Depression detection and management of staff on long-term sickness absence

Occupational health practice in the NHS in England

A national clinical audit: round 2

National report

Royal College of Physicians

fom
Faculty of Occupational Medicine

NHS Plus

Health and Work Development Unit

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A national clinical audit: round 2

Prepared on behalf of the Health and Work Development Unit Audit Development Group by:

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December 2010

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NHS Plus

As part of the Government's Health, Work and Wellbeing Strategy, NHS Plus promotes the benefits of good health at work. Operating through a network of over 130 NHS Occupational Health (OH) units across England, NHS Plus helps build healthy and productive workforces. In order to ensure the delivery of the highest quality OH services, NHS Plus commissioned a further audit of national depression detection practices from the Health and Work Development Unit. This round of audit builds on the first ever national audits of OH practice in England which were completed in 2008. For further information, see www.nhsplus.nhs.uk

The Royal College of Physicians

The Royal College of Physicians plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. It provides physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, it advises and works with government, the public, patients and other professions to improve health and healthcare.

Health and Work Development Unit

The Health and Work Development Unit at the Royal College of Physicians aims to improve the health of the workforce through the delivery of national quality improvement projects. HWDU measures and raises standards, and reduces variability, of occupational health care through the development of evidence-based guidelines and conduct of national clinical and organisational audits. HWDU also works to improve the implementation of NICE public health guidance for the workforce.

Faculty of Occupational Medicine

The aim of the Faculty of Occupational Medicine is for healthy working lives through:

- maximising people's opportunities to benefit from healthy and rewarding work while not putting themselves or others at unreasonable risk
- elimination of preventable injury and illness caused or aggravated by work
- access for everyone to advice from a competent occupational physician as part of comprehensive occupational health and safety services.

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Foreword

Dear colleagues,

This report completes the first cycle of national clinical audit within an occupational health care setting. It is a timely reminder of the important place of occupational health services in supporting NHS staff. Safeguarding the health and wellbeing of its own workforce must be a priority for the NHS as it answers pressing challenges to improve both the quality and efficiency of patient care.

The results reported here demonstrate the progress made towards improving the quality of occupational health care provided to NHS staff. Not only has the audit reached further in this round, with more occupational health services participating and many more cases entered, it has also affirmed the readiness of occupational health professionals to test and demonstrate the quality of their services and a determination to make them better. I am confident that the Health and Work Development Unit audit programme will follow the example of national clinical audits established in other areas, with repeat cycles of audit driving up the quality of care year on year.

Those with responsibilities for providing and commissioning occupational health services will recognise the significance of the findings of this audit, and I hope that trusts will respond by supporting their occupational health departments in making the changes necessary to raise standards further.

Last, I congratulate NHS occupational health services and the Health and Work Development Unit on their achievement and their intention to build on the foundations they have laid.

Dame Carol Black
National Director for Health and Work

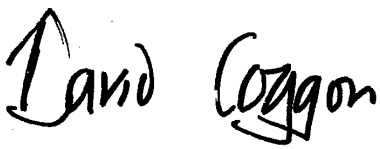
On behalf of NHS Plus and the Faculty of Occupational Medicine, we would like to congratulate occupational health professionals across England for completing this second round of national clinical audit. Not only have you contributed more cases in this round, but more importantly you have demonstrated improvements in the quality of the consultations audited. The high participation rate achieved is fundamental to the success of the audit and demonstrates a clear commitment by the occupational health (OH) community to quality improvement.

The Faculty and NHS Plus have a remit to improve the quality of OH services nationally. This audit complements the Faculty's newly launched service accreditation scheme and together these initiatives give NHS OH services an opportunity to develop and improve.

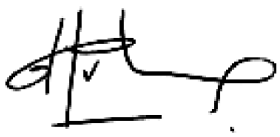
We encourage participants to review their local results in the context of the national picture, and to act on their findings. NHS Plus will host a conference on February 14th at the Royal College of Physicians to disseminate the audit results – during the conference we will continue the work of identifying the barriers to change you are encountering and the tools that would help you to overcome these barriers.

NHS Plus and the Faculty are dedicated to supporting the NHS as it seeks to lead the way in providing high quality health, work and wellbeing services. We want to ensure access for everyone to competent occupational health clinicians and to maximise people's opportunities to benefit from healthy and rewarding work. This audit represents a major step towards this aim. Audit participation is an essential component of quality improvement, service accreditation and revalidation for doctors.

We look forward to the ongoing challenge of supporting OH professionals in meeting these requirements and to raising standards of OH care in the NHS.



Professor David Coggon
President, Faculty of Occupational Medicine



Dr Christopher Harling
Director, NHS Plus

1 Executive summary

The national clinical audit of occupational health (OH) care for NHS staff on long-term sickness absence was established in 2008. This report describes the findings from round two and progress made since round one.

Round one examined the extent to which OH doctors and nurses were considering whether depression might be contributing to the period of sickness absence audited. For round two we extended the audit to include barriers to return to work, and the use of psychological and physical therapies provided by the employer.

People on long-term sickness absence are at a high risk of depression and it is a common co-morbidity, whatever the presenting diagnosis. Depression is an independent predictor of non-return to work, regardless of the primary diagnosis, and the longer a person is off work the less likely they are to return.

The audit questions reflect evidence-based guidance from the National Institute for Health and Clinical Excellence (NICE) on depression and the management of long-term sickness absence.

Following data collection for round one, HWDU held a national dissemination conference and facilitated nine regional implementation workshops. These events gave participants the opportunity to discuss their audit results, share good practice and develop action plans.

The national results show the progress that has been made since 2008. Local results (provided to each participant) will enable OH services to compare themselves against best practice, to benchmark against other OH services in England and to measure change in performance since the first audit round.

This audit offers a unique opportunity for all OH providers to focus on clinical quality.

How to interpret your trust's results

Each participating trust has received its own results for comparison with the national results. These sets of data only provide part of the picture – we advise that they are considered in conjunction with the following factors:

- A sample of 40 consecutive eligible cases was requested. Trust results based upon a smaller number of cases may not accurately represent local practice and should be interpreted with caution.
- Audit relies on documentation and we recognise that actions may have been carried out but not recorded. This may be due to competing priorities and/or lack of resources. We comment on the importance of good documentation and we expect that this audit will lead to improvements in documentation as well as practice.
- All audits demonstrate variation in practice both within and between services. Participants now have a measure of progress since the first round and a new baseline from which they can measure future improvements in performance.

- This audit measures a very specific area of OH practice. The results cannot be extrapolated as a measure of the full range of diverse activities undertaken by OH services. Each OH service will operate under different local circumstances. We also note that results could be heavily influenced by local policies and practice, ie referral time for sickness absence cases.
- The HWDU has not ranked trusts or services. The local results should be interpreted by each service itself, taking into account knowledge of its commissioning trust.
- The report is a tool for reviewing the OH care provided to the staff of a trust. It may be used by each trust for facilitating dialogue between OH services and the trust management to develop the most effective mechanisms for improvements.
- We make recommendations for the questions that should be asked during a consultation based on the most appropriate guidelines available. We recognise that the exact nature and number of questions, for example to detect depression and assess its severity, will vary depending on the presentation of the case. The NICE Guideline on depression states that '…the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.'[1]

Key findings and recommendations

Case note audit: first consultation with NHS staff off work for at least four weeks for any health-related reason

Participation

- 82% (152/186) of OH services providing to NHS trusts in England participated in the audit.
- The number of cases entered nationally was 7,636; an increase of 21% from 2008.

Sickness absence

- The average length of sickness absence at the audited appointment was eight weeks, however 30% of cases had been off sick for least 12 weeks and 5% had been absent for over six months.

NHS trusts need effective systems for early referral to OH for staff on long-term sick.

Depression assessment

- The proportion of cases assessed for signs and symptoms of depression rose from 58% in 2008 to 67% in 2010. This increase was particularly marked for cases where the presenting diagnosis was a physical one (15% to 52%).

[1] National Institute for Health and Clinical Excellence. *Depression in adults with a chronic physical health problem: Treatment and management* (CG91). London: NICE, 2009.

A diagnosis of depression should be considered in staff on long-term sickness absence, including where they present with a physical illness.

- The proportion of cases with detected depression who were asked about thoughts of suicide rose from 31% in 2008 to 49% in 2010.
- The proportion of cases with detected depression who were asked about alcohol use rose from 33% in 2008 to 46% in 2010.
- In both audit rounds 70% of cases were asked if they thought workplace factors had contributed to any depression (in 2010, 57% of these cases thought that workplace factors had contributed compared with 64% in 2008).

In 2010 there was an increase in the frequency and quality of assessments for depression. Scope remains for OH professionals to ask more often about core symptoms of depression, suicidal thoughts, alcohol use and work factors.

Fitness for work

- In over 95% of cases entered into the audit, the OH professional noted an action plan, documented the individual's fitness for work and communicated with the patient's line manager.

Treatment services funded by the employer

- Of the 1,757 cases entered into the audit who were receiving or waiting to receive physiotherapy, the employer provided this treatment for 382 (22%). 2,215 cases were receiving, or waiting to receive, psychotherapy, and this was being provided by the employer for 1,169 (53%).

Therapy services provided by employers are being accessed by staff on long-term sickness and are likely to contribute to an earlier return to work.

Type of trust analysis

- There were few differences found in the results between types of trust, although compliance was slightly poorer in Mental Health and Ambulance trusts than in the other types of trust.[2]

National dissemination conference and regional implementation workshops

- Temporal analysis suggests that greater progress was made by OH services where at least one member of the service attended an implementation event.

Audit data can show where change is necessary and what progress has been made. National, regional and local activities support individuals and services to make these changes.

[2] We did not include all the types of trust in these analyses as for some categories there were too few consultations to allow meaningful interpretations to be made.

Conclusions

We have now completed the first full cycle of a national clinical audit of aspects of OH care for NHS staff.

We know that many OH services initiated interventions to improve their practice following the first round of audit. The improvements they have made suggest that the process has been valuable, and should contribute to better outcomes for staff on long-term sickness absence and their employers.

Next steps

OH providers

We recommend that OH departments consider their own results in light of the targets and in comparison with the national results.

Where consultations do not meet the standards set in the NICE guidance, we recommend that OH professionals review their practice and develop mechanisms for service improvement. These might involve some or all of the following activities:

- education and training
- sharing good practice between staff of the department, regionally and more widely
- using tools to facilitate improvement, for example algorithms, and developing action plans
- developing systems to support comprehensive documentation of consultations.

HWDU

- We will distribute a depression detection and management algorithm based on the relevant NICE guidance.
- We will hold a national conference for OH professionals on 14 February 2011. At the conference we will disseminate the audit findings, discuss progress made since 2008, and facilitate sharing of good practice.
- We will consult OH professionals about developing the audit tool further to meet their needs, for example we will discuss inclusion of a generic section on record keeping standards.

The participants in this audit will be key stakeholders for these activities.

2 Introduction

This national comparative clinical audit measures how well occupational health (OH) professionals are assessing and managing depression in NHS staff in England on long-term sickness absence.

The first round data were collected in 2008 with subsequent quality improvement initiatives during 2009. Here we report the findings from the second round of data collection in 2010. In this second round we have expanded the audit to include a section on barriers to return to work and the use of psychological and physical therapies.

Long-term sickness absence

OH doctors and nurses frequently see employees who have been on long-term sickness absence. We know that the longer an employee is off sick, the less likely they are to make a successful return to work.[3] Long-term sickness absence has repercussions for the individual, their family, their employer, the benefit system and the wider economy and society as a whole.

The evidence base for what works in enabling an early return to work is growing, and in 2009 the National Institute for Health and Clinical Excellence (NICE) produced guidance on the management of long-term sickness absence. This recommends that (ideally after two to six weeks' absence) a suitable person discusses with the employee: 'the reasons for sickness absence, whether they have received appropriate treatment, how likely it is that they will return to work and any perceived (or actual) barriers to returning to work (including the need for workplace adjustments)'.[4]

Some barriers to returning to work can be overcome through physical adaptations in the workplace, changes in working hours or temporary redeployment. People with psychological barriers may respond to evidence-based psychological interventions such as cognitive behavioural therapy. Some NHS trusts provide such treatments for their staff.

When assessing staff on long-term sickness absence, OH professionals need to consider both physical and psychological barriers to work. Where appropriate, referral to physiotherapy or psychological therapy may speed recovery and enable an earlier return to work.

Sickness absence and depression

Mental health and stress problems account for 30% of sickness absence amongst NHS staff.[5] Sickness absence due to depression is on average longer than absence due to physical illness, and depression is now the most common cause of long-term sickness absence and incapacity benefit

[3] Department for Work and Pensions. *Pathways to work: Helping people into employment.* London: DWP, 2002.
[4] National Institute for Health and Clinical Excellence. *Management of long-term sickness and incapacity for work* (PH19). London: NICE, 2009.
[5] Ministerial Task Force for Health Safety and Productivity, Office TC. *One year on report.* London: Health and Safety Executive, 2005.

claims. Depression is often not recognised, especially when an employee already has a physical health problem. However, depression often co-occurs with physical health problems.[6,7]

The NICE guideline on the treatment and management of depression in adults with chronic physical health problems notes that many patients with established physical diseases become depressed during the course of their illness.[8] Recognition of depression in this population is important and can lead to improved outcomes. Depression is an independent predictor of non-return to work, regardless of the primary diagnosis. Unrecognised depression can be a major barrier preventing return to work but there are effective treatments for depression that may have occupational benefits if detected early by an OH service.

To facilitate optimum management of staff on long-term sickness absence it is important that all clinicians involved in their care regularly attempt to assess for depression; and this includes OH professionals. While there are no specific guidelines for such assessment by OH professionals, there are relevant guidelines on the management of depression in primary and secondary care and on the management of long-term sickness absence.[9,10,11] We used these national guidelines to develop standards against which the care provided by OH doctors and nurses looking after NHS staff in England can be measured.

Aims of the national audit

This audit examines clinical aspects of OH care in managing those on long-term sickness absence: detecting symptoms of depression, communication between the OH professional and other health professionals and the employer, identifying barriers to return to work and the use of psychological and physical therapies.

The aim is to improve OH care of NHS staff on long-term sickness absence by;

1 Improving the detection of depression in NHS staff on long-term sickness absence.
2 Assessing variations in practice in the OH care of staff on long-term sickness absence across trusts in England.
3 Measuring the extent to which the recommendations made in the 2008 national audit have been implemented.
4 Enabling OH services to compare the quality of their approach to detecting depression in staff on long-term sickness absence against evidence-based criteria.

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[6] Harvey SB, Ismail K. Psychiatric aspects of chronic physical disease, *Medicine* 2008;(36):471–474.
[7] Magni G, Caldieron C, Rigatti-Luchini S and Mersky H. Chronic musculoskeletal pain and depressive symptoms in the general population; An analysis of the 1st National Health and Nutrition Examination Survey data, *Pain* 1990;43(3):299–307.
[8] National Institute for Health and Clinical Excellence. *Depression in adults with a chronic physical health problem: Treatment and management* (CG91). London: NICE, 2009.
[9] National Institute for Health and Clinical Excellence. *Depression: The treatment and management of depression in adults* (CG90). London: NICE, 2009.
[10] Note that CG90 *Depression: The treatment and management of depression in adults* and CG91 *Depression in adults with a chronic physical health problem: treatment and management* are partial updates to National Institute of Health and Clinical Excellence. *Depression: management of depression in primary and secondary care* (CG23). London: NICE, 2004.
[11] National Institute for Health and Clinical Excellence. *Management of long-term sickness and incapacity for work* (PH19). London: NICE, 2009.

5 Measuring progress against the 2008 baseline and creating a current snapshot of practice against which future progress, both locally and nationally, can be measured.

The aim of the audit is not to produce a league table of OH services or assess individual performance. Information on profession, qualifications or seniority of the OH clinicians managing the cases is not collected. Nor is comparison made between trusts using NHS OH services and trusts outsourcing to private sector providers. The average data for each trust will be reported confidentially in comparison to the 2008 and 2010 national average data. Trust level data will not be put into the public domain by the Health and Work Development Unit (HWDU) or NHS Plus. A list of participating trusts is available in Appendix 1.

Inter-audit period: implementation of change

Following feedback of individual results in December 2008, and national average results in January 2009, the HWDU held a national dissemination conference and facilitated a series of nine regional implementation workshops. Events were open to all NHS OH teams, irrespective of whether they had participated in the audit.

At the dissemination conference we discussed the audit findings. We used an electronic voting system to gather participants' views about national clinical audit. We used this feedback to improve this audit round, and to inform our implementation support at a national level.[12]

The regional implementation workshops included facilitated discussions on what delegates had already done as a result of participating in the audit; what barriers they had come across; presentations by delegates who had already taken their audit results forward; and completion of action plans. HWDU developed an action plan template based on NICE guidance on identifying and overcoming barriers to change (Appendix 2).[13] HWDU collected copies of delegates' action plans and looked for themes in the barriers and actions that would be taken to overcome them. The workshop report is available on the NHS Plus website.[14]

Revising the audit tool and process for the second round of audit

Following round one the audit tool, accompanying help materials and the process of the audit were reviewed to identify areas for improvement.

Feedback was requested from participants at the close of data collection, during the dissemination conference and at the regional workshops. During data collection the HWDU kept a record of questions raised with the help desk relating to the audit tool and help notes. We checked comments entered onto the webtool by participants and we reviewed the inter-rater reliability data.

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[12] Williams S, Rogers C, Peel P, Harvey SB, Henderson M, Madan I, Smedley J and Grant R. Measuring how well the NHS looks after its own staff: methodology of the first national clinical audits of occupational health services in the NHS. *Journal of Evaluation in Clinical Practice* (in press).

[13] National Institute for Health and Clinical Excellence. *How to change practice: Understand, identify and overcome barriers to change.* London: NICE, 2007.

[14] http://www.nhsplus.nhs.uk/providers/clinicaleffectiveness-audits-conferencereport.asp (accessed December 2010).

This feedback was considered by the in-house team, clinical leads and audit development group who agreed revisions to the audit tool, help notes and process.

The revisions focused on:

- Clarity of questions and instructions. Some minor amendments were made.
- Scope. A new section was developed for the audit tool based on the NICE public health guidance on the management of long-term sickness absence.[15]
- Balance between trust and service data. Much discussion was held around this point during the first round. Some concerns were raised by OH services that provided to more than one trust. In this audit round we collected data by OH service, but gave participants the option to enter data by trust. The methodology was designed to ensure that comparisons could still be made with the 2008 data.
- Leadership. For this audit round we recruited a nurse co-lead to the leadership team.
- Inclusion criteria. In 2008 we audited the first appointment following four weeks of absence. For some cases this was not their first appointment for this period of sickness as they had attended OH within the first four weeks of absence too. In 2010 we audited the first appointment only, which must have been held after 4 weeks of absence.
- Recruitment. In this audit round we recruited by OH service provider.

[15] National Institute for Health and Clinical Excellence. *Management of long-term sickness and incapacity for work* (PH19). London: NICE, 2009.

3 Methods

Notes on terminology

Sites

Trusts may have their own in-house occupational health (OH) service or commission OH from another provider. Because some trusts use more than one OH service and some OH services provide to more than one trust, we used the term 'site' for each combination of an OH provider and trust. Each site had a unique login code to access the secure web data collection tool (webtool).

Types of trust

Trusts were allocated into type of trust according to the lists available on the NHS Choices website.[16] Trusts that fell into multiple categories and groupings made up of very small samples were not included in the type of trust analyses.

Case notes

A case note refers to the entry referring to a consultation in the OH record.

Case

A case is a member of staff from a participating trust who was seen by their OH department and whose consultation was audited. The case is also described as the patient during this report.

Audit Development Group

The audit tool was developed by practising clinicians supported by the Health and Work Development Unit (HWDU) Audit Development Group. In 2008 the Group included specialists in OH (nurses, doctors and academics), psychiatry, management and human resources, audit and clinical standards, and medical statistics. For the 2010 round we shifted the balance of the membership, recruiting a higher proportion of practising OH nurses and doctors.

Audit tool design

National guidelines

There is no national guideline on detecting depression in employees on long-term sickness absence. Thus the audit tool (Appendix 3) is based on the National Institute for Health and Clinical Excellence (NICE) guideline on the management of depression in adults with a chronic physical health problem and the treatment and management of depression in adults.[17,18]

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[16] www.nhs.uk/aboutnhs/HowtheNHSworks/authoritiesandtrusts/Pages/authoritiesandtrusts.aspx, accessed March 2010.

[17] National Institute for Health and Clinical Excellence. *Depression in adults with a chronic physical health problem: Treatment and management* (CG91). London: NICE, 2009.

[18] National Institute for Health and Clinical Excellence. *Depression: The treatment and management of depression in adults* (CG90). London: NICE, 2009.

Since the first round of this audit in 2008, NICE published guidance for primary care and employers on the management of long-term sickness and incapacity for work.[19] We have adapted and extended the audit to reflect this guidance.

Rationale

People on long-term sickness absence are at high risk of depression and it is a common co-morbidity, whatever the presenting diagnosis.[20] Depression is an independent predictor of non-return to work, regardless of the primary diagnosis, and the longer a person is off work the less likely they are to return.

The aim of OH depression assessment is to identify people with depression beyond those with an established diagnosis of the condition. Management of depression in the OH setting does not necessarily involve treatment; the focus is on optimisation of care to expedite recovery so that the employee is able to return to work. The audit questions were designed to identify whether consultations had covered the following aspects of management of depression:

- identification (primary and co-morbid)
- assessment of severity and risk in order to guide management decisions
- assessment of psychosocial and workplace factors (and hence barriers to recovery)
- recording of any current treatment
- communication with other appropriate healthcare professionals, patients themselves and employers/line managers as appropriate.

We defined 'long-term' sickness absence as four weeks or more. While there are many definitions, this period of time is commonly referred to in the literature. Questions about depression become increasingly appropriate as the period of sick leave increases. We therefore chose the first consultation with staff who had been absent for at least four weeks of absence as an appropriate point to audit case notes.

We have extended the audit tool to reflect the NICE guidance on the management of long-term sickness absence.[21] The new audit questions are designed to identify whether consultations have addressed barriers to work, and how and when staff access physiotherapy and psychological therapy.

Eligible cases

An NHS staff member's first consultation, between 1 January 2010 and 11 August 2010, with an OH doctor or nurse following at least four weeks of sickness absence, for any health-related reason. Cases must not have been seen at an earlier point in the current episode of sickness

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[19] National Institute for Health and Clinical Excellence. *Management of long-term sickness and incapacity for work* (PH19). London: NICE, 2009.

[20] People with chronic pain have been found to be more likely to have depression than those who do not. Magni G, Caldieron C, Rigatti-Luchini S and Merskey H. Chronic musculoskeletal pain and depressive symptoms in the general population; An analysis of the 1st National Health and Nutrition Examination Survey data *Pain* 1990;43(3):299–307.

[21] National Institute for Health and Clinical Excellence. *Management of long-term sickness and incapacity for work* (PH19). London: NICE, 2009.

absence. Participants were asked to submit a sample of 40 consecutive eligible consultations into the audit.[22]

Recruitment of trusts

OH care for staff is provided by NHS trusts in England in a range of different ways. In carrying out our audit, we observed that there is a certain level of flux as service provision is re-tendered and reorganised.

At the time of this audit there were 447 trusts in England and 186 OH service providers. Trusts either have an in-house OH service, contract their service from another provider (or, for a small number, more than one provider), usually a different (local) NHS trust. Some OH providers serve multiple NHS trusts.

Recruitment for this audit was organised by OH service. Each service provider was encouraged to submit a sample for each trust to which they provide OH care, however this was not mandatory. If the service provider had consistent services and staff delivering their service across multiple trusts they need only submit one set of records. These results can be seen as indicative of the service they provide to all of their trusts. This was a change to the first round recruitment process where we recruited by trust. This change was made following the feedback received from the first audit round and is designed to reflect how OH services are provided.

All OH providers to NHS trusts in England were eligible to take part. The HWDU wrote to directors of OH departments, trust chief executives, heads of HR departments and clinical audit or governance departments, inviting them to participate in the audit.

Data collection and entry

This audit is a retrospective case note review of process. The objective is to compare and contrast the process of care documented in the case notes with national evidence-based guidance. As in the previous audit round, our case note audit required the relevant information to have been documented. Full and accurate documentation of a consultation is an essential part of patient care. Clinical records demonstrate that an appropriate assessment has taken place, allow progress between appointments to be assessed, and facilitate continuity of care where more than one clinician is involved in the case. The General Medical Council guidance for doctors states that 'you must keep clear, accurate and legible records'.[23] The Faculty of Occupational Medicine guidance on ethics describes the maintenance of OH clinical records as 'the foundation of a high standard of professional care. Such records ensure good communication for inter-professional working and aid assessment of employee health'.[24]

All data were entered through a specially designed audit website that was open from 24 May 2010 until 11 August 2010. Access to each site's data was password protected for confidentiality. For each case note audited, the webtool routed the data collector through the questions, making

[22] Many sites told us that they had fewer than 40 eligible consultations during the audit period but that they had entered all that met the criteria.

[23] General Medical Council. *Good Medical Practice*. London: GMC, 2006.

[24] Faculty of Occupational Medicine. *Guidance on ethics for occupational physicians*. 6th Edition. London, FOM, 2006.

available only the applicable answers, and responses were validated prior to completion of a case. No patient-identifiable data were requested. Help notes and definitions were provided as were free text 'comment boxes' to enable the data collector to give any clarifications. The audit tool can be found in Appendix 3 and the helpnotes in Appendix 4.

The HWDU ran an audit helpdesk for participants throughout the data collection period. We contacted OH departments by email, post and telephone at intervals throughout the data collection period to encourage them to participate and offer support in using the web-based data collection tool.

We specified that OH doctors and nurses should analyse case notes retrospectively and record the answers to the audit questions. Where feasible, data collection should have been carried out by somebody other than the clinician who wrote the case notes. More than one data collector could enter data for any one site – the site codes and passwords were specific to each site, rather than individuals (no clinician-identifiers were used). Participants were advised that actions not explicitly documented in the case notes should not be recorded as having being performed, even if they were known to be normal practice for a particular OH professional or department.

Pilot

The audit tool and help notes were piloted in April 2010. The audit tool was revised in light of analysis of the data and feedback from participants.

Data analysis

We present descriptive statistics throughout this report without inference (p-values or confidence intervals). This means that differences between groups of cases are described but not tested for statistical significance. Where it is informative, analyses are presented broken down by risk factors and casemix, however these are not adjusted for by more sophisticated statistical models.

The interpretation of results rests as far as possible with audit participants, who are best placed to understand their meaning in the local context and to formulate quality improvement strategies as a result. The role of central analysis is to produce valid, reliable and high-quality local and national statistics through extensive checking and data cleaning.

Statistical analysis was carried out by the medical statistician at the Royal College of Physicians using SPSS Version 18. Results were interpreted by the Audit Development Group and the project team. For clarity, figures are usually given without decimal places and graphs may be truncated to omit extreme values.

Inter-rater study

Establishing good agreement between auditors is an important part of the process of validation as valid data by definition will have to be reliable. We asked sites to nominate a second OH professional to repeat the data collection for the first five cases entered into the audit. This was to enable us to assess the reliability of the questions, ie the extent to which different auditors agreed when asked to interpret the same set of notes.

Numerical questions (age, date of appointment and weeks off work) are examined in terms of the simple difference between them. For categorical questions (mostly Yes/No) the kappa statistic was used to measure agreement. Kappa scores can be found in Appendix 5.

Presentation of results

The national report shows the pooled, anonymised results from all participating trusts in 2010 and the national average obtained in the 2008 audit round. National results are presented as percentages.

Because NHS OH care is organised and funded at a trust level, we analysed results and produced local reports for individual trusts/sites rather than individual OH services. However OH services will be able to infer a consistent performance across all trusts they serve if the staff members delivering the care are consistent.

Site-specific reports are provided to participating organisations with their site level information presented alongside the national data.

4 Results

It is important to recognise that the findings from this case note audit reflect documentation from the audited consultation. The results cannot reflect discussion that was not documented.

Inclusion of cases

8,664 completed cases were entered in this audit round. 15 of these were deleted because the participants' free-text comments described a case that did not meet the eligibility criteria. A further 1,013 reliability duplicates were set aside, leaving **7,636** completed cases for analysis.

2008	2010	21% increase between 1st and 2nd audit round
6,286	7,636	

286 sites (up nine from 277 in 2008), covering 279 NHS trusts (267 in 2008) submitted cases to the audit. 238 (83%) sites entered 10 or more cases, increasing from 219 (79%) in 2008. There was a two-fold increase (16% 45/277 to 29% 82/286) in the percentage of trusts contributing forty or more cases. Half of the cases (50%, 3852/7,636) came from 91(32%) of sites, as compared with 50% (3171/6,286) from 78 (28%) of sites in 2008.

Trust participation

81% (360/447) of trusts in England commission their occupational health (OH) service from a provider that participated in the audit. OH providers that entered case notes for some but not all of their trusts may wish to share their results with those trusts for whom they did not enter data. In these situations OH services will need to consider the likelihood of uniformity of clinical practice across their trusts when presenting results.

82% (152/186) of OH services providing to NHS trusts in England participated in the audit. Some services entered multiple sets of data, each set representing one trust for which they provide a service. The work undertaken by these 152 participating service providers is summarised in the next table:

Datasets submitted by provider	Number of providers	Cases submitted			
		Median[25]	IQR[26]	Range[27]	Total cases
1	86	37	26–40	1–61	2,782
2	31	59	37–70	25–128	1,778
3	20	84	52–98	25–115	1,521
4–8	15	93	60–137	30–232	1,555
TOTAL	**152**	**40**	**30–62**	**1–232**	**7,636**

[25] Median: The middle number or average of the two middle numbers in an ordered sequence of numbers.
[26] Inter-quartile range: The range within which the middle half of the results lie, one quarter being lower and one quarter higher.
[27] Range: The interval between the smallest and largest values.

Type of trust[28]	Total (England)	Participating trusts
Acute	168	134 (80%)
Ambulance	11	7 (64%)
Mental health	59	44 (75%)
Primary care	206	91 (44%)
Mixed (providing more than one type of service)	3[29]	2 (67%)
TOTAL	**447**	**278 (62%)**

In both 2008 and 2010 over 80% of trusts in England commissioned their OH service from a provider that participated in the audit, yet the proportion of trusts for which data was entered was lower in 2010 (62%) compared with 2008 (69%).

These findings probably reflect the reorganisation of PCTs since the first audit round. While PCTs were splitting into commissioning and provider organisations, in many cases their OH provider continued to service them as one unit. Many such OH providers chose to enter a data set for just one of the two new organisations, so the proportions entered into the audit fell from 58% (75/129) to 44% (91/206). When PCTs are excluded from both analyses the participation rate amongst the remaining trust types increases from 74% in 2008 to 78% in 2010.

There was wide variation in the number of cases entered by different sites. In order to assess whether results from sites contributing a small number of cases were likely to be representative of their practice (and thus not bias the audit results as a whole), we compared the demographics of cases from these sites with those from sites with a larger number of cases. No noticeable differences in terms of age, gender and occupation were found.

The graph overleaf shows the variation by trust in the number of cases entered into the audit for the 278 trusts (median 30, IQR15–40 cases).

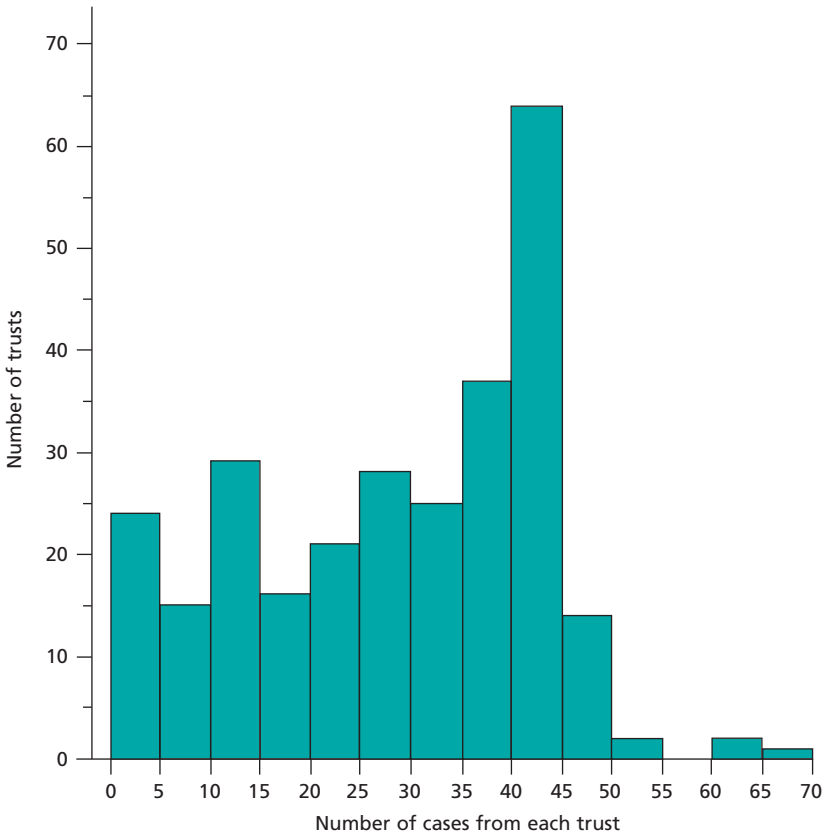
We ask participants to note that if a small number of cases were entered for their site they should interpret their site-specific results with caution.

Inter-rater reliability duplicates

In total, 210 sites entered 1,013 duplicate cases onto the webtool i.e. duplicates of a case already entered into the audit.

The original and duplicate records of these 1,013 cases were used to calculate the inter-rater reliability statistics of agreement (see Appendix 5). The duplicate records were subsequently excluded from the main analyses (which used only the first entry of each pair of records). Of 48 categorical questions assessed in the 2010 audit reliability analyses, the median kappa statistic value was 0.77, IQR 0.63–0.83 (values of 0.61–0.80 indicate good agreement and values of over 0.80 indicate very good agreement). These results are very encouraging in terms of the utility of the audit tool and the overall reliability of the results.

[28] Care trusts have been removed from the trust categorisation in this audit round.
[29] This total includes States of Guernsey Health & Social Services and States of Jersey Health & Social Services.



Eligible cases

An NHS staff member's first consultation, between 1 January 2010 and 11 August 2010, with an OH doctor or nurse following at least four weeks of sickness absence, for any health-related reason. Cases must not have been seen at an earlier point in the current episode of sickness absence.

Casemix and demographics

Data collectors were asked to enter the age, gender and occupational group of each employee whose case notes were audited. The responses are shown below.

Question 1.1: Age

National 2008 (6,286 cases)		National 2010 (7,636 cases)	
Median	**IQR**	**Median**	**IQR**
46	38–53	46	38–53

Question 1.2: Gender

	National 2008 (6,286 cases)		National 2010 (7,636 cases)	
	Number	%	Number	%
Women	5,274	84	6,422	84
Men	1,012	16	1,214	16

Question 1.3: Occupation (excluding unknowns)

	National 2008 (6,265 cases)		National 2010 (7,626 cases)	
	Number	%	Number	%
Allied health professionals	748	12	802	11
Ancillary staff	1,143	18	1,012	13
Clerical	1,019	16	1,261	17
Doctor	115	2	132	2
Nurse (including nursing assistants)*	2,832	45	4,133	54
Other	408	7	286	4

*the 2008 question on occupation did not make any reference to nursing assistants.

In 2010 there was an increase in the proportion of nurses, and a small decrease in the proportions of ancillary and 'other' staff, compared with 2008. This may reflect a clear instruction in 2010 to classify nursing assistants as nurses. In 2008 it is likely that nursing assistants were spread across the three categories; nurse, ancillary staff and 'other'.

Overall the demographics of cases entered in the 2010 audit were very similar to those reported in the 2008 audit. The median age of cases entered into the audit (46 years) was very similar to the median age of all staff in the NHS (43 years).[30] The proportion of women in our audit (84%) was higher than the proportion of women employed in the NHS (77%).[31]

A higher proportion of nurses (54%) and a lower proportion of doctors (2%) were entered into this audit than would be expected from current demographics of the NHS workforce in England (nationally 30% are nurses and 10% are doctors).[32] This may be because doctors have very low levels of sickness absence and nurses relatively high levels.[33] It could also be that nurses are more, and doctors less, likely to be referred to their OH department.

[30] Information provided by The Information Centre, November 2008.
[31] Information provided by The Information Centre, November 2008.
[32] The Health and Social Care Information Centre. *Staff in the NHS 1997–2007.* The NHS Information Centre, Workforce and Facilities Team, England, 2008.
[33] The Health and Social Care Information Centre. *Sickness absence rates in the NHS: April – June 2010.* The NHS Information Centre, Workforce and Facilities Team, England, 2010.

It is important that trusts ensure that all staff groups have full access to OH services and are encouraged to seek advice.

Referral diagnosis

8.2.1 What was the diagnosis as described in the referral to OH?

1.3 Occupation	Cardio-vascular	Malig-nancy	Musculo-skeletal	Other	Psycho-logical	Respira-tory (non-malignant)	Surgery (non-malignant)	All diagnostic categories
All occupations (2010)	208 (3%)	304 (4%)	1,933 (28%)	818 (12%)	2,300 (33%)	150 (2%)	1,223 (18%)	6,936 (100%)
All occupations (2008)	164 (3%)	173 (3%)	1,274 (24%)	657 (12%)	2,088 (39%)	146 (3%)	792 (15%)	5,294 (100%)

In 91% (6,936/7,636) of cases the presenting symptom/problem was reported in the referral. This is an increase from 84% in 2008 (5,294/6,286). In both 2008 and 2010 the most common diagnosis described in this referral was psychological and the second most common was musculoskeletal. For 4% of sites (11/286), accounting for 0.6% (43/7,636) of cases, all the cases entered into the audit were referred with a psychological diagnosis (Question 8.2.1). We contacted the majority of these sites who were able to confirm these were chance findings rather than representing a misunderstanding of the inclusion criteria. Overall 79% (5,456/6,936) of cases were referred with a psychological or musculoskeletal diagnosis or as a result of surgery.

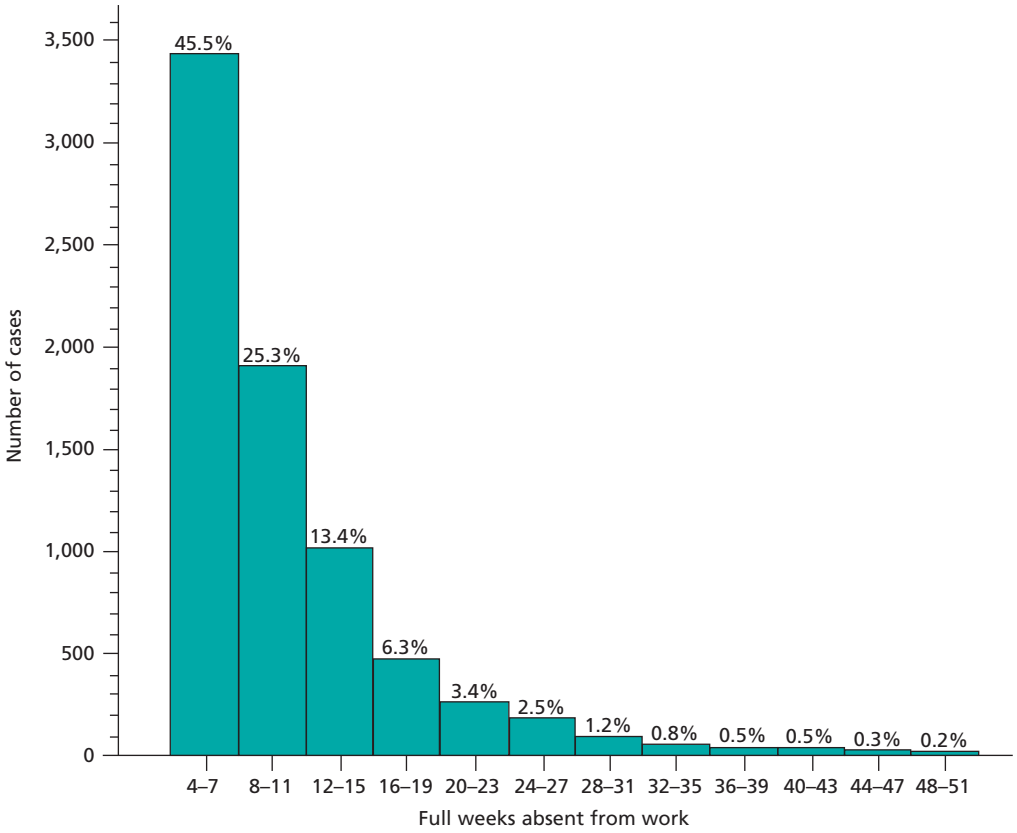
The inclusion of a diagnosis in nearly all referrals suggests that line managers are communicating helpfully when referring their staff to OH units.

Period of absence from work at the time of the audited appointment (first appointment following at least four weeks off work)

These data were collected as they provide useful background information about the population of cases included in the audit:

1.5: How many full weeks had the patient been absent from work at the time of this appointment?	National 2008 (6,286 cases)		National 2010 (7,636 cases)	
	Median	IQR	Median	IQR
	9	6–14	8	5–12

The graph below shows the number of weeks that cases had been absent from work at the time of the audited appointment. The height of the bar shows how many cases are in each category:



This graph is truncated at 52 weeks for clarity. 67 cases (1% of the total) had been off work for 52 weeks or longer at the time of audited appointment.

The median period off work at the time of the audited appointment was eight weeks with no clear differences between occupational groups or for different diagnoses, apart from those with malignancy (median 18 weeks). The drop in median from nine weeks in 2008 to eight weeks in 2010 may reflect a move by trusts to refer staff on long-term sick at an earlier stage during their absence. Trusts should apply caution when interpreting their local results as these will depend on several factors including their local trigger points for referral to OH, and the case mix entered into the audit.

30% of cases had not been seen in the first 12 weeks of sickness absence and 5% of cases were seen after six months. This is a decrease in referral time from 2008 when 37% of cases had not been seen the first 12 weeks of sickness absence and 8% of cases were seen after six months. Following six months of absence a patient has an 80% chance of being off work for five years.[34] This finding shows that earlier referral may be crucial and there is ongoing scope for trusts to decrease their referral times.

[34] National Institute for Health and Clinical Excellence. *Management of long-term sickness and incapacity for work* (PH19). London: NICE, 2009.

Depression detection by Occupational Health

Rationale

Individuals with chronic disease and particularly those on long-term sickness absence are at high risk for depression, whatever the presenting diagnosis.[35] The NICE guideline on the management of depression in adults with a chronic physical health problem notes that many patients with established physical diseases become depressed during the course of their illness.[36] Recognition of depression for this population is important and can lead to improved outcomes. Depression is an independent predictor of non-return to work, regardless of the primary diagnosis, and the longer a person is off work the less likely they are to return to work.[37]

Target

OH professionals should always consider the possibility of psychological problems underlying or complicating the clinical picture when staff present after four weeks of sickness absence, independent of the apparent reason for absence.[38]

Audit results

2.1: Is there any evidence that the OH professional has attempted to assess whether or not the patient might be depressed?	National 2008 (6,286 cases)		National 2010 (7,636 cases)	
	Number	%	Number	%
Yes	2,650	42	3,130	41
Yes, but no evidence of depression*	1,019	16	1,958	26
No	2,617	42	2,548	33

*For the 2008 audit the option stated 'distress' rather than depression.

The proportion of all cases assessed for depression rose from 58% in 2008 to 67% in 2010. However there has been no increase in the proportion of cases found to have evidence of depression. This may be because OH professionals were previously very good at selecting those cases in whom an assessment of depression might yield positive findings. Alternatively, it may be that they were less likely to document having made an assessment where there was no indication that the patient was depressed.

The proportion assessed did not vary noticeably by age, gender or occupational group (once the nature of the referral diagnosis was taken into account, see below).

[35] Egede LE (2007) Major depression in individuals with chronic medical disorders: prevalence, correlates and association with health resource utilization, lost productivity and functional disability *Gen Hosp Psychiatry* 29(5):409–16.

[36] National Institute for Health and Clinical Excellence. *Depression in adults with a chronic physical health problem: Treatment and management* (CG91). London: NICE, 2009.

[37] Mykletun A, Overland S, Dahl AA *et al* (2006) A population-based cohort study of the effect of common mental disorders on disability pension awards *Am J Psychiatry* 163(8):1412–8.

[38] Where a target of 'all consultations' has been set in this report we acknowledge that there may be rare and exceptional cases where the action would be inappropriate, for example if the patient had not given consent.

Full and accurate documentation of a consultation is an essential part of patient care. This includes documentation of negative findings. Clinical records demonstrate that an appropriate assessment has taken place, allow progress between appointments to be assessed, and facilitate continuity of care where more than one clinician is involved in the case.

There were some differences between types of NHS trust.[39] 40% (60/150) of Ambulance trust staff were assessed, comprising 21% (32/150) with some evidence of depression and 19% (28/150) with no evidence of depression.[40] By contrast, 71% (876/1,229) of staff of Mental Health trusts were assessed, comprising 47% (572/1,229) with some evidence of depression and 25% (304/1,229) with no evidence of depression. Similar differences were seen in 2008, when 33% of Ambulance trust staff were assessed compared with 61% of Mental Health trust staff.

We looked at whether detecting depression in people with at least four weeks of absence from work was dependent on the reported problem at referral (Question 8.2).

Percentage of patients assessed for depression

Audit	Referred with psychological diagnosis	Referred with musculo-skeletal diagnosis	All other categories of referral diagnosis
2010	95% (2,189/2,303)	48% (921/1,936)	55% (1,481/2,706)
2008	83% (1,727/2,091)	12% (147/1,277)	17% (340/1,943)

One of the main findings of the 2008 audit was the relatively low level of depression assessment in people referred for non-mental health reasons (15%, 487/3,220). It is therefore striking that in the 2010 audit there was a substantial increase in such assessments; now more than half (52%, 2,402/4,642) are being assessed. Depression assessments remain high for cases in which a referral for a psychological diagnosis had been made.

This finding shows that compared to 2008 more staff on long-term sick leave are now being assessed for depression. Nonetheless a third of those on long-term sick leave are not being assessed, particularly where the presenting problem is a physical one.

From this point until Section 8 on Communication, the questions were only asked for those 3,130 cases for which the answer to Question 2.1 was 'Yes' (ie only when the OH professional had attempted to assess if the patient might be depressed *and* there was evidence of depression).

Depression symptoms

Rationale

The OH professional's discussions during consultations with staff who have had at least four weeks of sickness absence and show signs or symptoms of depression should cover the core features of depressive illness. The symptom list included in the audit question below is based on

[39] Trust type throughout is considered on the basis of the trust the patients are employed by, rather than where the OH service is based.

[40] 'Yes' to Question 2.1 indicates the OH professional had attempted to assess for depression and evidence of depression was found.

the World Health Organisation's International Statistical Classification of Diseases and Related Health Problems, 10th Revision (2007) (ICD-10) but is not exhaustive. The OH professional should be able to ask sufficient details to diagnose or exclude depression in order to advise the most appropriate care. This is a crucial aspect of the stepped care approach recommended by NICE, and without knowledge of the ICD-10 symptoms it would be difficult to assess the appropriate level of treatment indicated.[41]

Audit results

3.1: Please indicate if the OH Professional has asked the patient any questions about the following aspects of depression:	National 2008 (2,650 cases)		National 2010 (3,130 cases)	
	Number	%	Number	%
Loss of interest	1,105	42	1,643	52
Loss of appetite or weight	1,089	41	1,570	50
Difficulty concentrating	1,192	45	1,576	50
Depressed mood/sadness	1,971	74	2,555	82
Lack of energy/fatigue	1,149	43	1,617	52
Sleep disturbance	1,685	64	2,250	72

Compared to the 2008 audit there was an increase in the proportion of patients asked about all symptoms of depression. Each symptom was enquired about in at least 50% of cases where depression was suspected. 25% (791/3,130) were asked about all six symptoms of depression, an increase of more than one third compared to 2008. In 2008, 11% of patients were not asked about any of the symptoms listed. In the 2010 audit this figure had decreased to 6%.

		Number of symptoms asked about						
Audit	Cases	None	One	Two	Three	Four	Five	All Six
2010	3,130	6% (175)	13% (414)	14% (433)	16% (496)	13% (408)	13% (413)	25% (791)
2008	2,650	11% (288)	14% (383)	16% (436)	17% (455)	13% (353)	9% (251)	18% (484)

In addition, we found that:

- 'Depressed mood/sadness' and 'sleep disturbance' were still asked about more frequently than other aspects.
- Where only one of the items was not asked, it was most commonly 'loss of appetite/weight' (123/413) or 'difficulty concentrating' (also 123/413). This is notable as cognitive difficulties have been suggested as one of the reasons for poor occupational function in depression.[42]

[41] National Institute for Health and Clinical Excellence. *Depression: The treatment and management of depression in adults* (CG90). London: NICE, 2009.
[42] Harvey SB and Henderson M. Occupational Psychiatry. *Psychiatry* 2009;8(5):174–179.

- In 48% (1,514/3,130) of cases of suspected depression there was evidence of the OH professional enquiring about both low mood and loss of interest in their usual activities. Recent NICE guidance (Section 1.3) on the detection of depression specifically recommends the use of these two questions.[43]

These findings suggest that OH professionals have increased the number of depressive symptoms they enquire about. In almost half of cases where depression was suspected the two questions recommended by NICE were utilised. Despite this many people have relatively few questions asked of them. In particular questions about concentration would seem pertinent.

Suicide or self harm

Rationale

For patients with depression, there is a clear NICE recommendation that healthcare professionals should always ask directly about suicidal ideas and intent.[44] If thoughts about suicide or self harm are reported, plans and previous actions should be asked about as they constitute key risk factors for future suicide and self harming.

It might be argued that it would not be appropriate for OH professionals to ask some cases with distress about suicide and self harm. However, if cases present having had at least four weeks off work and showing evidence of depression, the risk of suicide indicates that OH professionals should ask these questions.[45] The responses should always be recorded in the notes.

Thoughts of suicide are relatively common. The presence of a mood disorder is one of the strongest risk factors for both suicidal thoughts and actual self harm.[46]

Audit results

		National 2008 (2,650 cases)		National 2010 (3,130 cases)	
		Number	%	Number	%
4.1: Is there any evidence that the OH professional has asked the patient about thoughts of suicide or deliberate self harm?	Yes	823/2,650	31	1,529/3,130	49
4.1.1: If yes to 4.1, did the patient report thoughts of suicide or self-harm?	Yes	256/823	31	343/1,529	22
4.1.1.1: If yes to 4.1.1, is there any evidence that the OH professional has ASKED about the patient's plans for suicide or self-harm?	Yes	171/256	67	254/343	74
4.1.1.2: If yes to 4.1.1, is there any evidence that the OH professional has ASKED about any previous suicidal acts or actual self-harm?	Yes	124/256	48	162/343	47

[43] National Institute for Health and Clinical Excellence (2009) *Depression: the treatment and management of depression in adults* (CG90).

[44] National Institute for Health and Clinical Excellence (2009) *Depression: the treatment and management of depression in adults* (CG90).

[45] Suicide and self harm were considered together in this audit as assessments carried out by the occupational health professional are similar for both.

[46] Nock MK, Borges G, Bromet EJ *et al* (2008) Cross-national prevalence and risk factors for suicidal ideation, plans and attempts *Br J Psychiatry* 192(2):98–105.

Among the cases in which evidence of depression was detected, 49% were asked about thoughts of suicide or deliberate self harm. This represents an increase of three-fifths compared to the 2008 audit. When thoughts of suicide or self harm were asked about, a quarter (22%) of cases reported thoughts of this kind. 74% of cases that reported thoughts of suicide or self harm were asked about actual plans, and 47% were asked about any previous acts.

Thus 11.0% of cases (343/3,130) who had been off work for at least four weeks and had documented evidence of depression reported thoughts of suicide or self-harm, compared with 9.7% (256/2,650) of cases in 2008. So when OH professionals asked about suicidal thoughts more frequently, they picked up a slightly higher proportion of depressed patients than previously. This suggests that some cases of suicidal thoughts may have been missed in 2008 because the question was asked less often.

The cases where suicidal thoughts were detected represent 4% (343/7,636) of all cases submitted to the audit (ie 4% of all cases that had been off work for four weeks or more, for any health-related reason). It is difficult to make direct comparisons with community surveys, however these results seem to indicate that individuals on long-term sickness absence may be at increased risk of suicidal ideation.[47] We note that there are some situations in which documentation is more likely, such as when the employee appears at risk of suicide or broaches the subject him/herself.

There were no obvious differences between age bands (<35, 35–45, 45–54, 55+), sexes or occupational groups in terms of the above questions having been asked.

We looked at how often cases with a current diagnosis of depression were asked about thoughts of suicide or self harm compared with those who had no diagnosis of depression but presented with some evidence of depression: 54% (1,133/2,110) of cases with a current diagnosis of depression were asked about thoughts of suicide or self harm compared with 39% (396/1,020) of those that had some evidence of depression but no recorded diagnosis of depression.[48,49]

The 2010 audit has shown increases in the level of questioning compared to results from 2008. Nearly half of those with evidence of depression were asked about thoughts of suicide or self harm. While this is an increase, it should be noted that those on long-term sickness are at increased risk for self harm and thus some form of risk assessment should be included whenever depression or distress is detected.

Psychosocial context

Rationale

A person's psychosocial context is an important factor in their depression and their return to work. The NICE guideline states that '…when assessing a person with depression, healthcare professionals should consider the psychological, social, cultural and physical characteristics of the patient and the quality of interpersonal relationships. They should consider the impact of

[47] The British Household Survey found that just under 1% of the population had reported suicidal thoughts in the previous week (Jenkins R, Bebbington P, Brugha TS *et al* (1998) British psychiatric morbidity survey *Br J Psychiatry* 173:4–7).

[48] Made either prior to or during the consultation (Question 7.1 was answered 'yes').

[49] These questions were only made applicable for patients who presented with some evidence of depression.

these on the depression and the implications for choice of treatment and its subsequent monitoring'.[50]

Therefore questions about psychosocial aspects should always be asked of cases who have had at least four weeks of sickness absence and also show signs of depression.

We acknowledge that the answers to some of these questions may not have been documented in the case note entry audited, as the OH professional may have assessed these factors during this illness episode but prior to any sickness absence. However, use of alcohol and street or illicit drugs could be a changing situation and therefore should be asked about regularly, particularly when an employee has been absent from work. Research evidence shows that 16% of those with depression have a current diagnosis of alcohol problems compared with 7% in the general population. Alcohol problems are associated with worse outcomes with respect to course of illness, suicide/death risk, social functioning, healthcare utilisation and capacity to work.[51,52]

Audit results

5.1: Is there any evidence (within this consultation)* that the OH professional has asked any questions about the following aspects of the patient's life?	National 2008 (2,650 cases)		National 2010 (3,130 cases)	
	Number	%	Number	%
Patient's spouse or partner, or documented that patient is single	1,685	64	2,349	75
Patient's children or family, or documented that patient has no children	1,578	60	2,113	68
Use of alcohol	874	33	1,449	46
Use of street or illicit drugs	248	9	672	21

*The 2008 wording was (within the first assessment after 4 weeks off work).

A greater proportion of patients were asked about psychosocial factors compared to 2008. Three-quarters were asked about their partner. The proportion asked about illicit drugs more than doubled. Nonetheless this was still less than a quarter, and less than half were asked about their alcohol consumption.

We also found that:

- 17% (536/3,130) were asked about only one of these aspects (most commonly about their spouse/partner (299/536) or about their children/family (179/536))
- 30% (936/3,130) were asked about two
- 22% (685/3,130) were asked about three

[50] National Institute for Health and Clinical Excellence (2009) *Depression: the treatment and management of depression in adults* (CG90).

[51] Sullivan LE, Fiellin DA and Connor PG (2005) The prevalence and impact of alcohol problems in major depression: a systematic review *American Journal of Medicine* 118(4):330–41.

[52] Vahtera J, Poikolainen K, Kivimäki M, Ala-Mursula L and Pentti J (2002) Alcohol intake and sickness absence: a curvilinear relation *Am J Epidemiol* 156(10):969–76.

- 17% (530/3,130) were asked about all four
- 14% (443/3,130) were not asked about any of these aspects.

There were no obvious differences between occupational groups in terms of whether the above questions were asked.

The following tables show variation by age and gender in how often these questions were asked:

5.1: Is there any evidence that the OH professional has asked any questions about the following aspects of the patient's life?	Age <35 years (581 cases)		Age 35–44 years (924 cases)		Age 45–54 years (1,112 cases)		Age 55+ years (513 cases)	
	Number	%	Number	%	Number	%	Number	%
Patient's spouse or partner, or documented that patient is single	456	78	709	77	812	73	370	72
Patient's children or family, or documented that patient has no children	401	69	670	73	749	67	293	57
Use of alcohol	280	48	434	47	495	45	240	47
Use of street or illicit drugs	160	28	191	21	228	21	93	18

5.1: Is there any evidence that the OH professional has asked any questions about the following aspects of the patient's life?	Men (481 cases)		Women (2,649 cases)	
	Number	%	Number	%
Patient's spouse or partner, or documented that patient is single	366	76	1,983	75
Patient's children or family, or documented that patient has no children	300	62	1,813	68
Use of alcohol	270	56	1,179	45
Use of street or illicit drugs	125	26	547	21

Whilst the differences with regard to age and gender were subtle, it nevertheless showed that, with the exception of alcohol, the questions were asked less often as the age of the case increased. Women were asked questions about children/family more often than men, while men were more likely to be asked about alcohol and illicit substances.

These questions were asked more frequently in consultations that included questions about thoughts of suicide/self-harm than those that did not, regardless of the response (results not shown).

A better understanding of potential barriers to recovery would be gained by asking about aspects of home and family life more often. Importantly, more consultations should include questions about alcohol and illicit drug use.

Workplace factors

Rationale

Identification of workplace factors that are perceived to have contributed to any depression is a key role of the OH professional and therefore relevant questions about the workplace should always be asked. If employees think that workplace factors have caused or contributed to any depression, then the OH professional should usually consider discussing this with the employer.

The NICE guideline on depression states that where a patient's depression has resulted in loss of work or disengagement from other social activities over a longer term, a rehabilitation programme addressing these difficulties should be considered.[53] The NICE guideline on long-term sickness absence applies to all cases of sickness absence, regardless of the diagnosis. It recommends that an assessment is made of perceived (or actual) barriers to returning to work (including the need for workplace adjustments).

Audit results

		National 2008 (2,650 cases)		National 2010 (3,130 cases)	
		Number	%	Number	%
6.1: Is there any evidence that the OH professional has asked the patient if they think workplace factors have caused or contributed to any depression?	Yes	1,849/2,650	70	2,180/3,130	70
6.1.1: If yes to 6.1, did the patient think workplace factors have caused or contributed to any depression?	Yes	1,188/1,849	64	1,235/2,180	57
6.1.1.1: If yes to 6.1.1, is there any evidence that the OH professional has considered discussing this with the employer?	Yes	995/1,188	84	1,043/1,235	84

The 2008 and 2010 audit results were very similar. 70% of cases off work for at least four weeks, and with evidence of depression, were asked about the contribution of workplace factors to any depression. 57% thought that workplace factors had caused or contributed to their depression. In 84% of this latter subset the OH professional considered discussing this with the employer. Interestingly, this was not an area of focus for the regional and national workshops which followed the 2008 audit. It is unclear whether this is the reason for the lack of change in results between the two audits, or whether this represents a ceiling effect.

Different types of trust were compared and only small differences were found.

The percentage of cases asked about workplace factors varied notably between occupational groups, as did the percentage who felt that workplace factors had contributed to any depression (see table below). There were no obvious differences between occupational groups in terms of

[53] National Institute for Health and Clinical Excellence (2009) *Depression: the treatment and management of depression in adults* (CG90).

whether the OH professional had considered discussing workplace factors with the employer (data not shown).

	6.1: Is there any evidence that the OH professional has asked the patient if they think workplace factors have caused or contributed to any depression?				6.1.1: If yes to 6.1, did the patient think workplace factors have caused or contributed to any depression?			
	National 2008		National 2010		National 2008		National 2010	
	Number	%	Number	%	Number	%	Number	%
Allied health professionals	250/331	76	208/307	68	170/250	68	138/208	66
Ancillary staff	270/425	64	221/347	64	144/270	53	87/221	39
Clerical	345/468	74	435/575	76	250/345	72	265/435	61
Doctor	48/62	77	42/50	84	31/48	65	30/42	71
Nurse	833/1,206	69	1,194/1,740	69	524/833	63	661/1,194	55
Other	97/151	64	78/107	73	66/97	68	52/78	67

The proportion of patients being asked about their perception of the role of workplace factors has remained high. However, *all* patients off work for four weeks presenting with depression should be asked about the contribution of workplace factors. Differences were found between occupational groups in both audits, and the reasons for these remain unclear.

Current management

Rationale

OH professionals should ask cases with at least four weeks of sickness absence and a current diagnosis of depression about contact with other healthcare professionals concerning their depression and also about any medication they are being prescribed for the depression.

Audit results

		National 2008 (2,650 cases)		National 2010 (3,130 cases)	
		Number	%	Number	%
7.1: Is it documented that the patient has a current diagnosis of depression from either the OH professional or another healthcare professional?	Yes	1,921/2,650	72	2,110/3,130	67
7.1.1: If yes to 7.1, is there any evidence that the patient has been asked about contact with other healthcare professionals *concerning their current depression*?**	Yes	1,770/1,921	92	2,007/2,110	95

continued

Audit results – *continued*

		National 2008 (2,650 cases)		National 2010 (3,130 cases)	
		Number	%	Number	%
7.1.1.1: If yes to 7.1.1, which professionals?	GP	1,561/1,770	88	1,867/2,007	93
	Psychiatrist/ community psychiatric nurse/mental health team	375/1,770	21	374/2,007	19
	Counsellor/ therapist/ cognitive behavioural therapy therapist	1,051/1,770	59	992/2,007	49
7.1.2: If yes to 7.1, is there any evidence that the OH professional has asked about any medication that is being prescribed *for the depression*?	Yes, patient being prescribed medication	1,464/1921	76	1,595/2,109	76
	Yes, patient NOT being prescribed medication	297/1,921	15	390/2,109	18
	No, patient not asked	156/1,921	8	124/2,109	6

** 'Current' was added to the 2010 audit for 7.1.1 and was not there for the 2008 audit.

Amongst the 67% (2,110/3,130) of cases that had a current diagnosis of depression, 95% were asked by the OH professional about contact with other healthcare professionals and 94% (1,985/2,109) were asked if medication was being prescribed for the depression.

There were very few differences in these results between the different types of trust.

Very high levels of enquiry about contact with other health professionals and medication use have persisted in this audit, similar to 2008.

Communication

This section applies to all 7,636 cases in the audit, whether or not the OH professional screened for depression.

Rationale

Communication is fundamental to the role of the OH professional. Core groups for liaison include the employee, their line manager, their GP and where depression is diagnosed, any mental health professionals involved.

For most cases, the OH professional should communicate with the employee's line manager following an appointment after four weeks of sickness absence (many of these will have been referred by their manager). The GP should be contacted in cases where it is appropriate to do

so, such as where there is a significant work-related component to the employee's diagnosis or recovery. [54,55]

As regards communicating with employees themselves, the *Copying Letters to Patients* initiative originated in the Government's NHS Plan and has been rolled out since 2003. It states that letters between clinicians about a patient's care will be 'copied to the patient as of right'.[56] There is divergence among OH professionals about whether, and under which circumstances, they should follow this guidance. Some OH professionals, when writing to line managers and/or GP, send a copy to the employee. Others will discuss the content of such correspondence with the employee and may decide not to send copies to patients routinely.

Thus, the targets for communication are as follows:

- Most consultations should result in communication with the employee's line manager.
- Communication with the employee's GP will depend on the case and the results below should be interpreted locally.
- Mental health professionals should be contacted where appropriate.
- Communication with the employee him/herself will depend on the case and the policy of the OH professional and their department and hence the results should be interpreted locally.

Audit results

8.1: Is there any evidence that the OH professional has communicated (telephone or letter or email) with any of the following?	National 2008 (all 6,286 cases)		National 2010 (7,636 cases)	
	Number	%	Number	%
GP	832	13	651	9
Patient's line manager	6,020	96	7,466	98
A mental health professional	246	4	131	2
The patient (eg copy of letter to the GP or manager)	3,605	57	5,584	73

Nationally, communication with the employee's line manager was, at 98%, in line with the target. As stated above, the other results should be interpreted locally. Our results suggest that between 2008 and 2010 there has been a trend towards more OH professionals providing patients with copies of the correspondence relating to their case. Despite this, the audit also revealed that communication practice continues to vary widely between OH services, as 7% (21/286) of sites communicated with none of their patients and 42% (121/286) communicated with all their patients (this was unrelated to the number of cases entered per site – results not shown).

[54] We note that communication does not always involve informing the GP, it might for example include asking the GP for further information.

[55] The FOM Guidance on Ethics for Occupational Physicians advises that 'In normal circumstances, and subject to the consent of the individual, the occupational physician should inform the general practitioner, who is responsible for maintaining continuity of the patient's medical care, of work-related facts which may have a bearing on the health of the individual'. Faculty of Occupational Medicine (2006) *Guidance on ethics for occupational physicians, 6th Edition*, paragraph 2.5.

[56] See Department of Health *Copying letters to patients*, www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/Copyingletterstopatients/DH_4000431, accessed December 2010.

For the subgroup of cases who had at least four weeks off work and evidence of depression, communication by the OH professional for those who had a current diagnosis of depression compared with those who did not are shown below:

	Patients documented with a current diagnosis of depression from either the OH professional or another healthcare professional (ie 7.1=YES)			
8.1: Is there any evidence that the OH professional has communicated (telephone or letter or email) with any of the following?	**National 2008 (1,921 cases)**		**National 2010 (2,110 cases)**	
	Number	**%**	**Number**	**%**
GP	384	20	273	13
Patient's line manager	1,842	96	2,057	97
A mental health professional	183	10	103	5
The patient (eg copy of letter to the GP or manager)	1,148	60	1,623	77

Amongst cases with evidence of depression, the proportion where the OH professional corresponded with the GP has decreased since 2008, while the proportion with correspondence copied to the patient has increased. It is possible that patients whose GPs were previously corresponded with are now being given the letters themselves.

Finally, the responses were broken down according to whether thoughts of suicide or self-harm had been recorded. This showed a similar pattern of changes in recipient of correspondence between 2008 and 2010, ie the OH professional has communication more frequently with the patient. Where thoughts of self harm have been identified, either the GP or a mental health professional should be contacted.

	4.1.1 If YES (to 4.1), did the patient report thoughts of suicide or self harm?			
8.1: Is there any evidence that the OH professional has communicated (telephone or letter or email) with any of the following?	**National 2008 (256 cases)**		**National 2010 (343 cases)**	
	Number	**%**	**Number**	**%**
GP	71	28	51	15
A mental health professional	42	16	30	9
The patient (eg copy of letter to the GP or manager)	172	67	268	78

In light of the continuing divergence of opinion about what constitutes best practice in communicating with the employee, we conclude that OH, as a profession, needs to develop national guidance in this area. The Faculty of Occupational Medicine would be well placed to initiate this work and we recommend that this is taken forward and that OH nurses, other healthcare professionals, employee and patient representatives are involved.

Barriers to work

This section is new to the 2010 Audit. Identifying potential barriers to work is an essential part of the role of an OH professional. Recent NICE guidance on long-term sickness absence recommends that enquiries are made about any perceived (or actual) barriers to returning to work (including the need for workplace adjustments).

		National 2010 (7,635** cases)	
		Number	%
9.1: Has the OH professional documented that they have discussed/identified barriers to return to work and/or enablers for return to work?	Yes	7,011	92

**Not known for 1 case.

In almost all cases (92%) the OH professional is considering barriers and enablers to work. This finding is reassuring as the relationship between work and health is fundamental to the role of the OH professional.

Physiotherapy and psychological therapies

Rationale

Cognitive behavioural therapy (CBT) can be an effective treatment for depression. There is also evidence that psychological therapies with a CBT approach can facilitate a return to work following long-term sickness absence, regardless of the presenting diagnosis. This is particularly the case where psychological barriers to recovery exist. In some cases of musculo-skeletal disorder a physical therapy approach may be beneficial. This evidence is reflected in the NICE guidance on long-term sickness absence which recommends that referral for evidence-based psychological therapies, and in some cases physiotherapy, are considered for cases where intervention is likely to speed recovery.

Psychological and physical therapies will not be appropriate for all cases of sickness absence extending beyond four weeks. While questions 9.2 and 9.3 examine how and when staff access physiotherapy and psychological therapy, we are not expecting all cases audited to have received these treatments.

In answering this question, data collectors were asked to make a judgment about whether these therapies were likely to be appropriate for the case in question. They were asked to tick a 'not applicable' box if it was very clear from the case notes that the therapy was not appropriate.

Audit results

Has the OH professional documented that the patient is receiving, or has been referred to	Yes	No	Not applicable (very clear from the case notes that the therapy is not appropriate)
9.2: physiotherapy for their current problem?	1,757 (23%)	1,069 (14%)	4,810 (63%)
9.3: psychological therapy for their current problem?	2,215 (29%)	1,776 (23%)	3,645 (48%)

The results above show that almost a quarter of all cases entered into the audit were receiving, or waiting to receive, physiotherapy. Just over a quarter of all cases were receiving, or waiting to receive, psychological therapy. The tables below show for those where therapy was deemed appropriate, the proportions referred, the referral route and who provided the therapy.

Physiotherapy		National 2010 (2,826** cases)	
		Number	%
9.2: Has the OH professional documented that the patient is receiving, or has been referred to, physiotherapy for their current problem?	Yes	1,757	62
9.2.1 If YES (to 9.2) , was the patient referred by the OH professional, at this consultation, to a staff physiotherapy service (i.e. financed by the employing trust or via the OH provider)	Yes	249	14
9.2.2 If YES (to 9.2) , was the patient already receiving/ referred to a staff physiotherapy service (i.e. financed by the employing trust or via the OH provider) at time of this consultation	Yes	133	8
9.2.3 If YES (to 9.2) , was the patient already receiving/ referred to physiotherapy by GP or other treating specialist	Yes	1,364	78
9.2.4 If YES (to 9.2) , was the patient facilitated by the OH professional to receive physiotherapy accessed through their GP or hospital specialist	Yes	60	3

**Excludes 4810 'not applicable' cases for question 9.2.

Psychological therapy		National 2010 (3,991** cases)	
		Number	%
9.3 Has the OH professional documented that the patient is receiving, or has been referred to, psychological therapy for their current problem?	Yes	2,215	55
9.3.1 If YES (to 9.3), was the patient referred by the OH professional, at this consultation, for staff psychological therapy (i.e. financed by the employing trust or via the OH provider)	Yes	805	36
9.3.2 If YES (to 9.3), was the patient already receiving/ referred to staff psychological therapy (i.e. financed by the employing trust or via the OH provider) at time of this consultation	Yes	364	16
9.3.3 If YES (to 9.3), was the patient already receiving/ referred for psychological therapy by GP or other treating specialist	Yes	1,041	47
9.3.4 If YES (to 9.3), was the patient facilitated by the OH professional to receive psychological therapy through their GP, hospital specialist or other route	Yes	117	5

**Excludes 3645 'not applicable' cases for question 9.3.

The employer funded the treatment for 22% (382/1,757) of cases receiving, or referred to, physiotherapy; for psychological therapies this percentage rose to 53% (1,169/2,215). These findings suggest that employers are providing valuable treatment services which are likely to contribute to an earlier return to work for staff on long-term sickness.

	National 2010			
8.2.1 If YES (to 8.2), please state the diagnosis as described in the referral to OH	9.2 Has the OH professional documented that the patient is receiving, or has been referred to, PHYSIOTHERAPY for their current problem?		9.3 Has the OH professional documented that the patient is receiving, or has been referred to, PSYCHOLOGICAL THERAPY for their current problem?	
	Number	%Yes	Number	%Yes
Psychological	36/2,303	2	1638/2,303	71
Musculo-skeletal	1,235/1,936	64	112/1,936	6
Surgery (non-malignant)	300/1,225	24	50/1,225	4
Cardio-vascular	15/208	7	14/208	7
Malignancy	7/304	2	34/304	11
Respiratory (non-malignant)	5/150	3	10/150	7
Other	49/819	6	121/819	15
Total (all with a diagnosis)	1647/6945	24	1979/6945	28

When looked at by diagnostic category, the highest proportion of cases receiving physiotherapy were musculoskeletal (64%), followed by surgery (24%). For psychological therapies, those with a psychological diagnosis were most likely to receive this treatment (71%) followed by those with malignancy. These results suggest that cases are receiving therapies relevant to their condition.

Fitness for work and action plans

Rationale

A central role of the OH professional is to advise on an individual's fitness for work and this should always be documented in the case notes. Where the individual is off work due to sickness absence, the case notes should conclude with an action plan.

Target

100% of case notes should document the individuals fitness for work.

100% of case notes should conclude with an action plan.

		National 2010 (7,636 cases)	
		Number	%
9.4 Has the OH professional documented the individual's fitness for work?	Yes	7,459	98
9.5 Has the OH professional documented an action plan?	Yes	7,403	97

Almost all consultations audited contained information on potential barriers to return to work, an opinion on the individual's fitness for work and an action plan. This is consistent with the role and potential added benefits of an OH service.

Additional analysis

Following the 2009 audit, 66% of NHS trusts (255/389) sent at least one delegate to the dissemination conference and/or an implementation workshop (the intervention group). At these events we discussed the audit findings, particularly concentrating on the benefits of a depression assessment. At the workshops, participants developed action plans for overcoming barriers to implementing the audit recommendations.

We conducted a temporal analysis, comparing changes over time between the intervention and non-intervention groups. There is some indication that trusts in the intervention group made more progress than those in the non-intervention group. The full analysis is shown in Appendix 6.

The intervention groups more frequently documented that they had assessed for depression. They also more frequently asked about all six symptoms of depression and achieved a higher rate of asking the patient about thoughts of suicide or deliberate self harm. They were more likely to ask questions about aspects of the patient's life (spouse/partner, children/family, alcohol/use of illicit drugs) when evidence of depression was detected.

There was no observable difference between the intervention and non-intervention group in terms of the age of cases seen, the number of weeks absent from work, gender, occupation and type of employing trust, suggesting that the casemix within both groups was similar and unlikely to account for the differences seen.

5 Conclusions

The occupational health (OH) community has successfully completed the second round of audit of long-term sickness absence and depression detection in NHS staff in England. The results show that much progress has been made. Compared with 2008, this 2010 round has seen an increase in both the number of trusts participating and the number of cases entered by each trust; this year we are able to report on an additional 21% of cases.

We know that many trusts initiated interventions to improve their practice following the first audit round. Trusts were supported by a national conference and regional implementation workshops where a major focus was on the frequency and quality of depression assessments. The results indicate that these interventions had a positive effect in audit performance.

The focus on depression is reflected in this year's results which show an increase in both the frequency and the quality of assessments for depression in NHS staff off work for more than four weeks. OH professionals considered the possibility of depression in about two-thirds of cases. Where depression was identified, there is also an increase in the percentage who were asked about thoughts relating to suicide and self harm, possibly reflecting increased confidence in addressing this difficult area. OH professionals continue to demonstrate their unique contribution, evidenced by the high proportion of patients asked about the contribution of workplace factors and the near universal documentation of potential barriers to return to work.

Our data show that for 22% (382) of these long-term sick cases receiving, or referred to, physiotherapy the employer is funding the treatment. For psychological therapies this proportion rises to 53% (1,169). These findings suggest that employers are providing valuable treatment services which are likely to contribute to an earlier return to work for staff on long-term sickness absence.

Despite these positive and encouraging findings, areas remain where significant improvement is possible. It continues to be the case that patients presenting with a physical health diagnosis are much less likely to be asked about depression. When depression is enquired about, symptoms which may be pertinent to occupational functioning (for example attention and concentration) could be considered in more cases. Fewer than half of the cases with evidence of depression were asked about their alcohol consumption or thoughts of self harm or suicide; questions about these important aspects of depression need to be asked more often.

We have now completed the first full cycle of a national audit of aspects of OH care for NHS staff. The improvements made since round one suggest that the process has been valuable, and should contribute to a better outcome for staff on long-term sickness absence and their employers.

6 Next steps

Occupational health (OH) providers

We recommend that OH departments consider their own results in light of the targets and in comparison with the national results.

Where consultations do not meet the standards set in the NICE guidance, we recommend that OH professionals review their practice and develop mechanisms for service improvement. These might involve some or all of the following activities:

- education and training
- sharing good practice between staff of the department, regionally and more widely
- using tools to facilitate improvement, for example algorithms, and developing action plans
- developing systems to support comprehensive documentation of consultations.

HWDU

- We will distribute a depression detection and management algorithm based on the relevant NICE guidance.
- We will hold a national conference for OH professionals on 14 February 2011. At the conference we will disseminate the audit findings, discuss progress made since 2008, and facilitate sharing of good practice.
- We will consult OH professionals about developing the audit tool further to meet their needs, for example we will discuss inclusion of a generic section on record keeping standards.

The participants in this audit will be key stakeholders for these activities.

Appendix 1 Participating NHS trusts

The following Trusts entered data into this audit:

2gether NHS Foundation Trust
Aintree University Hospitals NHS Foundation Trust
Airedale NHS Trust
Alder Hey Children's NHS Foundation Trust
Ashford & St Peter's Hospital NHS Trust
Ashton, Leigh and Wigan Community Healthcare NHS Trust
Avon and Wiltshire Mental Health Partnership NHS Trust
Barking Havering & Redbridge University Hospitals NHS Trust
Barnet & Chase Farm Hospitals NHS Trust
Barnet, Enfield and Haringey Mental Health NHS Trust
Barnsley Hospital NHS Foundation Trust
Barts and The London NHS Trust
Basildon and Thurrock University Hospital NHS Foundation Trust
Basingstoke and North Hampshire NHS Foundation Trust
Bedford Hospital NHS Trust
Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust
Berkshire Healthcare NHS Foundation Trust
Birmingham Women's NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Brighton and Sussex University Hospitals NHS Trust
Calderdale & Huddersfield NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Camden and Islington NHS Foundation Trust
Central and Eastern Cheshire Primary Care Trust
Central and North West London NHS Foundation Trust
Central London Community Healthcare NHS Trust
Central Manchester University Hospitals NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
City Hospitals Sunderland NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
Community Health Stockport
Cornwall Partnership NHS Trust
Countess of Chester Hospital NHS Foundation Trust
County Durham & Darlington NHS Foundation Trust
Coventry & Warwickshire Partnership NHS Trust
Cumbria Partnership NHS Foundation Trust
Dartford & Gravesham NHS Trust
Derbyshire County Primary Care Trust
Devon Partnership NHS Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
Dorset HealthCare NHS Foundation Trust
Dudley and Walsall Mental Health Partnership NHS Trust
Ealing Hospital NHS Trust
East and North Hertfordshire NHS Trust
East Cheshire NHS Trust
East Kent University Hospitals NHS Foundation Trust
East Lancashire Hospitals NHS Trust
East London NHS Foundation Trust
East Midlands Ambulance Service NHS Trust
East Sussex Hospitals NHS Trust
Epsom and St Helier University Hospitals NHS Trust
Frimley Park Hospital NHS Foundation Trust
Gateshead Health NHS Foundation Trust
George Eliot Hospital NHS Trust
Gloucestershire Hospitals NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Hampshire Partnership NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Hereford Hospitals NHS Trust
Herefordshire Primary Care Trust
Hillingdon Hospital NHS Trust
Hinchingbrooke Health Care NHS Trust
Homerton University Hospital NHS Foundation Trust
Humber NHS Foundation Trust
Imperial College Healthcare NHS Trust
Isle of Wight NHS Primary Care Trust
James Paget University Hospitals NHS Foundation Trust
Kent & Medway NHS & Social Care Partnership Trust
Kettering General Hospital NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Kingston Hospital NHS Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Leeds Partnerships NHS Foundation Trust
Leicestershire Partnership NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Liverpool Heart and Chest Hospital NHS Trust
Luton and Dunstable Hospital NHS Foundation Trust
Maidstone and Tunbridge Wells NHS Trust

Manchester Mental Health & Social Care Trust
Mayday Healthcare NHS Trust
Medway Community Healthcare
Medway NHS Foundation Trust
Mersey Care NHS Trust
Mid Cheshire Hospitals NHS Foundation Trust
Mid Staffordshire NHS Foundation Trust
Mid-Essex Hospital Services NHS Trust
Newham University Hospital NHS Trust
NHS Barnet
NHS Barnsley
NHS Bassetlaw
NHS Bath & North East Somerset
NHS Bedfordshire
NHS Berkshire West - Community Health
NHS Brent
NHS Brent - Community Services
NHS Bury
NHS Camden
NHS Central Lancashire
NHS City and Hackney
NHS Cornwall and Isles of Scilly - Community Services
NHS Coventry
NHS Devon
NHS Devon Provider Services
NHS Doncaster
NHS Dorset
NHS Dudley
NHS Ealing
NHS East Riding of Yorkshire
NHS East Sussex Downs and Weald
NHS Eastern and Coastal Kent - Community Services
NHS Enfield
NHS Gloucestershire
NHS Halton and St Helens
NHS Hammersmith and Fulham
NHS Haringey
NHS Harrow
NHS Hertfordshire
NHS Heywood, Middleton and Rochdale
NHS Hounslow
NHS Hull
NHS Islington
NHS Kensington and Chelsea
NHS Kingston
NHS Knowsley
NHS Leeds
NHS Leicester City
NHS Lincolnshire
NHS Liverpool - Community Health
NHS Luton
NHS Manchester
NHS North Lincolnshire
NHS North Staffordshire - Community Health
NHS Northamptonshire
NHS Nottingham City
NHS Nottinghamshire County
NHS Oldham
NHS Plymouth
NHS Portsmouth (Solent Healthcare)
NHS Richmond
NHS Richmond - Community Health Services
NHS Rotherham
NHS Salford
NHS Sefton
NHS Sheffield
NHS Somerset
NHS South East Essex
NHS South of Tyne - Gateshead Primary Care Trust
NHS Southwark
NHS Sutton and Merton
NHS Telford & Wrekin - Community Healthcare Provider Services
NHS Telford and Wrekin
NHS Tower Hamlets
NHS Trafford
NHS Walsall - Community Health
NHS Wandsworth - Community Services Wandsworth
NHS Warwickshire
NHS West Kent
NHS West Sussex
NHS Western Cheshire
NHS Westminster
NHS Wiltshire
NHS Worcestershire
Norfolk and Norwich University Hospitals NHS Foundation Trust
North Bristol NHS Trust
North Cumbria University Hospitals NHS Trust
North East Ambulance Service NHS Trust
North East London NHS Foundation Trust
North Essex Partnership NHS Foundation Trust
North Middlesex University Hospital NHS Trust
North Tees & Hartlepool NHS Foundation Trust
North West Ambulance Service NHS Trust
Northampton General Hospital NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
Northern Devon Healthcare NHS Trust
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Northumberland,Tyne and Wear NHS Trust
Northumbria Healthcare NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Nottinghamshire Healthcare NHS Trust
Nuffield Orthopaedic Centre NHS Trust
Oxford Radcliffe Hospitals NHS Trust
Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust
Oxleas NHS Foundation Trust
Pennine Care NHS Foundation Trust

Peterborough & Stamford Hospitals NHS Foundation Trust
Plymouth Hospitals NHS Trust
Portsmouth Hospitals NHS Trust
Robert Jones/Agnes Hunt Orthopaedic Hospital NHS Trust
Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust
Royal Berkshire NHS Foundation Trust
Royal Bolton Hospital NHS Foundation Trust
Royal Cornwall Hospitals Trust
Royal Devon & Exeter NHS Foundation Trust
Royal Free Hampstead NHS Trust
Royal National Orthopaedic Hospital NHS Trust
Royal Surrey County Hospital NHS Trust
Royal United Hospital Bath NHS Trust
Salford Royal NHS Foundation Trust
Salisbury NHS Foundation Trust
Sandwell & West Birmingham Hospitals NHS Trust
Scarborough and North East Yorkshire Healthcare NHS Trust
Sheffield Children's NHS Foundation Trust
Sheffield Health and Social Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
Shropshire County Primary Care Trust - Community Services
Shropshire County Primary Care Trust
South Birmingham Community Health
South Central Ambulance Service NHS Trust
South Devon Healthcare NHS Foundation Trust
South Downs Health NHS Trust
South Essex Partnership University NHS Foundation Trust
South London Healthcare NHS Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
South Staffordshire Primary Care Trust
South Tyneside NHS Foundation Trust
South West London & St Georges Mental Health NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
South Western Ambulance Service NHS Trust
Southampton City Primary Care Trust
Southampton University Hospitals NHS Trust
Southend University Hospital NHS Foundation Trust
Southport & Ormskirk Hospital NHS Trust
St George's Healthcare NHS Trust
St Helens & Knowsley Teaching Hospitals NHS Trust
States of Guernsey Health & Social Services
Stockport NHS Foundation Trust
Stoke on Trent Community Health Services
Suffolk Mental Health Partnership NHS Trust
Surrey & Borders Partnership NHS Foundation Trust
Taunton & Somerset NHS Foundation Trust
Tavistock & Portman NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
The Christie NHS Foundation Trust
The Dudley Group of Hospitals NHS Foundation Trust
The Leeds Teaching Hospitals NHS Trust
The Mid Yorkshire Hospitals NHS Trust
The Newcastle upon Tyne Hospitals NHS Foundation Trust
The North West London Hospitals NHS Trust
The Pennine Acute Hospitals NHS Trust
The Princess Alexandra Hospital NHS Trust
The Queen Elizabeth Hospital King's Lynn NHS Trust
The Queen Victoria Hospital NHS Foundation Trust
The Rotherham NHS Foundation Trust
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
The Royal Wolverhampton Hospitals NHS Trust
The Shrewsbury and Telford Hospital NHS Trust
The Walton Centre NHS Foundation Trust
Trafford Healthcare NHS Trust
Trafford Provider Services
University College London Hospitals NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
University Hospital of North Staffordshire NHS Trust
University Hospital of South Manchester NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
University Hospitals Coventry & Warwickshire NHS Trust
University Hospitals of Leicester NHS Trust
University Hospitals of Morecambe Bay NHS Trust
Walsall Hospitals NHS Trust
West Hertfordshire Hospitals NHS Trust
West London Mental Health NHS Trust
West Middlesex University Hospital NHS Trust
West Midlands Ambulance Service NHS Trust
West Suffolk Hospital NHS Trust
Western Sussex Hospitals NHS Trust
Weston Area Health NHS Trust
Winchester & Eastleigh Healthcare NHS Trust
Wolverhampton City Primary Care Trust - Provider Services
Worcestershire Acute Hospitals NHS Trust
Worcestershire Mental Health Partnership NHS Trust
Wrightington, Wigan & Leigh NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
York Hospitals NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

The following services are represented by the data collected:

2gether NHS Foundation Trust
5 Boroughs Partnership NHS Trust
Abermed Ltd
Aintree University Hospitals NHS Foundation Trust
Airedale NHS Trust
Ashford & St Peter's Hospital NHS Trust
Atos Healthcare
Barking Havering & Redbridge University Hospitals NHS Trust
Barnet & Chase Farm Hospitals NHS Trust
Barnsley Hospital NHS Foundation Trust
Barts and The London NHS Trust
Basildon and Thurrock University Hospital NHS Foundation Trust
Basingstoke and North Hampshire NHS Foundation Trust
Bedford Hospital NHS Trust
Bradford Teaching Hospitals NHS Foundation Trust
Brighton and Sussex University Hospitals NHS Trust
Calderdale & Huddersfield NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Central London Community Healthcare NHS Trust
Central Manchester University Hospitals NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
City Hospitals Sunderland NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
County Durham & Darlington NHS Foundation Trust
Coventry & Warwickshire Partnership NHS Trust
Dartford & Gravesham NHS Trust
Derbyshire County Primary Care Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Dorset HealthCare NHS Foundation Trust
Dudley and Walsall Mental Health Partnership NHS Trust
Ealing Hospital NHS Trust
East and North Hertfordshire NHS Trust
East Kent University Hospitals NHS Foundation Trust
East Lancashire Hospitals NHS Trust
East Sussex Hospitals NHS Trust
Epsom and St Helier University Hospitals NHS Trust
Frimley Park Hospital NHS Foundation Trust
Gateshead Health NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Healthworks
Hereford Hospitals NHS Trust
Hillingdon Hospital NHS Trust
Hinchingbrooke Health Care NHS Trust
Homerton University Hospital NHS Foundation Trust
Humber Mental Health Teaching NHS Trust
Imperial College Healthcare NHS Trust
Isle of Wight NHS Primary Care Trust
Kettering General Hospital NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Kingston Hospital NHS Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Leeds Partnerships NHS Foundation Trust
London Borough of Hammersmith and Fulham Council
Luton and Dunstable Hospital NHS Foundation Trust
Maidstone and Tunbridge Wells NHS Trust
Mayday Healthcare NHS Trust
Medway NHS Foundation Trust
Mersey Care NHS Trust
Mid Cheshire Hospitals NHS Foundation Trust
Mid Essex Hospital Services NHS Trust
Mid Staffordshire NHS Foundation Trust
NHS Camden - Provider Services
NHS Dorset
NHS Haringey
NHS Hertfordshire
NHS South of Tyne - Sunderland Teaching Primary Care Trust
NHS Telford and Wrekin
NHS Warwickshire
NHS West Sussex
Norfolk and Norwich University Hospitals NHS Foundation Trust
North Cumbria University Hospitals NHS Trust
North East Ambulance Service NHS Trust
North Essex Partnership NHS Foundation Trust
North Middlesex University Hospital NHS Trust
North Tees & Hartlepool NHS Foundation Trust
Northampton General Hospital NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
Northern Devon Healthcare NHS Trust
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
Nottingham University Hospitals NHS Trust
OH Works Ltd
Oxford Radcliffe Hospitals NHS Trust
Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust
Peterborough & Stamford Hospitals NHS Foundation Trust
Plymouth Hospitals NHS Trust
Portsmouth Hospitals NHS Trust
Royal Berkshire NHS Foundation Trust

Royal Bolton Hospital NHS Foundation Trust
Royal Cornwall Hospitals Trust
Royal Devon & Exeter NHS Foundation Trust
Royal Free Hampstead NHS Trust
Royal National Orthopaedic Hospital NHS Trust
Royal Surrey County Hospital NHS Trust
Royal United Hospital Bath NHS Trust
Salford Royal NHS Foundation Trust
Salisbury NHS Foundation Trust
Sandwell & West Birmingham Hospitals NHS Trust
Scarborough and North East Yorkshire Healthcare NHS Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
Solent Healthcare
South Devon Healthcare NHS Foundation Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
South Tyneside NHS Foundation Trust
Southampton University Hospitals NHS Trust
Southend University Hospital NHS Foundation Trust
Southport & Ormskirk Hospital NHS Trust
St George's Healthcare NHS Trust
St Helens & Knowsley Teaching Hospitals NHS Trust
States of Guernsey Health & Social Services
Stockport NHS Foundation Trust
Suffolk Mental Health Partnership NHS Trust
Surrey & Borders Partnership NHS Foundation Trust
Taunton & Somerset NHS Foundation Trust
Team Prevent
The Dudley Group of Hospitals NHS Foundation Trust
The Leeds Teaching Hospitals NHS Trust
The Mid Yorkshire Hospitals NHS Trust
The Newcastle upon Tyne Hospitals NHS Foundation Trust
The North West London Hospitals NHS Trust
The Pennine Acute Hospitals NHS Trust
The Princess Alexandra Hospital NHS Trust
The Queen Elizabeth Hospital King's Lynn NHS Trust
The Rotherham NHS Foundation Trust
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
The Royal Wolverhampton Hospitals NHS Trust
Trafford Healthcare NHS Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
University Hospital of South Manchester NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
University Hospitals Coventry & Warwickshire NHS Trust
University Hospitals of Leicester NHS Trust
University Hospitals of Morecambe Bay NHS Trust
Walsall Hospitals NHS Trust
Wellbeing@work
West Hertfordshire Hospitals NHS Trust
West London Mental Health NHS Trust
West Middlesex University Hospital NHS Trust
West Suffolk Hospital NHS Trust
Western Sussex Hospitals NHS Trust
Winchester & Eastleigh Healthcare NHS Trust
Worcestershire Acute Hospitals NHS Trust
Wrightington, Wigan & Leigh NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
York Hospitals NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

Appendix 2 Action plan template

Guideline implementation action plan	
Title of guideline	
Implementation lead	
Which recommendations do we need to implement?	

Barriers to change	Action to overcome barriers	Deadline
Awareness and knowledge		
Motivation		
Acceptance and beliefs		
Skills		
Practicalities		
Barriers beyond our control		

Appendix 3 Audit tool

National Clinical Audit

Depression detection and the management of staff on long-term sickness absence

Case Note Review

Please answer all questions and complete one proforma per case.

Eligible cases must meet the following criteria:

- Cases must have been seen by an OH doctor or nurse following at least 4 weeks' absence from work for **any health-related reason** (please note that cases do not need to have a diagnosis of depression to be eligible for the audit).
- Cases must not have been seen at an earlier point in the current episode of sickness absence (please note that this is a change from the first round)
- The consultation following at least 4 weeks' sickness absence must have been held no earlier than 1st January 2010.

You may extract information from the consultation notes being audited (electronic or paper) and any letters or reports that were produced at this time.

Site Code ☐

Instructions for completion:

1. Please use a ball-point pen for all sections.
2. Please cross the boxes as appropriate (☒ or ⊗).
3. Please refer to the accompanying help booklet.
4. Data should be submitted to HWDU via our webtool at http://audit.rcplondon.ac.uk/hwdu.
5. The help desk can be contacted on 020 3075 1583 or hwdu@rcplondon.ac.uk.

PART ONE: DEMOGRAPHIC INFORMATION

IMPORTANT! Please check that your case matches the eligibility criteria described above.

1.0 Case number ☐

1.1 Age (years) ☐

1.2 Gender ◯ Male ◯ Female

1.3 Occupation (tick one only):

- ◯ Doctor
- ◯ Nurse (including nursing assistants)
- ◯ Ancillary staff
- ◯ Clerical
- ◯ Allied health professionals
- ◯ Not documented
- ◯ Other (please specify) ☐

1.4 Please enter the date of the case note entry that is being audited: ☐

1.5 How many full weeks had the patient been absent from work at the time of this appointment? ☐

PART TWO: DEPRESSION SCREENING

2.1 Is there any evidence that the OH Professional has attempted to assess whether or not the patient might be depressed?

◯ Yes

◯ Yes, but no evidence of depression

◯ No

If 'Yes', please continue to answer parts 3 to 8.

If 'Yes, but...', please go to part 8.

If 'No', please go to part 8.

IMPORTANT! Please note that most of the following questions relate to whether a question has been asked, NOT whether the patient has got the symptom described.

PART THREE: DEPRESSION SEVERITY

3.1 Please indicate if the OH Professional has asked the patient any questions about the following aspects of depression.

Please tick all that apply:

❑ Loss of interest

❑ Depressed mood/sadness

❑ Lack of energy/fatigue

❑ Sleep disturbance

❑ Loss of appetite or weight

❑ Difficulty concentrating

❑ None of the above

PART FOUR: SUICIDE OR SELF HARM

4.1 Is there any evidence that the OH Professional has asked the patient about thoughts of suicide or deliberate self harm? ◯ Yes ◯ No

4.1.1 If yes, did the patient report thoughts of suicide or self harm? ◯ Yes ◯ No

4.1.1.1 If yes, is there any evidence that the OH Professional has ASKED about the patient's plans for suicide or self harm? ◯ Yes ◯ No

4.1.1.2 If yes, is there any evidence that the OH Professional has ASKED about any previous suicidal acts or actual self harm? ◯ Yes ◯ No

PART FIVE: PSYCHOSOCIAL CONTEXT

5.1 Is there any evidence (within this consultation) that the OH Professional has asked any questions about the following aspects of the patient's life?

Please tick all that apply:

- ❑ Patient's spouse or partner, or documented that patient is single
- ❑ Patient's children or family, or documented that patient has no children
- ❑ Patient's use of alcohol
- ❑ Patient's use of street or illicit drugs
- ❑ None of the above

PART SIX: WORKPLACE FACTORS

6.1 Is there any evidence that the OH Professional has asked the patient if they think workplace factors have caused or contributed to any depression? ◯ Yes ◯ No

6.1.1 If yes, did the patient think that workplace factors have caused or contributed to any depression? ◯ Yes ◯ No

6.1.1.1 If yes, is there any evidence that the OH Professional has considered discussing this with the employer? ◯ Yes ◯ No

PART SEVEN: CURRENT MANAGEMENT

7.1 Is it documented that the patient has a current diagnosis of depression from either the OH Professional or another healthcare professional? ◯ Yes ◯ No

7.1.1 If yes, is there any evidence that the patient has been asked about any current contact with other health professionals concerning their current depression? ◯ Yes ◯ No

7.1.1.1 If yes, please tick all that apply:

- ❑ GP
- ❑ Counsellor/therapist/CBT therapist
- ❑ Psychiatrist/CPN/mental health team

7.1.2 If yes, is there any evidence that the OH Professional has asked about any medication that is being prescribed ***for the depression***?

- ◯ Yes, patient being prescribed medication
- ◯ Yes, patient NOT being prescribed medication
- ◯ No, patient not asked

PART EIGHT: COMMUNICATION

8.1 Is there any evidence that the OH Professional has communicated (telephone or letter or email) with any of the following?

Please tick all that apply:

- ❑ GP
- ❑ Patient's line manager
- ❑ None of the above
- ❑ A mental health professional
- ❑ The patient (eg copy of letter to GP or manager)
- ❑ Other

8.2 Is the presenting symptom/problem reported in the referral to OH? ◯ Yes ◯ No ◯ Not appropriate

8.2.1 If yes, please state the diagnosis as described in the referral to OH.
Please tick one option only:

- ◯ Psychological
- ◯ Musculoskeletal
- ◯ Surgery (non-malignant)
- ◯ Cardiovascular
- ◯ Malignancy
- ◯ Respiratory (non-malignant)
- ◯ Other

8.3 Please state the OH Professional's initial diagnosis as described in first clinical encounter.
Please tick one option only:

- ◯ Psychological
- ◯ Musculoskeletal
- ◯ Surgery (non-malignant)
- ◯ Cardiovascular
- ◯ Malignancy
- ◯ Respiratory (non-malignant)
- ◯ Other
- ◯ Not stated

PART NINE: BARRIERS TO WORK

9.1 Has the OH professional documented that they have discussed/identified barriers to return to work and/or enablers for return to work? ◯ Yes ◯ No

Questions 9.2 and 9.3 are to find out a little bit more about how and when staff access physiotherapy and psychological therapy. We are not expecting all cases audited to have received these treatments.

9.2 Has the OH Professional documented that the patient is receiving, or has been referred to, physiotherapy for their current problem? ◯ Yes ◯ No ◯ Not applicable

If yes, was the patient (please tick all that apply)

9.2.1 referred by the OH Professional, at this consultation, to a staff physiotherapy service (ie financed by the employing trust or via the OH provider) ◯ Yes ◯ No

9.2.2 already receiving/referred to a staff physiotherapy service (ie financed by the employing trust or via the OH provider) at time of this consultation ◯ Yes ◯ No

9.2.3 already receiving/referred to physiotherapy by GP or other treating specialist ◯ Yes ◯ No

9.2.4 facilitated by the OH Professional to receive physiotherapy accessed through their GP or hospital specialist ◯ Yes ◯ No

9.3 Has the OH Professional documented that the patient is receiving, or has been referred to, psychological therapy for their current problem? ◯ Yes ◯ No ◯ Not applicable

If yes, was the patient (please tick all that apply)

9.3.1 referred by the OH Professional, at this consultation, for staff psychological therapy (ie financed by the employing trust or via the OH provider) ◯ Yes ◯ No

9.3.2 already receiving/referred to staff psychological therapy (ie financed by the employing trust or via the OH provider) at time of this consultation ◯ Yes ◯ No

9.3.3	already receiving/referred for psychological therapy by GP or other treating specialist	◯ Yes	◯ No
9.3.4	facilitated by the OH Professional to receive psychological therapy accessed through their GP, hospital specialist or other route	◯ Yes	◯ No
9.4	Has the OH Professional documented the individual's fitness for work?	◯ Yes	◯ No
9.5	Has the OH Professional documented an action plan?	◯ Yes	◯ No

Appendix 4 Instructions and helpnotes

NATIONAL AUDIT OF DEPRESSION DETECTION AND MANAGEMENT OF STAFF ON LONG-TERM SICKNESS ABSENCE BY OCCUPATIONAL HEALTH SERVICES IN THE NHS: ROUND 2

HELP NOTES

Acknowledgements

The Health and Work Development Unit (HWDU) Audit Development Group thanks all those who have been involved in developing and piloting the audit tool, and colleagues for their help and advice. The audit has been commissioned by NHS Plus and endorsed by Professor Dame Carol Black, National Director for Health and Work.

These help notes contain all the information needed to participate in the audit. Please read them carefully before commencing data collection and entry onto the webtool. If you have any queries, or find that your occupational health (OH) provision does not fall into the structures described, please contact the audit help desk for advice either by email to hwdu@rcplondon.ac.uk or by phone on 020 3073 1583 (Monday – Friday, 10:00am–4:00pm).

Introduction

The HWDU aims to drive forward improvements in occupational health care both within the NHS and more widely; and works with the NHS and other industries at an organisational level to raise standards of employee health and wellbeing. This national comparative audit aims to:

- enable NHS services to benchmark the quality of their OH provision against evidence-based standards
- enable NHS services to measure change in performance from the first audit round
- enable NHS services to demonstrate variation in practice
- facilitate change through the delivery of useful data, and provide a basis for identifying change in the quality of care
- provide a forum for sharing experience and good practice.

Will occupational health services be ranked on the audit results? Will the audit results be made public?

The aim of the audit is not to produce a league table of OH services or assess individual performance. Information on profession, qualifications or seniority of the OH clinicians managing the cases is not collected. Nor is comparison made between trusts using NHS occupational health services and trusts outsourcing to private sector providers. The average data for each trust will be reported in comparison to the national average data, and trust-level data will not be put into the public domain by the HWDU or NHS Plus. HWDU will publish a list of participating trusts in the public report of national average results.

Methodology

How has this audit been designed?

The depression detection and management of staff on long-term sickness absence audit is a retrospective case note review of process. The objective is to compare and contrast the process of care documented in the case notes with national evidence-based guidance. The audit criteria are based on the National Institute of Clinical Excellence (NICE) guidance CG91 'Depression in adults with a chronic physical health problem', CG90 'Depression: The treatment and management of depression in adults' and PH19 'Managing long-term sickness absence and incapacity for work'.

An inter-rater study will be conducted for each sample of data to assess reliability of the audit tool and consistency between auditors.

Audit tool development has been overseen by a multidisciplinary steering group. The tool and help notes were piloted in 14 NHS OH services and amended in response to feedback and statistical analysis of the pilot data.

Eligibility

Who is eligible to take part?

All OH providers to the NHS in England are eligible to participate; services are strongly encouraged to submit a sample for each trust to which they provide OH care.

Site codes

OH services will receive a site code for each trust to which they provide OH care. It is important that each case is entered against the site code for the trust by which they are employed.

Cases

What are the inclusion/exclusion criteria?

- Cases must have been seen by an OH doctor or nurse following at least 4 weeks' absence from work **for any health-related reason**.
- Cases must not have been seen at an earlier point in the current episode of sickness absence.
- The consultation following at least 4 weeks' sickness absence must have been held no earlier than 1st January 2010.

How do I identify cases?

If you are not able to identify cases that meet the inclusion criteria retrospectively through your OH database, you are advised to tag suitable cases as they are seen in clinic. If you are a service which provides OH care to more than one trust, please tag cases from all trusts and remember that a sample of 40 cases will be entered for each trust.

Should you have any difficulty in identifying cases please contact the HWDU.

How should I sample cases?

OH services should submit a sample of 40 consecutive cases for each trust to which they provide care. If you are a service which provides OH care to more than one trust you should ensure that each sample contains cases employed by only one trust, and enter each sample using a different site code. HWDU will provide you with a site code for each sample.

The sample is constructed of consecutive cases. Starting with consultations held on 24th May please work backwards through your list of cases which meet the inclusion criteria until you reach 40 cases or consultations held on 1st January 2010. If you do not accumulate 40 cases please then include cases seen between 24th May and 11th August 2010. If you have not seen 40 cases between 1st January and 11th August 2010 please submit all the cases that you have seen. If there are any complications or difficulties in carrying out sampling as described above please contact the HWDU team for advice on your specific circumstances.

Ethics, confidentiality and data protection

Do I need to submit this audit to my local ethics committee?

It is the understanding of the HWDU that you will not need to submit this audit to your local ethics committee. No patient- or clinician-identifiable data will be collected, and the confidential, individual reports will contain the average data for the occupational health care provided to employees of a given trust in comparison to the national average data. If local arrangements require you to submit this audit and you need help with a proposal for ethics committee review please let us know and we will do our best to support you.

How do I ensure confidentiality/anonymity of clients? Should I inform our clients the audit is taking place?

Each OH service is responsible for ensuring that clients are aware that clinical audits are carried out by the service which may include their records so that they have the opportunity to opt out (for example by placing notices in staff/ waiting areas). Due to the sensitivity of auditing the case notes of employees we advise that a member of the OH service's clinical team extracts the data.

How are data confidentiality and security ensured?

Data will be submitted to HWDU via the webtool which is hosted on a secure server. OH services will be provided with (a) site code(s) and password(s) as described under 'Sampling'. These site codes and passwords are sent only to the registered audit lead and audit coordinator for each site. Under no circumstances should site codes or passwords be passed on to others outside the organisation. If a user believes that their password has been compromised they should inform the HWDU immediately. Users will only be able to see data in records from their own service. If a user detects what he or she believes is a breach of security or confidentiality then it is their responsibility not to disseminate the information obtained and to report the event to the HWDU immediately. In the interests of patient confidentiality, no name or number that could be linked to an individual should be used on the audit documentation or entered onto the webtool, including into the comment facility.

Data protection and information governance

The HWDU processes the contact details held for the purpose of managing this audit in line with the data protection act. The HWDU operates under the Royal College of Physicians' Clinical Standards Department information governance policy, which is available at www.rcplondon.ac.uk.

Data collection

How does the audit ensure the quality of the data collected?

Your designated lead clinician will take overall responsibility for the data submitted to the audit. The data should be extracted by a member of OH unit staff with clinical knowledge. Ideally a single individual should audit all 40 cases, and ideally individuals should not audit their own case notes; however we are aware that in practical terms this will not always be feasible for example due to small size of an OH unit. An inter-rater study will also be conducted using the first 5 cases of each sample to assess the reliability of the audit tool, see the section on the inter-rater study below.

When is data collection running?

The data collection period is 24th May to 11th August 2010.

How do I contact the help desk?

The help desk is open 10am to 4pm throughout the data collection period. It can be contacted by email to hwdu@rcplondon.ac.uk or phone to 020 3075 1583.

What should I do during data collection?

- Time should be set aside ahead of data collection by those responsible for co-ordinating and collecting data and using the results once they are fed back, in order to plan your trust's or service's participation. This should include familiarising yourselves with the audit tool and help notes.
- A minimum of two auditors should be identified.
- At the start of the data collection period you should check how many cases have been identified which meet the inclusion criteria; if this is below 40 you should continue tagging cases throughout the data collection period and include these in your sample.
- At the start of data collection you should also log in to the webtool to activate your account.
- You should enter your data into the webtool and lock each case once completed so that it is submitted to HWDU.
- A second auditor should independently re-audit the first 5 cases in each sample and enter these onto the webtool as inter-rater reliability cases.
- You should keep a secure, local record of the webtool case number that has been assigned to each case in your sample, including the inter-rater cases, until the end of data analysis. This is in case we need to contact you for any further information whilst we are cleaning and analysing your data.

How can I access the webtool and how do I use it?

- The webtool is accessed at https://audit.rcplondon.ac.uk/hwdu and full details of how to enter data online are available in the support document 'Guide to using the webtool'. This can be downloaded once you have logged into the website. If you have any difficulty getting started please contact the help desk and we will talk you through the process.
- Online help is available at the right hand side of the screen as you enter each case.
- Once a case has been completed please click on the closed lock symbol on your case management screen to lock it. Once a case is locked it is automatically submitted to HWDU and can no longer be edited without being unlocked by HWDU.
- The webtool has been designed for data to be entered at the time of extraction from the case notes. A printable version of the audit tool is available should you prefer to collect data on paper before transferring it onto the webtool.
- Your raw data can be exported into spreadsheet format for additional, local analysis.
- Please note that the HWDU does not have capacity to accept audit data on paper proformas; all data should be submitted via the webtool.

How should my colleague enter the repeat audit of the first 5 cases for the inter-rater reliability study?

A second auditor must independently re-audit the first five cases of each sample. The first auditor should make a note of the **case number assigned by the system** when entering the case onto the webtool and match this to the corresponding client case note number. The second auditor should then

enter their data on the case as a new entry on the webtool, and link the two entries using the case number assigned by the system when the first case was entered. This allows us to know when analysing the data that the two cases refer to the same client.

How do I complete the proforma?

- The data submitted must reflect what is in the records.
- The audit tool should contain data only from the consultation being audited.
- The data must not represent what the auditor knows or assumes about the clinical state of the individual case.
- Data may be collected by any member of the clinical team.
- Data should be extracted from any source as long as it relates to the single consultation being audited. This may include letters, reports, paper case notes,, electronic case notes, your OH database.
- The webtool has a comment facility should you need to explain an entry on the audit tool. Please note that comments should be short and relevant to the question on the audit tool. Comments will not be included in the final analysis but may inform the statistician during analysis.
- 'Yes' means was done, was recorded.
- 'No' means was not done, was not recorded; if there is no record 'it was not done'.
- 'Not applicable' means that there was a clinical judgement/decision, recorded in the notes, that this was not applicable for the patient.

Results and publication

How will the results be disseminated?

Participation lists and the audit data will be available to NHS Plus, who commissioned the audit. Data will not be put into the public domain by NHS Plus or the HWDU. Trusts and/ or services will not be ranked and performance indicators will not be used as the data are not deemed mature enough.
A generic report will be publicly available describing the national average picture, and each trust or service will be provided with a confidential report detailing their average results in comparison to the national average results.

National Audit of depression detection and the management of long-term sickness absence: help notes for the case note review

Eligible cases must meet the following criteria:

- Cases must have been seen by an OH doctor or nurse following at least 4 weeks' absence from work for **any health-related reason** (please note that cases do not need to have a diagnosis of depression to be eligible for the audit).
- Cases must not have been seen at an earlier point in the current episode of sickness absence (please note that this is a change from the first round)
- The consultation following at least 4 weeks' sickness absence must have been held no earlier than 1st January 2010.

You may extract information from the consultation notes being audited (electronic or paper) and any letters or reports that were produced at this time.

Part one: Demographic information

Question Number	Question Text	Help Notes
1.0	Case number	A case number will be allocated automatically by the webtool. Please keep a secure local record of the correspondence between webtool case number and local case note until data analysis has been completed (so that you can refer to the notes again should further information be required).
1.1	Age (years)	Please record the age, rounded down to full years, of the employee at the time the first consultation occurred, ie after the employee had been absent for at least four weeks. This value must be 16–80 (any other value will be rejected by the webtool).
1.2	Gender	
1.3	Occupation	'Ancillary' includes domestics, porters, electricians, catering and allied staff. 'Allied health professionals' includes radiographers, physiotherapists, occupational therapists, speech therapists, dieticians, dentists, chiropodists, podiatrists. 'Nursing' includes nursing assistants.
1.4	Please enter the date of the case note entry that is being audited.	Please record the date of the appointment after the employee has been absent for at least four weeks. Please remember this is the only appointment you should use when extracting data for this audit. The earliest date that will be accepted by the webtool is 1st January 2010 (as this is the earliest date at which cases are eligible to be included in the sample).
1.5	How many full weeks had the patient been absent from work at the time of this appointment?	This should be at least 4 weeks. Please round down to the neaest full week.

Part two: Depression detection

Question Number	Question Text	Help Notes
2.1	Is there any evidence that the OH Professional has attempted to assess whether or not the patient might be depressed? ***If 'Yes', please continue to answer part 3 to 8*** ***If 'Yes, but no evidence of distress' go to part 8*** ***If no, please go to part 8.***	Tick one of the 'Yes' options if there is any evidence that the OH Professional has enquired about psychological distress in any way. The term 'depression' does not need to appear in the notes for this box to be marked 'yes', but there must be some reference to the employee's mood or level of emotional distress. 'Yes, but no evidence of distress' should be ticked when there is clear documentation that there is no distress (eg Patient is reported as being happy, positive, etc). If the OH Professional appears to have considered psychological distress, and a lack of distress is not very clearly documented, 'Yes' should be ticked. If there is any doubt about the level of distress 'Yes' should be recorded. 'No' should be ticked when there is not evidence at all that the OH Professional has considered psychological distress.

Part three: Depression severity

Question Number	Question Text	Help Notes
3.1	Please indicate if the OH Professional has asked the patient any questions about the following aspects of depression. Please tick all that apply: ❑ Loss of interest ❑ Depressed mood/sadness ❑ Lack of energy/fatigue ❑ Sleep disturbance ❑ Loss of appetite or weight ❑ Difficulty concentrating ❑ None of the above	Tick the appropriate box if there is any evidence that the OH Professional has asked about each one of these symptoms. You can tick as many boxes as are appropriate. It does not matter whether the employee actually had these symptoms, just whether the OHP asked about them.

Part four: Suicide or self harm

Question Number	Question Text	Help Notes
4.1	Is there any evidence that the OH Professional has asked the patient about thoughts of suicide or deliberate self harm?	This question is enquiring about whether the OH Professional has asked about different aspects of self harm. If the OH Professional has not asked any questions about suicidal thoughts or ideas of self harm, then you should tick 'No'. If they have asked about suicidal thoughts and the patient has reported some thoughts of suicide or self harm then you should go on and answer 4.1.1 and 4.1.2.
4.1.1	If yes, did the patient report thoughts of suicide or self harm?	
4.1.1.1	If yes, is there any evidence that the OH Professional has asked about the patient's plans for suicide or self harm?	'Patient's plans for suicide or self harm' refers to aspects such as methods, timing or steps that a patient has taken or considered (eg purchasing tablets, identifying a time, making a will, writing a suicide note, etc).
4.1.1.2	If yes, is there any evidence that the OH Professional has asked about any previous suicidal acts or actual self harm?	Tick 'Yes' if the OH Professional has asked about any previous occasion in which the patient has harmed themselves or attempted to commit suicide. This includes statements such as 'no previous self harm'. 'Yes' should be ticked whenever there is evidence the OH Professional has asked about prior self harm, regardless of the patient's response.

Part five: Psychosocial context

Question Number	Question Text	Help Notes
5.1	Is there any evidence (within this consultation) that the OH Professional has asked any questions about the following aspects of the patient's life? Please tick all that apply: ❑ Patient's spouse or partner, or documented that patient is single ❑ Patient's children or family, or documented that patient has no children ❑ Patient's use of alcohol ❑ Patient's use of street or illicit drugs ❑ None of the above	This question is seeking to identify if the OH Professional has gained information about the employee's general situation. The actual details of the employee's situation are not important, just whether the OH Professional has recorded the information. Once again you can tick between one and four of the options provided.

Part six: Workplace factors

Question Number	Question Text	Help Notes
6.1	Is there any evidence that the OH Professional has asked the patient if they think workplace factors have caused or contributed to any depression?	'Workplace factors' may include the type of work undertaken, an employee's perception of 'stress' in their job, interpersonal disputes with work colleagues, the hours they are asked to work, or any other factors specific to their work.
6.1.1	If yes, did the patient think that workplace factors have caused or contributed to any depression?	
6.1.1.1	If yes, is there any evidence that the OH Professional has considered discussing this with the employer?	Communication of this information to the employer may be via a phone call, an e-mail, a personal discussion or a letter. There must be some evidence that the OHP considered or actually carried out this communication. Tick yes if it is clearly documented that such a communication was suggested by the OHP, but the patient declined.

Part seven: Current management

Question Number	Question Text	Help Notes
7.1	Is it documented that the patient has a current diagnosis of depression from either the OH Professional or another healthcare professional?	Tick 'yes' if a current diagnosis was made and recorded either prior to the initial consultation (by another healthcare professional) or made at the end of the initial consultation (by the OH Professional). The diagnosis may be recorded by the OH Professional in either their consultation notes or the communication which resulted from this consultation.
7.1.1	If yes, is there any evidence that the patient has been asked about contact with other health professionals ***concerning their depression***?	In order to tick 'yes' there must be evidence that the OH Professional has specifically asked the employee if they have been in contact with any other health professionals. If there is evidence of correspondence with other health professionals which includes a discussion or the employee's depression, then it is reasonable to tick that box.
7.1.1.1	If yes, please tick all that apply: ❑ GP ❑ Counsellor/therapist/CBT therapist ❑ Psychiatrist/CPN/mental health team	
7.1.2	If yes, is there any evidence that the OH Professional has asked about any medication that is being prescribed ***for the depression***? ❑ Yes, patient being prescribed medication ❑ Yes, patient NOT being prescribed ❑ No, patient not asked	Tick 'yes, patient NOT being prescribed medication' if there is evidence that the OH Professional enquired about antidepressant medication, but the employee stated they had not been prescribed any. 'Yes, patient being prescribed medication' may be ticked if the OH Professional recorded the fact they were on some antidepressant medication. This may be recorded as part of a list of medication. If so the following are the most common antidepressants prescribed: Citalopram (Cipramil), Fluoxetine (Prozac), Fluvoxamine (Faverin), Paroxetine (Seroxat), Sertraline (Lustral), Mirtazepine (Zispin), Venlafaxine (Efexor), Duloxetine (Cymbalta), Escitalopram (Cipralex), Nefazodone (Dutonin), Reboxetine (Edronax), Moclobemide (Manerix), Phenelzine (Nardil), Lofepramine (Gamanil), Amitriptyline (Triptafen), Clomipramine (Anafranil), Dulsulpin (Prothiaden), Doxepin (Sinequan), Imipramine (Tofranil), Nortriptyline (motival), Trazadone (Molipaxin).

Part eight: Communication

Question Number	Question Text	Help Notes
8.1	Is there any evidence that the OH Professional has communicated (telephone or letter or e-mail) with any of the following? Please tick all that apply: ❑ GP ❑ Patient's line manager ❑ A mental health professional ❑ The patient (eg copy of letter to GP or manager) ❑ None of the above ❑ Other	Evidence of communication may be a copy of a letter or e-mail in the case notes, or record of a conversation having occurred (for example being documented in the case notes).
8.2 8.2.1	Is the presenting symptom/ problem reported in the referral to OH? If yes, please state the diagnosis as described in the referral to OH. Please tick one option only. ❑ Psychological ❑ Musculoskeletal ❑ Surgery (non-malignant) ❑ Cardiovascular ❑ Malignancy ❑ Respiratory (non-malignant) ❑ Other	Tick 'Yes' if the nature of the presenting problem was outlined in the referral document. If there was no referral (the patient self presented), then tick 'Not appropriate'. If more than one problem/ diagnosis is listed then record the diagnosis that is listed as the primary or main diagnosis.
8.3	Please state the OH Professional's initial diagnosis as described in first clinical encounter. Please tick one option only: ❑ Psychological ❑ Musculoskeletal ❑ Surgery (non-malignant) ❑ Cardiovascular ❑ Malignancy ❑ Respiratory (non-malignant) ❑ Other ❑ Not stated	The OH Professional's diagnosis should be recorded at the end of the clinical notes related to this initial assessment or in the correspondence written following this assessment. If more than one problem/diagnosis is listed then record the diagnosis that is listed as the primary or main diagnosis. This only needs to be the diagnosis recorded at the time of this initial assessment, even if this is different to the diagnosis that was agreed at a later time.

Part nine: Barriers to work

Question Number	Question Text	Help Notes
9.1	Has the OH Professional documented that they have discussed /identified barriers to return to work and/ or enablers for return to work?	This question is to find out whether the OH Professional has explored possible barriers to work, and/or potential enablers for return to work. The word 'barrier' or 'enabler' does not have to appear in the notes but it must be clear that the OH Professional is exploring barriers, or is looking for steps that might encourage a return to work. Examples of barriers: • level of illness and loss of function • home and personal factors such as illness in another family member, violence in the home, financial concerns, loss of motivation/confidence/self esteem, perception of disability/barriers to work • difficulty getting to/from work • workplace factors such as difficulty with equipment, workstation, hours, conflict with colleagues, subject of complaints, investigations into performance or behaviour, perceptions of pressure, workload, lack of support. Examples of enablers: • consent to be referred for physiotherapy/CBT/psychology/ psychiatry • letter to GP suggesting additional treatment for medical problem • support for domestic problems identified • involvement of the Access to Work scheme • advice on workplace adjustments such as risk assessments, equipment, rotas, hours, phased return, adjusted duties, redeployment • support from trade union, mediation services, CBT, psychologist, meeting with manager • advice to the manager on phased return, adjusted duties, redeployment, supporting attendance at physiotherapy etc, perceived work related matters and potential solutions
9.2	Has the OH Professional documented that the patient is receiving, or has been referred to, physiotherapy for their current problem? If yes, was the patient: (Please tick all that apply)	For the purposes of this audit we are not including other types of physical therapy such as chiropractic or osteopathy. Tick 'yes' if it is documented that the patient has been referred or has self-referred and is waiting to receive, or is already receiving, physiotherapy for their current problem. Also tick 'yes' if an outcome from the consultation being audited is a referral by the OH professional. In addition, tick 'yes' if a referral was offered but declined by the patient. Only tick 'not applicable' if it is very clear that physical therapy is not appropriate for this case.
9.2.1	• referred by the OH Professional, at this consultation, to a staff physiotherapy service (ie financed by the employing trust or via the OH provider)	• Tick 'yes' if there is evidence that the OH Professional has made a referral to a physiotherapy service at this consultation. This may be recorded in the case notes, letter to manager or referral letter. To tick 'yes' the physiotherapy service must be provided for staff of the trust. It may be a physiotherapist who is part of the OH team, or fast-track access for staff to a local NHS physiotherapy service, or other similar arrangement.

Part nine: Barriers to work – *continued*

Question Number	Question Text	Help Notes
9.2.2	• already receiving/referred to a staff physiotherapy service (ie financed by the employing trust or via the OH provider) at time of this consultation	• Tick 'yes' if there is evidence that the staff member is already receiving, or has already been referred (including self-referral), to a physiotherapy service provided for staff of the trust. It may be a physiotherapist who is part of the OH team, or fast-track access for staff to a local NHS physiotherapy service, or other similar arrangement.
9.2.3	• already receiving/referred to physiotherapy by GP or other treating specialist	• Tick 'yes' if the OH Professional has documented that the patient is already receiving, or has already been referred to, physiotherapy by their GP or another treating specialist (include self-referral to an external service).
9.2.4	• facilitated by the OH Professional to receive physiotherapy accessed through their GP or hospital specialist	• Tick 'yes' if there is evidence that the OH Professional has facilitated the patient in accessing physiotherapy through their GP or hospital specialist e.g. by writing to the GP or specialist requesting a physiotherapy referral.
9.3	Has the OH Professional documented that the patient is receiving, or has been referred to, psychological therapy for their current problem?	Tick 'yes' if it is documented that the patient has been referred or has self-referred and is waiting to receive, or is already receiving, psychological therapy for their current problem. Also tick 'yes' if an outcome from the consultation being audited is a referral from the OH Professional or advice to self refer from the occupational health professional. Psychological therapy can include counselling, CBT, computer-based CBT, psychotherapy and other types of psychological therapy provided by trained professionals. In addition, tick 'yes' if a referral was offered but declined by the patient.
	If yes, was the patient: (Please tick all that apply)	Only tick 'not applicable' if it is **very** clear that psychological therapy is not appropriate for this case.
9.3.1	• referred by the OH Professional, at this consultation, for staff psychological therapy (ie financed by the employing trust or via the OH provider)	Tick 'yes' if there is evidence that the OH Professional has made a referral for psychological therapy at this consultation. This may be recorded in the case notes, letter to manager or referral letter. To tick 'yes' the psychological therapy service must be provided for staff of the trust. It may be a therapist who is part of the OH team, or fast-track access for staff to a local NHS psychological therapy service, or other similar arrangement.
9.3.2	• already receiving/referred to staff psychological therapy (ie financed by the employing trust or via the OH provider) at time of this consultation	Tick 'yes' if there is evidence that the staff member is already receiving, or has already been referred (or self referred) to a psychological therapy service provided for staff of the trust. It may be a therapist who is part of the OH team, or fast-track access for staff to a local NHS psychological therapy service, or other similar arrangement.
9.3.3	• already receiving/referred for psychological therapy by GP or other treating specialist	Tick 'yes' if the OH Professional has documented that the patient is already receiving, or has already been referred to, psychological therapy by their GP or another treating specialist (include self-referral to an external service).
9.3.4	• facilitated by the OH Professional to receive psychological therapy accesses through their GP or hospital specialist	Tick 'yes' if there is evidence that the OH Professional has facilitated the patient in accessing psychological therapy through their GP or hospital specialist, eg by writing to the GP or specialist requesting a psychological therapy referral.

Part nine: Barriers to work – *continued*

Question Number	Question Text	Help Notes
9.4	Has the OH Professional documented the individual's fitness for work?	To tick 'yes' to this question there should be a documented assessment of the patient's current and likely future fitness for work eg • fit to return now/in future with/without adjustments • fit for alternative duties • not fit/not known if/when will be fit • will not be able to return to current work/will not be able to return to any work.
9.5	Has the OH Professional documented an action plan?	This may have a heading such as plan/action plan/rehabilitation plan. It is recorded at the end of the consultation being audited (and/or may be in a report to the manager). It will be a list of actions for the OH Professional and recommended actions for the patient, the manager, and others involved in the case eg: • advice to patient • letter to GP • referral to OH physio/psychologist • ask manager to consider phased return, adjusted duties, redeployment, support attendance at physiotherapy The plan does not need to include all the above as they may not all be relevant to the consultation being audited.

Appendix 5 Inter-rater reliability

Reliability (agreement between auditors) is not the same as validity (accuracy of measure). However establishing good agreement between auditors is an important part of the process of validation as valid data by definition will have to be reliable.

We compared the data entered on duplicate cases by first and second auditors (see Methods). Numerical questions (age, date of appointment and weeks off work) are examined in terms of the simple difference between them. For categorical questions (mostly Yes/No) the kappa statistic was used to measure agreement. Kappa values of 0.41 to 0.60 are said to indicate moderate agreement, values of 0.61–0.80 indicate good agreement whilst values of over 0.80 are very good. In practice any value of kappa much below 0.50 will indicate inadequate agreement.

Of 48 categorical questions assessed below in the 2010 Audit reliability analyses, the median kappa value was 0.77, IQR 0.63–0.83. Four questions had kappa values of below 0.40 and there were only four in the 'moderate' range; this is very encouraging in terms of the utility of the audit tool in the future and the overall reliability of the results.

The kappa is more useful than a percentage agreement, which is a crude rate of exactly the same answer occurring. In a question where almost all answers are YES we would expect a high percentage agreement purely by chance. What the kappa measures is agreement between two auditors in their ability to discriminate between YES and NO, for the same cases. When there may mostly be YES responses and only a few NO responses a low kappa value would indicate an inability for auditors to agree on when to classify as NO. Though the national statistic would be robust enough in that almost all patients are YES irrespective of auditor, the low kappa value for the question means that there is certainly a need to use caution when performing analyses that correlate this question with other questions, and particularly if any of these questions also display less than good inter-auditor reliability – associations between such variables may become diluted as a consequence.

Questions with an overall kappa value below 0.60 were confined to the 'Communications' and 'Barriers to Work' sections and all were questions for which almost all cases were either YES or almost all cases were NO.

Communications

- 8.1b Is there any evidence that the OH professional has communicated (telephone or letter or email) with PATIENTS LINE MANAGER (Kappa=0.28)
- 8.1c Is there any evidence that the OH professional has communicated (telephone or letter or email) with A MENTAL HEALTH PROFESSIONAL(Kappa=0.51)
- 8.1 Is there any evidence that the OH professional has communicated (telephone or letter or email) with NONE OF THE OPTIONS (Kappa=0.38)

Barriers to work

- 9.1 Has the OH professional documented that they have discussed/identified barriers to return to work and/or enablers for return to work? (Kappa=0.45)

- 9.2.2 If YES (to 9.2 PHYSIOTHERAPY), was the patient already receiving/referred to a staff physiotherapy service (i.e. financed by the employing trust or via the OH provider) at time of this consultation (Kappa=0.54)
- 9.2.4 If YES (to 9.2 PHYSIOTHERAPY), was the patient facilitated by the OH professional to receive physiotherapy accessed through their GP or hospital specialist (Kappa=0.20)
- 9.4 Has the OH professional documented the individual's fitness for work? (Kappa=0.32)
- 9.5 Has the OH professional documented an action plan? (Kappa=0.43)

The kappa statistic does not measure the nature of any disagreement between auditors and for this we need to inspect the raw data tables. Any future attempt to improve on the reliability of any audit item will bear most fruit if it focuses on the more frequent discrepancies in judgment. The tables of disagreement are not shown in this summary document.

There were no instances of notable systematic bias, i.e. there was no indication that one of the assessors was inclined to give more YES or NO answers than the other. In practice the shifts were relatively minor and not an issue in these results.

	Audit 2008		Audit 2010			Audit 2008		Audit 2010	
Question	Kappa	Cases	Kappa	Cases	Question	Kappa	Cases	Kappa	Cases
1.2 gender	0.97	853	0.98	1013	7.1.1.1b	0.84	364	0.84	226
2.1	0.85	853	0.82	1013	7.1.1.1c	0.76	364	0.64	226
3.1a	0.80	364	0.73	405	7.1.2	0.83	237	0.82	244
3.1b	0.88	364	0.85	405	8.1a	0.85	853	0.77	1013
3.1c	0.82	364	0.77	405	8.1b	0.47	853	0.28	1013
3.1d	0.64	364	0.63	405	8.1c	0.79	853	0.51	1013
3.1e	0.78	364	0.78	405	8.1d	0.81	853	0.71	1013
3.1f	0.88	364	0.87	405	8.1 (none)	0.63	853	0.38	1013
3.1 (none)	0.74	364	0.67	405	8.2	0.68	853	0.77	1013
4.1	0.93	364	0.90	405	8.2.1	0.91	701	0.90	898
4.1.1	0.88	96	0.86	205	8.3	0.87	853	0.86	1013
4.1.1.1	0.66	30	0.73	41	9.1	–	–	0.45	1013
4.1.1.2	0.56	30	0.69	41	9.2	–	–	0.78	1013
5.1a	0.83	364	0.77	405	9.2.1	–	–	0.88	210
5.1b	0.79	364	0.83	405	9.2.2	–	–	0.54	210
5.1c	0.91	364	0.90	405	9.2.3	–	–	0.79	210
5.1d	0.75	364	0.84	405	9.2.4	–	–	0.20	210
5.1 (none)	0.85	364	0.87	405	9.3	–	–	0.73	1012
6.1	0.79	364	0.73	405	9.3.1	–	–	0.80	274
6.1.1	0.85	209	0.86	272	9.3.2	–	–	0.73	274
6.1.1.1	0.67	150	0.63	148	9.3.3	–	–	0.79	274
7.1	0.80	364	0.78	405	9.3.4	–	–	0.60	274
7.1.1	0.48	239	0.67	245	9.4	–	–	0.32	1013
7.1.1.1a	0.75	364	0.63	226	9.5	–	–	0.43	1013

The differences between auditors in the numerical questions were as follows:

- 2010 audit: In 14% (138/1,013) of cases there was disagreement on age; 4% (38/1013) disagreed by more than one year.
- 2008 audit: In 16% (137/853) of cases there was disagreement on age; 3% (29/853) disagreed by more than one year.
- 2010 audit: 9% (95/1,013) disagreed on appointment date; 5% (53/1,013) disagreed by more than seven days.
- 2008 audit: 9% (79/853) disagreed on appointment date; 6% (47/853) disagreed by more than seven days.
- 2010 audit: 25% (258/1,013) disagreed on weeks off work; 4% (40/1,013) disagreed by more than four weeks.
- 2008 audit: 22% (88/853) disagreed on weeks off work; 5% (49/853) disagreed by more than four weeks.

Appendix 6 Intervention group temporal analysis

This analysis compares the two groups in respect of their 2008 and subsequent 2010 audit results for patients seen during the audit periods.

Category:	2008 Cases	2010 Cases
Trust and Provider	1,910	2,264
Provider only	556	723
Trust only	7	30
Improvement activity	2,473	3,017
NO improvement activity	2,048	2,470
Total in analysis	4,521	5,487

Age, weeks absent from work, gender, occupation and type of trust employer

		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Median	**IQR**	**Median**	**IQR**
Age	ALL	46	38–53	46	38–53
	Improvement activity	46	38–53	46	38–53
	NO improvement activity	46	38–54	47	39–54
Full weeks absent from work at time of this appointment	ALL	9	6–15	8	5–12
	Improvement activity	9	6–14	8	5–13
	NO improvement activity	9	6–15	8	5–12
		Number	**%**	**Number**	**%**
Male gender	ALL	752/4521	17	849/5487	15
	Improvement activity	431/2473	17	465/3017	15
	NO improvement activity	321/2048	16	384/2470	16
Occupation:					
• Allied health professionals	ALL	494/4521	11	574/5487	10
	Improvement activity	261/2473	11	321/3017	11
	NO improvement activity	233/2048	11	253/2470	10
• Ancillary staff	ALL	819/4521	18	738/5487	13
	Improvement activity	493/2473	20	464/3017	15
	NO improvement activity	326/2048	16	274/2470	11
• Clerical	ALL	709/4521	16	918/5487	17
	Improvement activity	370/2473	15	499/3017	17
	NO improvement activity	339/2048	17	419/2470	17
• Doctors	ALL	96/4521	2	95/5487	2
	Improvement activity	55/2473	2	52/3017	2
	NO improvement activity	41/2048	2	43/2470	2

continued

Age, weeks absent from work, gender, occupation and type of trust employer – *continued*

		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Number	**%**	**Number**	**%**
• Nurses (including nursing assistants)*	ALL	2032/4521	45	2956/5487	54
	Improvement activity	1076/2473	44	1566/3017	52
	NO improvement activity	956/2048	47	1390/2470	56
• Other	ALL	365/4521	8	200/5487	4
	Improvement activity	218/2473	9	115/3017	4
	NO improvement activity	147/2048	7	85/2470	3
Type of Trust employer					
• Acute	ALL	3021/4521	67	3619/5487	66
	Improvement activity	1655/2473	67	2080/3017	69
	NO improvement activity	1366/2048	67	1539/2470	62
• Ambulance	ALL	80/4521	2	83/5487	2
	Improvement activity	78/2473	3	44/3017	1
	NO improvement activity	2/2048	0.1	39/2470	2
• Mental Health	ALL	614/4521	14	794/5487	14
	Improvement activity	330/2473	13	379/3017	13
	NO improvement activity	284/2048	14	415/2470	17
• Mixed	ALL	153/4521	3	41/5487	0.7
	Improvement activity	86/2473	3	41/3017	1.4
	NO improvement activity	67/2048	3	0/2470	0
• Primary care	ALL	653/4521	14	950/5487	17
	Improvement activity	324/2473	13	473/3017	16
	NO improvement activity	329/2048	16	477/2470	19

*The 2008 question on occupation just had 'Nurse' as an option and made no reference to nursing assistants.

Depression detection

2.1: Is there any evidence that the OH Professional has attempted to assess whether or not the patient might be depressed?		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Number	**%**	**Number**	**%**
• Yes	ALL	1906/4521	42	2229/5487	41
	Improvement activity	979/2473	40	1216/3017	40
	NO improvement activity	927/2048	45	1013/2470	41
• Yes, but no evidence of depression*	ALL	713/4521	16	1375/5487	25
	Improvement activity	371/2473	15	779/3017	26
	NO improvement activity	342/2048	17	596/2470	24
• No	ALL	1902/4521	42	1883/5487	34
	Improvement activity	1123/2473	45	1022/3017	34
	NO improvement activity	779/2048	38	861/2470	35

*For the 2008 audit the option stated 'distress' rather than depression.

Depression symptoms

3.1: Please indicate if the OH Professional has asked the patient any questions about the following aspects of depression:		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Number	%	Number	%
• Loss of interest	ALL	816/1906	43	1166/2229	52
	Improvement activity	409/979	42	743/1216	61
	NO improvement activity	407/927	44	423/1013	42
• Loss of appetite or weight	ALL	792/1906	42	1125/2229	50
	Improvement activity	406/979	41	688/1216	57
	NO improvement activity	386/927	42	437/1013	43
• Difficulty concentrating	ALL	876/1906	46	1150/2229	52
	Improvement activity	461/979	47	705/1216	58
	NO improvement activity	415/927	45	445/1013	44
• Depressed mood/sadness	ALL	1426/1906	75	1824/2229	82
	Improvement activity	715/979	73	1014/1216	83
	NO improvement activity	711/927	77	810/1013	80
• Lack of energy/fatigue	ALL	848/1906	44	1172/2229	53
	Improvement activity	442/979	45	720/1216	59
	NO improvement activity	406/927	44	452/1013	45
• Sleep disturbance	ALL	1232/1906	65	1589/2229	71
	Improvement activity	653/979	67	930/1216	76
	NO improvement activity	579/927	62	659/1013	65

*For the 2008 audit the option stated 'distress' rather than depression.

Number of symptoms (3.1) asked about:		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Number	%	Number	%
• NONE	ALL	211/1906	11	137/2229	6.1
	Improvement activity	120/979	12	66/1216	5.4
	NO improvement activity	91/927	10	71/1013	7.0
• All SIX	ALL	363/1906	19	587/2229	26
	Improvement activity	196/979	20	394/1216	32
	NO improvement activity	167/927	18	193/1013	19

Suicide or self harm

		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Number	%	Number	%
4.1: Is there any evidence that the OH Professional has asked the patient about thoughts of suicide or deliberate self harm?	ALL	603/1906	32	1097/2229	49
	Improvement activity	322/979	33	657/1216	54
	NO improvement activity	281/927	30	440/1013	43
4.1.1: If yes to 4.1, did the patient report thoughts of suicide or self-harm	ALL	185/603	31	253/1097	23
	Improvement activity	86/322	27	144/657	22
	NO improvement activity	99/281	35	109/440	25
4.1.1.1: If yes to 4.1.1, is there any evidence that the OH Professional has ASKED about the patient's plans for suicide or self-harm?	ALL	124/185	67	184/253	73
	Improvement activity	63/86	73	103/144	72
	NO improvement activity	61/99	62	81/109	74
4.1.1.2: If yes to 4.1.1, is there any evidence that the OH Professional has ASKED about any previous suicidal acts or actual self-harm?	ALL	91/181	49	116/253	46
	Improvement activity	46/86	53	64/144	44
	NO improvement activity	45/99	45	52/109	48

Psychosocial content

5.1: Is there any evidence (within this consultation)* that the OH Professional has asked any questions about the following aspects of the patient's life?		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Number	%	Number	%
• Patient's spouse or partner, or documented that patient is single	ALL	1239/1906	65	1681/2229	75
	Improvement activity	626/979	64	951/1216	78
	NO improvement activity	613/927	66	730/1013	72
• Patient's children or family, or documented that patient has no children	ALL	1119/1906	59	1525/2229	68
	Improvement activity	559/979	57	859/1216	71
	NO improvement activity	560/927	60	666/1013	66
• Use of alcohol	ALL	671/1906	35	1036/2229	46
	Improvement activity	389/979	40	627/1216	52
	NO improvement activity	282/927	30	409/1013	40
• Use of street or illicit drugs	ALL	176/1906	9	498/2229	22
	Improvement activity	100/979	10	340/1216	28
	NO improvement activity	76/927	8	158/1013	16

*NOTE 2008 wording was 'within the first assessment after 4 weeks off work'.

Workplace factors

		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Number	%	Number	%
6.1: Is there any evidence that the OH Professional has asked the patient if they think workplace factors have caused or contributed to any depression?	ALL	1306/1906	69	1536/2229	69
	Improvement activity	673/979	69	870/1216	72
	NO improvement activity	633/927	68	666/1013	66
6.1.1: If yes to 6.1, did the patient think workplace factors have caused or contributed to any depression?	ALL	800/1306	61	853/1536	56
	Improvement activity	422/673	63	473/870	54
	NO improvement activity	378/633	60	380/666	57
6.1.1.1: If yes to 6.1.1, is there any evidence that the OH Professional has considered discussing this with the employer?	ALL	663/800	83	722/853	85
	Improvement activity	345/422	82	393/473	83
	NO improvement activity	318/378	84	329/380	87

Current management

		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Number	%	Number	%
7.1: Is it documented that the patient has a current diagnosis of depression from either the OH Professional or another healthcare professional?	ALL	1368/1906	72	1485/2229	67
	Improvement activity	686/979	70	845/12216	69
	NO improvement activity	682/927	74	640/1013	63
7.1.1: If yes to 7.1, is there any evidence that the patient has been asked about contact with other healthcare professionals concerning their current depression?**	ALL	1266/1368	93	1408/1485	95
	Improvement activity	632/686	92	794/845	94
	NO improvement activity	634/682	93	614/640	96
7.1.1.1: If yes to 7.1.1, which professionals?					
• GP	ALL	1107/1266	87	1302/1408	92
	Improvement activity	552/632	87	730/794	92
	NO improvement activity	555/634	88	572/614	93
• Psychiatrist/community psychiatric nurse/mental health team	ALL	262/1266	21	275/1408	20
	Improvement activity	139/632	22	147/794	19
	NO improvement activity	123/634	19	128/614	21
• Counsellor/therapist / cognitive behavioural therapy therapist	ALL	739/1266	58	716/1408	51
	Improvement activity	371/632	58	408/794	51
	NO improvement activity	368/634	59	308/614	50

continued

Current management – *continued*

		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Number	**%**	**Number**	**%**
7.1.2: If yes to 7.1, is there any evidence that the OH Professional has asked about any medication that is being prescribed for the depression?					
• Yes, patient being prescribed medication	ALL	1061/1368	78	1107/1485	75
	Improvement activity	555/690	80	625/845	74
	NO improvement activity	506/678	75	482/640	75
• Yes, patient NOT being prescribed medication	ALL	195/1368	14	286/1485	19
	Improvement activity	80/690	12	172/845	20
	NO improvement activity	115/678	17	114/640	18
• No, patient not asked	ALL	108/1368	8	91/1485	6
	Improvement activity	61/690	9	47/845	6
	NO improvement activity	57/678	8	44/640	7

* 'current' was added to the 2010 audit for 7.1.1 and was not there for the 2008 audit

Communication

8.1: Is there any evidence that the OH Professional has communicated (telephone or letter or e-mail) with any of the following?		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Number	**%**	**Number**	**%**
• GP	ALL	642/4521	14	472/5487	9
	Improvement activity	369/2473	15	305/3017	10
	NO improvement activity	273/2048	13	167/2470	7
• Patient's line manager	ALL	4343/4521	96	5356/5487	98
	Improvement activity	2397/2473	97	2933/3017	97
	NO improvement activity	1946/2048	95	2423/2470	98
• A mental health professional	ALL	179/4521	4	96/5487	2
	Improvement activity	101/2473	4	51/3017	2
	NO improvement activity	78/2048	4	45/2470	2
• The patient (eg copy of letter to the GP or manager)	ALL	2732/4521	60	4081/5487	74
	Improvement activity	1453/2473	59	2256/3017	75
	NO improvement activity	1279/2048	62	1825/2470	74
8.2: Is the presenting symptom/ problem reported in the referral to OH?*	ALL	3770/4113*	92	4973/5256*	95
	Improvement activity	2094/2261	93	2736/2885	95
	NO improvement activity	1676/1852	90	2237/2371	94

*Excluding cases for 8.2 being not appropriate or missing.

continued

Communication – *continued*

8.2.1: If yes to 8.2, please state the diagnosis as described in the referral to OH?		In BOTH audits 2008 results		In BOTH audits 2010 results	
		Number	%	Number	%
• Psychological	ALL	1456/3770	39	1599/4973	32
	Improvement activity	744/2094	36	907/2736	33
	NO improvement activity	712/1676	42	692/2237	31
• Musculo-skeletal	ALL	918/3770	24	1443/4973	29
	Improvement activity	531/2094	25	821/2736	30
	NO improvement activity	387/1676	23	622/2237	28
• Surgery (non-malignant)	ALL	560/3770	15	899/4973	18
	Improvement activity	323/2094	15	470/2736	17
	NO improvement activity	237/1676	14	429/2237	19
• Cardio-vascular	ALL	129/3770	3	152/4973	3
	Improvement activity	73/2094	3	75/2736	3
	NO improvement activity	56/1676	3	77/2237	3
• Malignancy	ALL	131/3770	3	200/4973	4
	Improvement activity	68/2094	3	98/2736	4
	NO improvement activity	63/1676	4	102/2237	5
• Respiratory (non-malignant)	ALL	103/3770	3	114/4973	2
	Improvement activity	55/2094	3	67/2736	2
	NO improvement activity	48/1676	3	47/2237	2
• Other	ALL	473/3770	13	566/4973	11
	Improvement activity	300/2094	14	298/2736	11
	NO improvement activity	173/1676	10	268/2237	12
8.3: Please state the OH Professional's initial diagnosis as described in first clinical encounter? (One option only)					
• Psychological	ALL	1757/4521	39	1806/5487	33
	Improvement activity	903/2473	37	1016/3017	34
	NO improvement activity	854/2048	42	790/2470	32
• Musculo-skeletal	ALL	1047/4521	23	1532/5487	28
	Improvement activity	603/2473	24	866/3017	29
	NO improvement activity	444/2048	22	666/2470	27
• Surgery (non-malignant)	ALL	667/4521	15	985/5487	18
	Improvement activity	376/2473	15	527/3017	17
	NO improvement activity	291/2048	14	458/2470	19
• Cardio-vascular	ALL	145/4521	3	156/5487	3
	Improvement activity	82/2473	3	79/3017	3
	NO improvement activity	63/2048	3	77/2470	3
• Malignancy	ALL	171/4521	4	226/5487	4
	Improvement activity	86/2473	3	111/3017	4
	NO improvement activity	85/2048	4	115/2470	5
• Respiratory (non-malignant)	ALL	120/4521	3	122/5487	2
	Improvement activity	61/2473	2	71/3017	2
	NO improvement activity	59/2048	3	51/2470	2
• Other	ALL	505/4521	11	604/5487	11
	Improvement activity	303/2473	12	307/3017	10
	NO improvement activity	202/2048	10	297/2470	12
• Not stated	ALL	109/4521	2	56/5487	1.0
	Improvement activity	59/2473	2	40/3017	1.3
	NO improvement activity	50/2048	2	16/2470	0.6

Copies of the full audit report are available from the Health and Work Development Unit:
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