arranged within 5 working days to see an occupational health nurse. If an appointment with an occupational health physician is required, this will be arranged within 10 working days.

Audit protocol: Date of referral and appointment to be recorded in staff OH notes.

Vaccination Immunisation

Standard: (a) All staff will be offered immunisation as appropriate for their occupation or work activities. An appointment will be given at their line managers' request.

(b) There will be an agreed immunisation policy setting out the requirements for staff groups.

(c) The OHS will be responsible for organising immunisations, boosters and blood testing and for recalling staff. Staff will be recalled when boosters are due depending on the Titre level and non-attendees recalled if they fail to turn up for vaccination or blood test.

Audit protocol: (a) Date of referral and appointment to be recorded in staff OH notes or PC.

Audit protocol: (b) Written immunisation policy available for inspection

Audit protocol: (c) Date of vaccination recall to be audited via the Hep B recall system.

Occupational Health Screening:

Standard: All employees who require health surveillance to meet COSHH Regulations will receive surveillance appropriate to their work or exposure

Audit protocol: Surveillance to be audited via system showing the date completed, results, previous test and follow up and when information was passed to line manager.

Access to Counselling Services

Standard: Following referral by the client or their manager, an appointment will be arranged within 48 hours. Immediate access to a counsellor can be provided by telephone.

Audit protocol: Date of referral and appointment to be recorded by the Counselling Service and available anonomised for audit.

NB: This standard is not to be seen as suggesting that the provision of counselling services for staff should be through the OHSS, nor should the OHSS keep a record of referral to the counselling service in their patient records. Further guidance on the setting up of a counselling service can be found in "The Provision of Counselling Services for Staff in the NHS"

Risk Assessment following accidents

Standard:	All accidents to staff, patients, and visitors reported through the Incident Reporting System will be followed up and, where necessary, a new risk assessment undertaken.
Audit protocol:	Details of the incident and follow up action, including new risk assessment, to be available as part of the Incident Reporting System.

Chapter Four
Getting Started

Beginning the process of commissioning

1. Health Authorities will need to identify a supplier or suppliers from whom to commission the range of functions and services given in Chapter 2. It is expected that in the majority of cases services will be provided by the local NHS Trust, however, in some areas local circumstances may mean that the service has to be purchased from a private sector provider.

2. Those commissioning services should note that it may be necessary to purchase the occupational health component and the health and safety component separately. This is likely to be the case where local NHS Trusts do not have an integrated occupational health and safety service or are unable to provide both services from within their own organisation. Health Authorities should ensure that the organisation(s) selected can meet the service delivery standards set out in Chapter 3 and that they are obtaining value for money.

Telephone service

3. It is recognised that in the early part of 2001/02 there will necessarily be a delay in rolling out these services and that GPs and their staff may not have access to a full range of services until later in the year, following needs and risk assessment by the provider(s).

4. Health Authorities should ensure that when commissioning services they arrange for GPs and their staff to have access, as a minimum, to a telephone advice service as soon as the contract is agreed. The availability of this service should be advertised to GPs and their staff.

Needs assessment

5. All occupational health and safety service (OHSS) advice and intervention must be based on sound needs assessment. Needs will vary widely from area to area and practice as some will already have taken action to deal with basic occupational health and safety problems. It is only once the initial assessment has been made that GPs and their staff will be able to identify, in co-operation with the OH service, their main requirements.

Risk assessment

6. Good risk management starts off with hazard identification and when seeking to identify risks it is necessary to avoid the mistake of overlooking the obvious. The fact that some activities may have been undertaken for long periods without incident does not mean they are risk free. Once hazards have been identified the risks will be assessed and appropriate action recommended to remove, minimise or control them.

One model – local variations

7. This document attempts to set out a model for the provision of OHSSs to all GPs and their staff wherever they might be based. However, it is recognised that there will need to be local variations to take account of local need. Examples of these can be found in Annex B. For this reason there will need to be very careful needs assessment of each client and the tailoring to their needs of the constituent of the basic model.

8. It is not yet clear at what level the needs assessment or tailoring process will need to take place. It would seem appropriate, to deal direct with PCGs, PCTs and individual practices. . Risk assessment is not a "one off" process. It is ongoing and needs to be brought into play when there are changes in working practices, in the working environment or when additional work is taken on that has not previously been assessed.

9. Control measures and policies will need to be introduced and communicated to all staff, which take account of the risk assessment and enable staff to carry out their duties with the least risk to their health or safety.

10. As important as the risk assessment identifying the effects of work on health are the policies relating to the effects of health on work.

11. It is recognised that in small employers such as GP practices there is not necessarily the expertise to carry out a full range of policies. The OHSS will be able to offer a variety of assistance in the areas of pre employment checks, health monitoring, substance misuse and immunisation.

Training

12. There is obviously a training need if GPs and their staff are to meet the challenges set by the current changes in the Primary Care Sector. Greater emphasis on health and safety, health promotion and OH will require GPs and their staff to supplement their current knowledge base through training. To assist with this the Health at Work in Primary Care project, has published a "General Practice Resources Directory – for promoting health at work. This provides an overview of training resources available to be used by small and medium sized enterprises such GP practices and PCGs.

Chapter Five

Referral to Service

Self referral facility for employees

1. Access to OHSS staff must be available to employees on a self referral basis and must not replace the need for GPs and their staff to register with an external general practice, in line with guidance from both the BMA's General Practitioners Committee and the Royal College of General Practitioners. This fact should be published to all staff and the confidential nature of the service should be stressed. In particular, staff should be encouraged to refer themselves if they are concerned about their own physical or mental occupational ill health. Early referral is likely to be of maximum benefit to employees.

2. Any employee should have access to an OHSS for telephone advice or for an appointment to see an OHSS professional. This facility should be available for services such as: pregnancy at work; work-related ill health; psychological support.

3. An OHSS service should supply an appropriate action plan or prophylaxis treatment following contamination from blood borne viruses e.g. Hepatitis B, Hepatitis C, and HIV.

Employer referral

4. A GP or other Primary Care employer can seek an independent medical opinion from a qualified OH Physician to assist with health related management problems, e.g:

   - frequent short spell absence attributed to sickness or injury;
   - long term sickness absence;
   - altered or impaired work performance without absence e.g. behavioural problems;
   - prior to return to work if the manager is concerned about an employee's ability to work;

- if there is reason to suspect that the member of staff is a drug or alcohol misuser, to monitor that person;
- where there is concern regarding an infection control issue;
- ill health retirement.

5. The consultation document "Supporting Doctors, Protecting Patients" made provision for the referral to an occupational health service in instances when a GP's performance is affected by ill health.

Chapter Six

Confidentiality

1. One reason why Primary Care practitioners are reluctant to use independent GPs and local occupational health services, is because of concern for confidentiality. Confidentiality of an occupational health service available to GPs and their staff must be ensured if it is to be accepted and used; ideally the service supplier should be independent and not a colleague of the user. The option of exchange arrangements with neighbouring occupational health units should be considered as one means of securing this. Alternatively (where possible), another means of ensuring confidentiality would be to make use of geographical distance, by placing the service outside of the users' locality.

2. GPs are few in number and well known in their local healthcare community; attendance by a local GP at a surgery or clinic will not go unnoticed. GPs will already be familiar with their ethical obligations to patients concerning confidentiality in "Duties of a Doctor – Guidance from the General Medical Council published by the GMC. However they may have less knowledge of the more detailed additional guidelines for occupational physicians detailed in the Faculty of Occupational Medicine "Guidance on Ethics. This handbook details procedures and processes for an ethical approach to confidentiality which should reassure the concerned GP that their attendance at the OH service will not pass informally among colleagues or inappropriately to managers.

3. In the case of a third party referral of a GP, any formal notification of attendance at the OH service would need to be considered and agreed as an appropriate action by both parties, as would any outcome such as a report following attendance. Any outcome, subject to the usual rules of medical confidentiality, would represent an opinion, based on medical evidence but not disclosing such evidence, of the fitness of the GP to continue working. Any further release of information about the medical condition of the GP referred would require their explicit written consent.

4. Concerns about confidentiality must not outweigh accessibility of OH services. Consideration must be given to the needs of GPs and their staff, many of whom will be less able to travel longer distances to access services. Local NHS OH services are familiar with balancing the needs for accessibility with the need to protect the privacy and confidentiality of other groups of doctors and NHS staff.

Levels of expertise

5. OHSs are team based. Most are led by nurses and may have only part time input from a doctor. Some OHs include other professionals such as physiotherapists, psychologists, counsellors and safety officers. Particular services will be provided by the most appropriate team member. Occasions will arise where a member of staff needs to have support from a specialist doctor. It is essential to ensure that arrangements are in place to provide support from a consultant occupational physician or other specialist occupational physician with experience and expertise in health care work, such a doctor would not necessarily be part of the OHSS team. Communication with the individual's own GP, subject to consent, and referral back to that GP for the continuing management of health problems, should also be considered.

Annex A

The Working Time Regulations

1. GPs themselves are classed as self employed and by definition are excluded from the scope of the Working Time Regulations. Nevertheless, it is recommended that, for their own health and wellbeing, GPs should aim to work hours which are in line with the provisions of the Working Time Regulations.

2. As employers, GPs should be aware that the Working Time Regulations came into force on 1st October 1998. The regulations provide for a maximum weekly working time limit of 48 hours a week, averaged over a 17 week referenced period, minimum rest periods, in work rest breaks, restrictions on night work and paid annual leave entitlements. For further information see HSC 1998/204 Working Time Regulations: Implementation in the NHS, and supporting guidance.

DISABILITY DISCRIMINATION ACT 1995

1. NHS employers should ensure that the requirements of the Disability Discrimination Act 1995 (DDA) are taken into consideration and that adjustments are made, **when reasonable**, to the workplace or to employment arrangements so that a disabled person is not at a disadvantage compared to a non-disabled person.

2. The introduction of the Disability Discrimination Act 1995 has reinforced the need to deal fairly when considering the employment of staff with health problems.

3. There is now a growing body of case law to help in predicting how the DDA will affect the employment of staff with disabilities problems and employment tribunals are paying particular attention to the selection process and how applicants are treated at interview

4. NHS employers should be aware that the DDA covers those affected by both physical and mental health problems.

Annex B
Possible Service Delivery Models

The Chambers Model

1. Dr Ruth Chambers, RCGP/DoH GP Stress Fellow, produced a paper in February 1997 suggesting the following national model for GP OH services.

2. The service should be run independently. The post and individual appointed as the organiser will vary depending on local variability of people available. However, the organiser should not be a member of the Health Authority or one of its personnel. The service should have the support and respect of the LMC, the Health Authority and grassroots GPs. In some cases the OH service might be run by a university, the CME network, the OH service in a District General Hospital, a NHS Trust, or a private organisation.

3. There would be a pro-active and reactive element to the provision of OH care which would include:

   - provision of stress management skills workshops and programmes;
   - help with health and safety legislation and implementation;
   - requested audits of practice performance in these areas;
   - stress constancy within practices;
   - help with minimising risk in the practice;
   - personal safety techniques;
   - advice about health promotion and monitoring of staff health.

4. The reactive element would include the provision of advice about referrals to other specialists for medical, alcohol and substance misuse.

5. The OH resource would include:

I Access to an experienced OH physician.

II Practical support and guidance from an OH nurse to undertake practice visits.

III An educationalist providing management skills, health and safety guidance sessions and other educational sessions about pro-active work.

IV Independent psychologist or counsellors. The experience and training of these would depend on availability in local areas. Counsellors would be experienced professionals familiar with the pressures on doctors and their typical behaviour patterns. The psychologists or counsellors would be readily available for one to one counselling even if there was an element of gatekeeping by telephone; one or more would be available to visit the practice staff group or organisation for stress management of the whole team.

V Some provision or prior agreement about out of area referrals for sick GPs to psychiatric in patient and out patient care outside the area where necessary, including seeking private provision if no suitable NHS alternative is available.

The Verow/Sandwell Model

6. Dr Peter Verow, Consultant OH Physician has set up a service for GPs and dentists in the West Midlands area.

7. The model is as follows:

(i) There is agreement by the Health Authority, LMC, LDC and the OH provider (local NHS Trust) as to the core services that need to be delivered. These include:

- one point of access for all OH advice;
- emergency advice for blood contamination incidents;
- provision of pre-employment advisory services;

- provision of service for management and self referrals for OH advice;

- provision of support for Risk Assessments/Safety Advisory Services.

(ii) Agreement as to the level of funding to provide the core services above. This to include in the first year:

- one full time OH Nurse;

- two sessions per week of Consultant OH time;

- three days per week administrative support;

- one session per week of Clinical Psychological time.

(iii) Agreement that the OH Nurse will undertake a needs assessment during the first year and produce a business plan in conjunction with the service users which will evaluate any modifications or additions to the core services that may be needed in order to provide a long term comprehensive service.

The Woodroof/Longdon Model

8. Dr Gerard Woodroof, Consultant Occupational Physician and Dr David Longdon, GP, are taking forward proposals for the provision of OH services to GPs and their staff in Devon and Cornwall.

9. They are using the following model:

- Stakeholders to include GPs, staff, Health Authorities, LMCs, GMC, Medical Insurers, PCGs and patients.

- The service would be independent, relevant, confidential, competent and respectful of the values of the customer.

- The service would include: pre employment health screens, immunisation policies, sickness absence advice, rehabilitation/ill health retirements, needlestick advice, counselling/mentoring, training/education and health and safety support, research/audit/governance.

10 The service will be sited in a pleasant neutral location away from hospital sites and have a small permanent staff supporting a network of specialists.

11. Services will be provided using a telephone advice system; internet pages giving details of how to manage needlestick injuries, immunisation etc; access to mentors, counsellors, clinicians out of area, OH physicians, health and safety training and support and to stress courses.

Annex C
Useful Publications

NHS Executive Publications:

The Management of Health, Safety and Welfare Issues for NHS Staff HSC(98)064

The Provision of Counselling Services for Staff in the NHS

AIDS/HIV Infected Healthcare Workers: Guidance on the Management of Infected Healthcare Workers.
www.open.gov.uk/doh/aids.htm

Publications are available from NHS Responseline

BMA Publications:

Standards in Private Practice: Occupational Health
http://www.aomrc.org.uk

Occupational Health Matters in General Practice. Chambers, Moore, Parker, Slovack, Radcliffe
ISBN 1857754638: Medical Publications

HDA Publications:

Health and Safety in General Practice

Violence and Aggression in General Practice

General Practice Resources Directory

General Practice Resources Directory

Publications are available from Marston Book Services, PO Box 269, Abingdon,
Oxon OX14 4YN

Health and Safety Commission Publications:

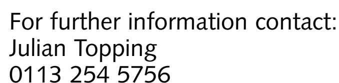
Revitalising Health and Safety
DETR, PO Box 236, Wetherby, West Yorkshire, LS23 7NB

Society of Occupational Medicine:

Disability Discrimination Act 1995 : Guidance for Occupational Physicians
The Society of Occupational Medicine, 6 St Andrews Place, Regents Park, London

UNISON:

The Health and Safety "Six Pack"
UNISON Communications Department, 1 Mabledon Place, London, WC1H 9AJ



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