NHS
National Patient Safety Agency
National Clinical Assessment Service

Handling concerns about practitioners' health

A guide for managers

First Edition

Contacting NCAS

NCAS Advice Line phone numbers and email contacts are listed below, with our emergency contact number if you need NCAS help outside normal business hours.

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Feedback

Working with partner organisations and stakeholders, NCAS will continue to develop this guide and resources. Feedback would be greatly valued and will help us when developing future good practice guides. Please send any comments to ncas@ncas.npsa.nhs.uk.

This is a general guidance document but NCAS can be contacted at any stage for advice about the handling of a specific case.

Contents

1. Introduction

1.1 Purpose and audience

The National Clinical Assessment Service advises healthcare organisations where they have a concern about the practice of a doctor, dentist or pharmacist. Almost one quarter of new referrals to NCAS have a health component – an estimated 1500 cases in nearly ten years of NCAS work. These cases have included concerns about mental health, substance misuse, behavioural problems where there is an underlying health problem, and physical disabilities which could affect practice.

This guide distils practical advice from NCAS experience and provides background information to help responsible managers and others in healthcare organisations who may be faced with handling concerns about a practitioner's health. The guide complements (and does not replace) the advice which responsible managers should seek from occupational health and human resources departments and from NCAS. It covers the management of health concerns in the workplace whether or not they are associated with concerns about performance.

NCAS has worked increasingly closely with occupational physicians over the last few years and this guide draws on their experience, particularly as presented in a joint meeting of the Faculty of Occupational Medicine, the Association of National Health Occupational Physicians (ANHOPS) and NCAS in May 2010. Occupational physicians have commented on the guide as it has developed. We have also drawn on the expertise of colleagues working in Europe and North America in the field of doctors' health. We are most grateful for all this input.

NCAS works throughout the UK and associated island states. In addition, through its memorandum of understanding with the Independent Health Advisory Service, NCAS serves member independent sector health organisations. While some aspects of this guide will not be applicable in all settings and all professional groups, the principles should apply generally.

The guide includes illustrative case studies based on NCAS experience but these are fictional composites, using fictional practitioner names taken from London Underground stations.

1.2 Policy background

Two major reports about the health of health professionals were published by the Department of Health in 2009-2010.

In 2009 reports were published from an *NHS Health and Wellbeing Review* led by Dr Steve Boorman. They covered the whole NHS workforce in England and identified the requirements for staff to maintain their own health and wellbeing while recognising the complexities of providing health care to clinical staff. The final report proposed that the consistency of occupational health services should be improved and recommended that occupational health services should provide a 'comprehensive, proactive staff health and well-being service' with simple access to effective care. Earlier interventions for staff with mental health and musculoskeletal conditions were proposed specifically, to help minimise the time staff are ill and to support early return to work.

This review was followed up in 2010 with *Invisible Patients: Report of the Working Group on the Health of Health Professionals*, the Group convened by the Director of NCAS. Its report covered the health of all regulated health professionals and included findings from literature reviews about how ill-health may affect practice in the workplace. It set out the evidence for a framework to prevent, identify and manage ill-health in health professionals. This guide covers some key aspects in the framework proposed in *Invisible Patients* report, in particular how concerns about practitioner health can be recognised and handled effectively in the workplace.

As recognition grows of the importance of identifying and treating health problems in health practitioners and as each health profession moves towards implementing revalidation processes, it is likely that more health difficulties

will come to light, providing the opportunity to deal with them sooner and more effectively. Responsible officers for doctors will have a key role – see *The Responsible Officer – Closing the gap in Medical Regulation – Responsible Officer Guidance.*

Earlier and more effective action is especially desirable at a time of financial constraint. The 2009 health and wellbeing review estimated that £555 million a year could be saved by reducing NHS staff sickness absence.

1.3 Terms

Key NCAS terms used in this guide are:

Practitioners: doctors, dentists and pharmacists. These are professions within NCAS' current remit, although organisations may find this guide useful for other health professionals.

Concerns about practice: any aspects of a practitioner's performance or conduct which may

- pose a threat or potential threat to patient safety
- expose services to financial or other substantial risk
- undermine the reputation or efficiency of services in some significant way
- be outside acceptable practice guidelines and standards

Responsible manager: the medical director/clinical director or other clinical or non-clinical manager to whom a practitioner reports and who holds responsibility for handling the possible impact of the practitioner's health on their clinical practice. The responsible manager's prime concern is fitness for purpose of the individual – is the practitioner fit to meet the requirements of their job? In medicine, the responsible manager may also be the responsible officer. If this is not the case, there should be clear lines of communication between the responsible manager and the responsible officer

Responsible officer: From 1st January 2011, a senior doctor who is appointed by a healthcare organisation to discharge responsibilities under the Medical Profession (Responsible Officers) Regulations 2010. Those responsibilities include: ensuring that the organisation carries out regular appraisals of medical practitioners; establishing and implementing procedures to investigate concerns about a medical practitioner's fitness to practise; where appropriate, referring a medical practitioner to the GMC; and making recommendations to the GMC about a medical practitioner's fitness to practise. The responsible officer may also be the responsible manager, but the distinction between the two aspects of their role is important. There should be clear lines of communication between the responsible manager and responsible officer where these roles are undertaken by separate individuals within an organisation.

1.4 Resources

The main text in this guide is supported by five resource annexes:

Resource A - Further reading

Resource B - Checklist for referral to an occupational physician

Resource C - Security planning

Resource D - Use of formal NHS procedures

Resource E - Additional sources of help

2 Practitioner health problems - evidence and experience

2.1 Research evidence

Invisible Patients: Report of the Working Group on the health of health professionals drew on literature reviews of the health of health professionals. These are listed in Resource A on further reading. This brief section summarises some of the findings included in the report.

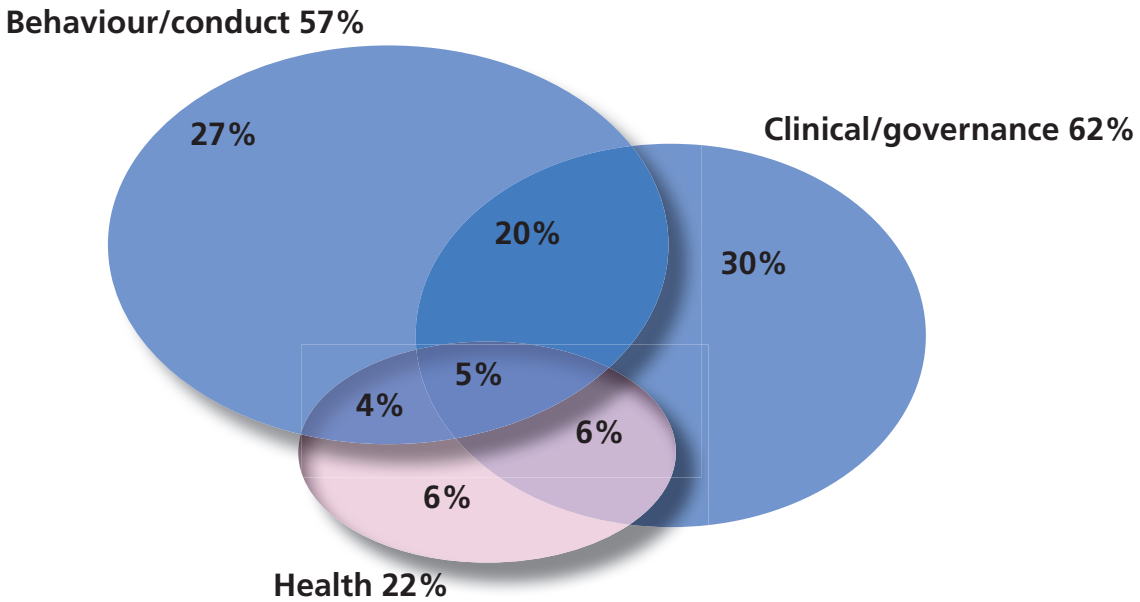
Research indicates that there are higher rates of depression and anxiety in health professionals than in other groups of workers. Several studies indicate that health professionals feel more stressed than other workers and stress has been linked to mental ill health. Rates of suicidal thoughts and completed suicides are significantly higher in doctors, dentists, nurses and pharmacists.

There are higher rates of substance misuse in health professionals than in other groups of workers. The British Medical Association has estimated that one doctor in 15 (7%) could experience some form of drug/alcohol dependence in the course of their career. A questionnaire study of UK dental professionals revealed that 6% of the 545 respondents had a 'drink problem' while 9% had 'alcoholic tendencies'.

Health professionals may be reluctant to seek help for health problems because of fears about stigma, confidentiality, inability to access suitable services or unwillingness to let down their patients or colleagues. As a result they may treat themselves or seek help from colleagues without going through proper channels, or they may not seek help until the condition has become severe.

2.2 NCAS experience

When cases are referred, NCAS staff summarise the concerns raised after discussion with the referring manager. Amongst almost 3000 cases handled between December 2007 and October 2010, about quarter were logged as having some sort of health component, either with or without other concerns. The chart shows how health concerns are overlapping behavioural and clinical concerns.



Referrals to NCAS for health reasons fall into three groups:

- cases where health is the dominant cause for concern
- cases where health is a secondary problem and the practitioner's clinical skills or behaviour are the main issue
- cases where the practitioner develops or declares a health problem at some stage during the case management process and needs to take sick leave.

Health difficulties in practitioners who are referred to NCAS include:

- anxiety, stress, burnout
- depression/hypomania
- substance/alcohol misuse
- indicators of cognitive impairment
- reduced manual dexterity
- loss of mobility/lifting and carrying ability
- sight and speech problems.

These are conditions and terms used when a practitioner is referred to NCAS and the list should be seen as indicative rather than exhaustive. But it shows the range of ill-health that practitioners are experiencing. Practitioners may be referred with a combination of health difficulties.

2.3 The challenge for healthcare managers

Those responsible for managing health professionals, and in particular those charged with monitoring performance, are in a good position to identify early signs of possible ill-health and refer on for assessment and treatment.

Box 1 – Case study

Dr Acton is a community dentist who has held his post for ten years. There are no concerns about his abilities as a practitioner but recently he has become moody and uncommunicative with colleagues. He does not come to team meetings. His secretary has complained that he is very 'snappy'.

Over the last few months there have been a number of concerns raised by patients about Dr Acton's behaviour. There has been one letter of complaint from a patient, who said that he was 'abrupt and unsympathetic'.

Dr Acton's line manager was concerned that his change in behaviour may be related to a health problem so he suggested that he go to see his GP. His GP diagnosed depression and prescribed medication to which Dr Acton responded well. He was keen to continue in practice while his depression was treated so his line manager reduced the number of sessions he undertook for a month. Within a few weeks his behaviour was much improved.

3. Handling concerns - a checklist

Handling concerns about practitioners' health in the workplace involves

- Identification – identifying the health concern and its potential impact on performance
- Recognition – the practitioner and the responsible manager recognising that there is an illness
- Management – managing the impact of the illness in the workplace.

Box 2 - Checklist for responsible managers

Identification

Is there a health problem?	• The concerns raised may suggest a health problem • In addition, where there are concerns about an individual's practice, consider whether health may be a contributing factor.
Could occupational health and HR help?	• Consider seeking advice from occupational health and human resources (HR) where these are available • Specialist assessment may be required (e.g psychiatry, psychology, neurology) - arranged through occupational health in liaison with the practitioner's GP, especially where the effect of the illness on work is unclear.

Recognition

Discuss with the practitioner	• Discuss the concerns with the practitioner, seek their views and keep them informed of any investigation of their practice • Ensure they have access to support • Occupational health may advise the practitioner on access to any additional local or national resources that offer support and/or treatment.

Management

Clarify roles and responsibilities	• If there is an identified, or possible, health problem, confirm who is managerially responsible for the case, i.e. for managing the impact of any ill-health on the quality of care or safety of patients • Confidentiality and consent issues need to be clarified and handled.
What are the risks for public protection, patient safety and service integrity – and how will these be managed?	• The responsible manager, taking advice from occupational health, may need to assess and manage risk to patients and/or staff • This may involve the practitioner taking sick leave (or the need for exclusion/suspension) while the risk is assessed and managed. (Risk assessment and management is covered in Chapter 7).
How will the practitioner's return to work be managed?	• Where the practitioner is away from work, plan early for the time they will return. This may require monitoring arrangements for health and performance, and support for rehabilitation.

Box 2 uses this structure to make a checklist for responsible managers. Subsequent chapters consider each of these points in more detail.

The responsible manager will also need to be clear about the legal framework applying in a specific case. A summary of some of the main provisions is in Resource D. Statutory instruments and frameworks differ from country to country and across the professions so it is important to access the relevant legislation and guidance. The 'must knows' sections on the NCAS website provide quick links to key NHS legislation in each country and each practitioner group.

The next three chapters are based on the assumption that the practitioner is committed to addressing the health problem and its possible impact on performance. For cases where there are difficulties working with the practitioner to address the concern, a different approach will be needed, covered in Chapter 7.

4. Identification and recognition

4.1 Is there a health problem?

In considering whether there is a health problem, it will be useful for the responsible manager to review the information available from the practitioner and (if appropriate) colleagues. The following questions may be useful prompts:

- Does the practitioner have any known health concerns (including addiction)?
- Have they taken sick leave?
- How are any health concerns being addressed?
- To what extent may any health concerns impact on the behaviour or performance of the practitioner?
- Could the practitioner's work be affecting their health?
- Who has spoken about the concern with the practitioner and what was their response?
- Are there any additional contributing factors (e.g. difficult relationships at work, family stressors)?
- Has there been a change in team dynamics/function?
- Is there substantiated evidence of significant risk to patient safety?

Box 3 introduces a case study which builds through this chapter and the next, starting here with the identification of a health concern.

Box 3 - Case study - Identification

Dr Leyton is a consultant paediatrician who has been working in Southern Hospital Trust for three years. Three months ago nurses reported concerns to you, the clinical director for paediatrics. Dr Leyton had been causing a distraction in A&E; she was not responding to her calls, not seeing patients she was supposed to be attending; and was becoming increasingly unreliable. The A&E lead Consultant, Dr Waterloo, has also spoken to you to complain and followed this up in writing. He states that Dr Leyton had visited A&E in the evening when she was not on call and was interfering with the work of the doctors by debating at great length what they should be doing with some paediatric cases, staying on into the early hours of the morning on at least two nights.

Colleagues have commented that Dr Leyton is increasingly unreliable, rushing about but not fully completing her work (e.g. making inadequate records after examinations) and seemingly unable to concentrate on any single aspect of her work. She is talking excessively about her personal life.

You consider that the doctor may be ill and that occupational health assessment is required, with access to specialist referral. You also realise that some sort of formal authority could well be needed and seek help from HR/medical staffing.

4.2 Could occupational health help?

Managing the impact of health problems in the workplace and deciding whether concerns about a practitioner's performance or behaviour are a result of ill-health will likely require input from an occupational physician who may, in turn, refer on for relevant specialist opinion. It is helpful if advice is given by specialists with experience of managing ill-health in health professionals.

Healthcare organisations should have a low threshold for referral to occupational health because significant health problems in practitioners may be concealed and difficult to diagnose by non-specialists. NCAS supports the view of some occupational physicians who advocate that an occupational health assessment should be offered to all practitioners where significant concerns have been identified about their practice.

The referring manager should give the occupational physician clear background information about the case and ask questions which make clear the expectations from the referral. It may be helpful for the referring manager to have a preliminary phone call with the occupational physician (keeping a note of the conversation) before making a referral. Resource B sets out a checklist of information to be considered for inclusion in a referral letter.

Normally the practitioner's consent should be obtained for a referral to occupational health and it is good practice for the referral letter to be copied to the practitioner. Where an employer or primary care organisation has concerns about the health of a practitioner, it may be reasonable for them to request that the practitioner attends for a medical examination. While the practitioner cannot be forced to undergo an examination, a failure to agree to the request could warrant further action (see Resource D).

The referring manager should seek confirmation of the timetable expected for the practitioner's appointment with the occupational physician and the report. The occupational physician may offer, or the manager may request, a case conference once the practitioner has been seen.

The occupational physician gives an independent assessment of the practitioner's health, the impact of any illness on work, the impact of work on health and fitness for work. They advise both the employer/contracting organisation and the practitioner about each of these issues and on reasonable adjustments that could be made to help the practitioner remain at or return to work. They provide support to the practitioner as part of the consultation. Occupational physicians can also liaise with the practitioner's GP to facilitate appropriate ongoing care.

Box 4, overleaf, shows what a consultation with an occupational physician may cover.

If the responsible manager is unable to access the occupational health advice they need, they can access services through NHS Plus. This is a network of occupational health departments across England, supplying services to NHS and non-NHS employers. Their website (http://www.nhsplus.nhs.uk) provides information about services by postcode and useful guides and resources. While there can be advantages in seeking advice outside a healthcare organisation, a disadvantage is that the service will not have detailed understanding of the practitioner's organisation/working environment.

4.3 Specialist assessment of health conditions

Where a specialist medical opinion is required to inform fitness for work the specialist referral may be made by an occupational physician. The referring doctor is responsible for identifying an appropriate specialist and for defining the areas to be covered by the report, ensuring that the report covers the questions being asked by the manager. A specialist health assessment will normally need to cover:

- diagnosis
- severity and prognosis of the condition
- likely impact of the condition on the practitioner's work
- recommendations on how the problem should be managed and monitored.

The occupational physician will discuss the choice of specialist with the practitioner, including whether a specialist might have a therapeutic role following the initial assessment. The referral will need to cover consent arrangements for disclosure of the report to the doctor making the referral.

Box 4 - Occupational physicians' clinical consultations with health professionals – as described by occupational physicians

- Review questions posed by responsible manager
- Set out role of occupational physician - to support the doctor and signpost to other sources of support; to write a report for the responsible manager
- Describe how this will be done - independent, impartial
- Establish consent and understanding of purpose of interview and ground rules
- Explain lines of communication and how information will be shared with referring manager (information disclosed only with the practitioner's consent, except in cases of public interest)
- Engage the practitioner and build trust to establish confidence
- Take good history including, where appropriate, psychiatric assessment
- Provide an objective view of the practitioner's self diagnosis/level of insight
- Offer investigations/tests where appropriate
- Be aware of the limits of occupational physician's own knowledge and competence (i.e. when specialist referral might be required)
- Interpret/clarify healthcare organisation policies and assessment procedures
- Put in place ongoing monitoring and support where needed
- Establish nature of risk and how this will be handled - may need tests and further information from third parties
- Consider how health and performance might interact
- Discussion of next steps and secure agreement to proceed.

This list takes account of the views of a meeting of occupational physicians hosted by ANHOPS, the Faculty of Occupational Medicine and NCAS on 5 May 2010.

4.4 Taking HR advice

HR professionals often have much experience in handling employees who are sick and their advice can be invaluable. Where available, HR can provide advice at an early stage to ensure the approach to managing the health problems is consistent with the requirements of local policies such as managing attendance, disability, redeployment, alcohol and substance misuse. HR will also advise on how any ongoing health issue may impact on the continued employment of the individual and at what stage options such as changes to working patterns or adjustment to the normal working environment may need to be considered, or phased retirement, ill health retirement or (having exhausted all other possibilities) termination on the grounds of incapacity. HR and occupational health can advise on the disability requirements of the Equality Act 2010 where this applies.

4.5 Gaining recognition of the problem

It is helpful for the responsible manager to discuss with the practitioner their perspective on the concerns and to explore the practitioner's willingness to see an occupational physician and take certified time off sick, if necessary. The plan for managing the impact of the health concerns on work and the responsibilities of different individuals should normally be discussed with and clearly communicated to the practitioner. The responsible manager may advise on access to personal support (normally through HR or occupational health who may provide access to counselling). If so, this advice should be confirmed in writing after discussion. Resource E lists further sources of support for health professionals with health problems.

Box 5 - Case study - Recognition

Prior to referral to occupational health you meet with Dr Leyton to discuss the concerns about her behaviour. She argues that she was simply catching up with people that she knew in A&E and that she didn't understand the problem. You ask how she is and she emphatically states she's "fine, never felt better; I feel so enthusiastic".

However, Dr Leyton agrees to see the occupational physician and then goes off sick. During the course of her sick leave she is seen by a psychiatrist and is formally diagnosed with bipolar disorder. She continues to attend her appointments with her psychiatrist and the Trust's occupational health service and after four months she is much better. The occupational physician finds her fit for work and reports this to the medical staffing manager who speaks to Dr Leyton and to you as the clinical director. Dr Leyton comes to see you and she is clearly working hard to come to terms with her diagnosis.

5. Management

5.1 Clarify roles and responsibilities

Responsible managers who are also clinicians should not attempt to diagnose and treat the practitioner's health problem but should focus on their managerial role. A responsible manager should not be expected to enquire in detail about health matters or to assess the impact of a practitioner's health on work and services: that is the role of the occupational physician.

The responsible manager needs to identify who has overall management responsibility for the practitioner's clinical practice. Often this will be the responsible manager themselves. The responsible manager's role will normally include

- seeking advice on the impact of the practitioner's health on their work from an occupational physician
- managing the practitioner in his/her role in delivering the service
- managing the impact of sickness absence or restriction of duties on the workload of colleagues.

Where the practitioner is a trainee their health condition may have implications for both their employment and their future career progression. In this case the workplace manager will need to work closely with the deanery, and it is likely that the deanery lead (e.g. the associate dean) will take overall responsibility for managing the case, substituting for the medical/clinical director in the role as responsible manager. They will need to liaise closely with the workplace manager and educational supervisor to ensure there is full "continuity of care" for the trainee. Extra time for training may need to be negotiated.

The responsible manager can seek advice from NCAS where there are concerns about the possible impact of health on practice.

If a colleague of the practitioner has identified a possible health problem, they should approach the responsible manager, senior manager or senior HR officer.

In summary, the distinct responsibilities for managing the illness and the effect of the illness are likely to be as follows:

- Responsibility for **managing the illness and its treatment** lies with the practitioner, their GP, the specialist treating them (if any)
- Responsibility for **managing the effects of the illness on the practitioner's work** lies with the practitioner, their responsible manager and, where this is agreed, their clinical colleagues
- The occupational physician's role is to **advise on an individual's fitness for work.** While their view is important, the final decision regarding the employment/contractual/list status of the practitioner rests with the healthcare organisation, i.e. the occupational physician is not responsible for managing the impact of the practitioner's health on their work (which is the role of the manager/HR) nor is the occupational physician responsible for providing treatment (that is the role of the GP or specialist services)
- The GP's role is to **manage the practitioner's health condition,** providing access to specialist assessment and treatment
- NCAS' role is to **advise on the handling of a case from a management perspective,** not on the diagnosis or clinical management of the individual's condition.

A case conference can be a most effective way of bringing together all those who are supporting the practitioner to clarify roles and agree channels of communication. The responsible manager may be in a good position to convene a case conference.

A staff absence due to ill-health, even for a couple of days, requires additional management effort and it is not unusual for managers to feel frustrated when a member of staff becomes unwell. However, personal feelings need to be put to one side so that a clear process can be followed.

Box 6 - Case study - Management

Dr Leyton has been deemed fit for work but the Trust needs to guard against the impact of a possible relapse. You discuss with Dr Leyton the need to arrange monitoring of her behaviour. A security plan (Resource C) will enable you, as the clinical director, to send her home if her behaviour suggests relapse of her illness, requesting that she sees her GP and provides sickness certification. If Dr Leyton does not agree to go home or to go to her GP, medical exclusion will be needed.

You will need to take account of reports from the occupational physician and the requirement to make 'reasonable adjustments', including consideration of flexible or part-time work, time off to attend therapy or psychiatric outpatient appointments, consideration of redeployment if necessary, provision of external support and potential supervision at work.

The Trust may need to review the way it handles illness and disability, including the potential for harassment/bullying from colleagues or stigma regarding attitudes to mental ill-health.

5.2 Confidentiality and consent

The rules of patient confidentiality for the practitioner apply to referrals to occupational health and information provided by the occupational physician to the employer. A practitioner may provide information to the occupational health service that they wish to be kept in confidence. The occupational physician's recommendations will be based on conclusions from the consultation but the detail of the diagnosis or other information provided does not need to be divulged to the manager. The practitioner should be assured that normally information about their health condition will be passed on only when they have consented to this. However, there may be circumstances where disclosure without consent is required in the public interest (see below), so absolute confidentiality cannot be assured.

As set out in Box 4 occupational physicians should ensure the practitioner has been informed about the purpose of the health assessment and its outputs, including any report to the referrer. The occupational physician should ensure that the practitioner has consented to the process, including the preparation and release of an occupational health report. They should also explain to the practitioner that if the public interest requires disclosure without the practitioner's consent, such disclosure could occur.

The occupational physician should offer to show the practitioner a copy of their report before it is sent unless

- the practitioner has already indicated they do not want to see it or
- disclosure would be likely to cause serious harm to the practitioner or any other person or
- disclosure would be likely to reveal third party information where the third party has not consented to disclosure and, in the circumstances, it would not be reasonable to disclose without their consent.

Any occupational health report should only disclose factual information relevant to the request, which can be substantiated and is presented in an unbiased manner. Normally the whole record about the practitioner will not be disclosed. The practitioner is able to refuse consent to disclose to the referrer and this refusal must be honoured by the occupational physician unless disclosure is required by law or there is an overriding public interest. Examples of such public interest include where failure to disclose would expose patients to risk of death or serious harm or where disclosure would assist in the prevention or detection of crime. The practitioner's consent should still be sought and they should be informed about the disclosure, unless this in itself would not be safe or practicable given the public interest considerations.

6. Return to work

6.1 Return to work programme

After a prolonged period of sick leave, a practitioner will need help to get back to work.

A return to work (RTW) programme may cover the following as required:

- Re-skilling and re-establishing CPD
- Reintegration into the workplace
- Alternative working arrangements
- Risk management (see Chapter 7).

Some of these topics are also discussed in another NCAS good practice guide, The Back on Track Framework for Further Training, but an overview is given here.

6.2 Re-skilling and re-establishing CPD

The NCAS action plan template provides a basis for planning and monitoring clinical performance, setting clear milestones with review arrangements and documentation at each step. The action plan template can be downloaded from the NCAS website as a Word document and adapted for local use.

The NCAS Back on Track team can advise and support the development of a re-skilling plan. If a phased return to work programme is planned, the practitioner's progress from one step to the next will be conditional on satisfactory completion of performance reviews.

As part of an RTW programme, practitioners may need help to re-establish a planned programme of continuing professional development, especially to cover any recent developments in their specialty and to address any deficiencies that they or colleagues identify in their practice following a period of sickness absence.

The practitioner may need support from a professional mentor to help rebuild confidence to take on a full range of responsibilities, particularly after a prolonged period away from work.

6.3 Reintegration into the workplace

Consider the option of phased return to work, with gradually increasing hours and with responsibilities depending on satisfactory health and performance against milestones. This may need a strict timetable with cover arrangements so that the practitioner does not work beyond what is agreed in order to 'help out' or in response to pressure from colleagues. Doing so may put the practitioner's health and longer term recovery at risk.

The team the practitioner is returning to may need support to achieve successful reintegration, especially if the individual has been off on long term sick leave.

6.4 Alternative working arrangements

The occupational physician may advise that there are particular components of the practitioner's role which increase the risk of relapse and suggest how these might be modified. Part-time working or a change of responsibilities may need to be considered.

The Doctors Support Network (www.dsn.org.uk) supports doctors who have experienced serious mental health problems. DSN experience is that their members who return to work successfully after serious mental illness usually have a phased return to work, and/or return to work part-time and accept a lower grade position (for example, ceasing to be a practice principal or moving from a consultant post into another career grade). Returning to work after an episode of severe depression may create particular difficulties, as a practitioner may be deemed fit for work but may still need support for some time before there is a return to full capacity.

Vocational rehabilitation officers may be very helpful in undertaking detailed workplace assessment and management of RTW programmes (for both physical and mental health problems). They may have backgrounds in nursing or occupational therapy.

For a practitioner returning to work after serious illness, assessing and managing risk may require continuing review by the occupational physician, review of the practitioner's clinical performance against agreed milestones and ongoing monitoring of any risk to patient safety.

Box 7 - Case study - returning to work

You are a primary care Medical Director. A GP on your patch, Dr Osterley, has been diagnosed with Parkinson's disease. Dr Osterley has been off sick but is now keen to return to work. You ask Dr Osterley to attend occupational health who seeks a view from the treating consultant. Once the occupational health report is available you hold a case conference with Dr Osterley, his GP and occupational health to devise an action plan which covers:

- when Dr Osterley should return to work
- how a phased return to work will be managed, including locum arrangements
- whether he should resume his full scope of practice (he previously carried out minor surgery)
- how his performance will be monitored to inform decisions about future scope of practice and working hours
- financial help that may be available to the practice (from the PCT and/or the practitioner's own insurance).

You also advise Dr Osterley to consider the provision for sickness absence in his practice partnership agree-

7. Protecting patients

There are particular challenges associated with handling health concerns in health professionals. The safety of patients is paramount and must be the primary focus of the responsible manager handling a practitioner's health problems. This chapter covers the assessment and handling of risk and those situations where the practitioner is unable or unwilling to acknowledge they have a health problem and/or to take appropriate action to manage their health problem and protect their patients.

7.1 Risk assessment and management

The responsible manager handling the case will be responsible for assessing and managing any risk to patients, colleagues and the service and, where necessary, taking appropriate specialist advice. The responsible manager should consider seeking advice from an occupational physician and arranging a case conference where necessary. The responsible manager should remind the practitioner of his or her own responsibility in helping manage any risk to patients caused by their illness.

The responsible manager, along with the occupational physician, should consider whether the practitioner should be advised to take sick leave while their health condition is assessed and managed. If the practitioner is unwilling to take sick leave and there appears to be a risk to patient safety, the manager may need to restrict the practitioner's duties, or exclude, suspend or take other appropriate action in accordance with existing NHS policies, statutory regulations and, where appropriate, in conjunction with regulatory bodies (see below).

Having taken advice from the occupational physician, the responsible manager should consider whether the practitioner's health condition may adversely affect their practice. If so, a detailed assessment of specific aspects of the practitioner's practice in the workplace may be required. The responsible manager may seek views from colleagues (e.g. peer review of performance) and/or the relevant medical royal college or an NCAS assessment.

The occupational physician may need to refer for a specialist medical opinion or obtain a report from a practitioner's treating consultant. If the practitioner does not agree to referral for examination by a specialist, the occupational physician will need to inform the manager. They may then need to consider issuing a formal instruction that the practitioner should attend and/or consider exclusion/suspension and/or referral to the regulator (see below).

The responsible manager should consider whether there is a need for ongoing monitoring of the practitioner's practice in the workplace and/or future assessment of risk. If so, they will need to consider how this will be achieved, possibly including formal arrangements for review of practice (see proposals for return to work in Chapter 6). Primary care organisations will need consider the use of their contractual or Performers List powers, and Trusts the use of powers under *Maintaining High Professional Standards* (see Resource D).

In some cases it may be appropriate for the responsible manager to consider a signed agreement with a practitioner who has a relapsing illness (e.g. bipolar disorder, multiple sclerosis or alcoholism). See Resource C for a **template security plan**, in which Part 1 is worked out with the practitioner to identify early warning signs and Part 2 is given to close colleagues so that they know what to do if the illness recurs. Consider whether colleagues need training in any aspects of a security plan.

A security plan could specify the action that will be taken if there are signs of relapse – advice to take sick leave, for example, with exclusion/suspension as a possible consequence of non-compliance with the plan. Having a security plan protects patients and provides assurance to line managers and colleagues that the practitioner will work only when fit to do so.

The security plan template can be downloaded from the resources section of the NCAS website.

Box 8 - Case study – Risk Management

You are a superintendent pharmacist handling concerns about a pharmacist. The pharmacist has been employed by your company for 10 years and there have been no complaints about the standard/quality of his work. The company is a chain of eight pharmacies.

Six months ago the pharmacist arrived for work smelling of alcohol on four occasions spanning a two week period. You met him after the fourth occasion and he informed you that his marriage had broken down. The pharmacist stated he was under considerable stress working full-time whilst trying to reach agreements in his divorce proceedings. He also admitted he had been "making the most of the single life" which included drinking significant amounts of alcohol several evenings each week.

The pharmacist agreed with you that this wasn't appropriate behaviour and you offered him two weeks' compassionate leave to sort out some of the issues related to his impending divorce. You and the pharmacist met after the period of leave and the pharmacist stated he felt much better about himself and his situation and wished to return to work, which he did.

No further concerns emerged until this week; you have been contacted by three of the support staff who work with the pharmacist. They all report that in the last couple of weeks the pharmacist has smelt of alcohol whilst at work. You are considering the following:

- patient safety - discussing with the pharmacist whether they should take sick leave until their difficulties have been addressed
- how you will make a referral of the practitioner to occupational health
- what policies and procedures in your company may have a bearing on the situation
- whether the regulator needs to be involved.

7.2 Taking formal action locally

In some circumstances the responsible manager will need to take a view as to whether the practitioner's incapacity gives grounds for taking action against the practitioner. A decision should not normally be taken until all local procedures on managing attendance, sickness and disability have been exhausted and should be based on the available medical information and occupational health advice.

Lack of capability arising from ill health is potentially a fair reason for dismissal and therefore a reason for taking action. However, the employer/contracting organisation needs to show that a fair and proper procedure has been followed so they can defend any subsequent challenge. To do this it will be important to demonstrate that the following factors have properly been taken into account:

- The nature of the illness
- The likely duration of the illness
- The prognosis and predictability of the illness
- Any specialist health information
- Sickness records and attempts to assist a return to work
- The needs of the service
- Adherence to local procedures and stipulated sickness standards (targets)
- Any approach is consistent with relevant legislation
- The provisions for sick pay

- The duty to make reasonable adjustment and seek alternative employment
- Consultation with the practitioner and their representative.

There are formal disciplinary procedures that make reference to health and the impact of health on an individual's ability to continue at work. PCO contractual or Performers List powers, NHS (Pharmaceutical Services) Regulations and Trust procedures under Maintaining High Professional Standards or Agenda for Change may be required. More information about these is provided in Resource D. However, you are advised to seek advice from HR colleagues and may benefit from specialist legal advice.

In some cases the practitioner may apply for ill health retirement; this is a voluntary undertaking by the practitioner. Any decision to grant an application by the Pensions Agency is separate from and not linked to any decision the responsible manager may take to bring the employment to an end on the grounds of incapacity. As such, a decision not to grant ill health retirement does not necessarily prohibit a termination on the grounds of incapacity subject to legal considerations including the duty to make reasonable adjustments. HR will have a key role in this decision.

7.3 Addressing misconduct

In some instances the management of the case may be particularly challenging because of the behaviour of the practitioner. This may involve, for example, failing to communicate/attend meetings with the responsible manager about their sickness, a lack of willingness to attend occupational health or to provide appropriate consent for the disclosure of health information and may also include the practitioner making a counter challenge/complaint in response to any action. In these circumstances it will be important to explore the reasons for the practitioner's stance and to investigate any complaint they may have.

Where difficulties persist, the responsible manager will need to set out explicitly and in writing the responsibilities of the practitioner to comply with sickness management requirements, along with the consequences of not doing so. For example, a practitioner who fails to give consent to the disclosure of health information should be made aware that any decision regarding their continued employment or contracting arrangements may be taken in the absence of the available health information and/or the failure to comply in this way may give rise to action on the grounds of professional misconduct.

In some cases the responsible manager will need to determine as far as is possible the extent to which any misconduct is in part or wholly attributable to health factors. This may be done by providing occupational health with specific information about the concerns identified and the context or situations in which these arise (as set out in Chapter 4). A decision will then need to be taken as to whether the concern should be treated primarily as a health matter or one of conduct, informed by the medical evidence and evidence of the misconduct. This may be of particular importance when a practitioner becomes sick during an investigation of concerns about conduct or performance.

7.4 Involving the regulator

In *Your health matters: useful tips and contacts* the General Medical Council says: 'Only a small number of sick doctors are referred to the GMC each year. There is usually no need for GMC involvement for a sick doctor who has insight into the extent of their condition, is seeking appropriate treatment, following the advice of their treating physicians and/or occupational health departments in relation to their work, and restricting their practice appropriately.'

The GMC document, *Good Medical Practice* gives further guidance on the responsibility of the individual doctor about their own health and the health of their colleagues. All practising doctors are expected to conduct themselves in a way that promotes good medical practice and to recognise when their health may compromise their ability to do so. Doctors should abide by the guidance in *Good Medical Practice* and, in addition, should 'Protect those you manage from risks to their health, respond constructively to signs that colleagues have health problems. In particular you should be alive to mental health problems, depression, and alcohol and drug dependence and help and support colleagues who have health problems'.

The GMC and General Dental Council (GDC) have advised (in Memoranda of Understanding with the London based NHS Practitioner Health Programme) that referral to the regulator should be considered where:

- A practitioner's practice is impaired because of their illness and they are not willing to refrain from work (NHS and private practice) or take sick leave
- A practitioner is working but they are not complying with treatment and/or monitoring of a condition which may impair their practice
- A practitioner turns up to work intoxicated (i.e. his fitness to practise is called into question because of his use of drugs or alcohol)
- A practitioner is involved in illegal activity (drink driving, taking illegal drugs (including opiates), forging prescriptions, any other fraud).

The General Pharmaceutical Council (GPhC) says that health concerns should be referred to them when a pharmacist's 'ability to practise safely may be affected and there may be a risk to patient safety'.

In Standards for Dental Professionals the GDC says: 'If you believe that patients might be at risk because of your health, behaviour or professional performance, or that of a colleague, or because of any aspect of the clinical environment, you should take action. You can get advice from appropriate colleagues, a professional organisation or your defence organisation. If at any time you are not sure how to continue, contact us [the GDC]'.

Box 9 - Case study – health and misconduct

Dr Moorgate is a consultant and concerns about his conduct have been identified following reports that he has been shouting at patients. The Trust has attempted to conduct an investigation and to convene a disciplinary hearing. Dr Moorgate has declined to be interviewed and has requested three postponements on the grounds that he is too unwell to attend because of the stress caused; this has delayed the hearing by six months. He has also been on sick leave for five months. The Trust has requested that Dr Moorgate attend occupational health which he has refused to do and he has almost exhausted his full sick pay entitlement. There are rumours that he has been working at his private practice during sick leave.

It is open to Dr Brixton, as the responsible manager, to take the following steps:

- Request once again that the practitioner attend occupational health, setting out the reasons for doing so and stressing that in the absence of any available health information the Trust may now have no option but to base their decision on the limited information which they have to hand and this may not be in his best interests
- Check the practitioner's contract of employment. This may contain a provision requiring the practitioner to attend OH. Whilst it is not possible to force a practitioner to undergo a medical examination, the failure to do so can be treated as a disciplinary matter if it is a requirement in the contract. If this provision exists, it should be drawn to the practitioner's attention. (Note: this is a requirement under the standard Consultant Contract)
- As the practitioner has been long term sick, the Trust should consider whether he qualifies as disabled under the Equality Act 2010 (section 6) and if so, to comply with its duty to make any reasonable adjustments
- Inform the practitioner, if there is sufficient evidence to do so, of the allegation that he is working elsewhere whilst on sick leave, invite the practitioner's comments on this allegation and decide, taking account of any comments the practitioner chooses to make, whether there should be a formal investigation
- If, having given the practitioner reasonable notice of the disciplinary hearing proposed above, the practitioner fails or declines to attend and reasonable enquiries do not give any good reason for this, then at a further hearing where he failed to attend, it would be open to the Trust, having taken account of all the relevant circumstances of the case, to consider whether it was appropriate to proceed in the practitioner's absence, taking account of any submissions made by or on behalf of the practitio-

Resource A - Further reading

NCAS publications

NCAS has three other good practice guides which could help in the management of health concerns. They can be all be found at www.ncas.npsa.nhs.uk/resources. Direct links are available in the online version of this document.

- How to conduct a local performance investigation (2010)
- Handling performance concerns in primary care (2010)
- The Back on Track Framework for Further Training (2010)

Other publications

Report of an independent inquiry into the care and treatment of Daksha Emson MB BS, MRCPsych, MSc and her daughter, Freya. North East London NHS Strategic Health Authority. 2003. (www.rcpsych.ac.uk)
This is the report of the Panel of Inquiry set up to investigate the causes of the deaths by extended suicide of Dr Daksha Emson and her three month old daughter, Freya. The report looks at the care and support received by Dr Emson, who had bipolar affective disorder, and makes recommendations.

Doctors as patients. Petre Jones. Radcliffe Publishing Limited. 2005.
This book shares the experiences of a number of doctors with mental ill-health.

Mental health and ill health in doctors. Department of Health. 2008. (www.dh.gov.uk)
This report looks at mental health and ill-health in doctors and the factors that influence them. It outlines ways in which the NHS can provide appropriate services and encourage doctors and other health workers to seek early advice and support for mental health problems.

A systematic review of the health of health practitioners. Institute of Occupational Medicine. 2009.
This report covers the systematic review of the literature on the physical health of health practitioners within the regulated health professions which informed the *Invisible Patients* report (see below).

The mental health of health care professionals: A review for the Department of Health. Institute of Psychiatry. 2009. (www.dh.gov.uk)
This report covers the systematic review of the literature on the mental health of health practitioners within the regulated health professions which informed the *Invisible Patients* report (see below).

Fitness to Practise: The health of healthcare professionals. Ipsos MORI. 2009.
This report covers the findings of research on attitudes of NHS healthcare professionals and the general public towards sickness and reporting in the NHS. It also informed the *Invisible Patients* report (see below).

Invisible Patients: Report of the Working Group on the health of health professionals. Department of Health. 2010. (www.dh.gov.uk)
The report identifies some priorities for employing and contracting bodies and for health profession regulatory bodies.

NHS Health and Wellbeing Review: Interim and Final Reports. Department of Health. 2009. (www.nhshealthandwellbeing.org).
These reports provide a comprehensive review of the health and wellbeing of the NHS workforce (including non-clinical staff) and make recommendations as to how these can be improved.

The London Practitioner Health Programme has produced two annual reports on its activities: one-year report (www. php.nhs.uk)

Websites

The **NHS Employers** website (www.nhsemployers.org) has a section entitled NHS Well-being at work with a range of resources on health and wellbeing in the workplace.

The **Department for Work and Pensions** website also has a health, work and wellbeing section (www.dwp.gov.uk/health-work-and-well-being) with advice on management practices.

The **National Institute for Health and Clinical Excellence** website (www.nice.org.uk) includes Guidance for primary care and employers on the management of long term sickness and incapacity with quick reference guides and checklists.

The **NHS Plus** website (www.nhsplus.nhs.uk) provides information about occupational health services by postcode with other useful guides and resources.

The **NCAS** website (www.ncas.npsa.nhs.uk) is growing as NCAS experience grows and ideas on good practice are clarified.

Resource B - Checklist for referral to an occupational physician

This checklist can guide the referral letter from a responsible manager to an occupational physician. It takes account of the views of a meeting of occupational physicians hosted by ANHOPS, the Faculty of Occupational Medicine and NCAS in May 2010.

While the checklist is a good start, it may be helpful for the manager to have a preliminary phone call with the occupational physician before making a referral to ensure that all necessary background information is provided in a particular case.

Information to be provided by the responsible manager:

- Name, grade and specialty of practitioner
- Current working status (e.g. sick leave, full/restricted duties)
- Patterns of sickness absence/attendance
- Description of concerns that have prompted the referral (including concerns about health, behaviour and performance) – a description of actual events/problems/interactions is more useful than a manager's interpretation
- Status of any complaint/investigation
- Source of concerns (e.g. colleagues, practitioner, patients, appraisal). (The manager will need to consider whether it is appropriate to disclose information about third parties, such as the individuals who have raised concerns)
- Any relevant issues relating to the practitioner's work context (e.g. workload, relationships within team, recent change in duties)
- Any relevant issues relating to the practitioner's personal circumstances (if known)
- Action already taken with regard to risk assessment (e.g. sick leave advised, supervision, exclusion)
- Input from HR
- Information provided to the practitioner and their response
- Who holds the management responsibility for handling the case
- The practitioner's consent to the referral
- Questions for the occupational physician (see below).

Questions the responsible manager may wish to ask the occupational physician:

It is helpful for the responsible manager to be clear about their expectations in the referral to the occupational physician. These may include seeking answers to some of the following questions.

- Are there underlying health conditions that would explain the concerns?
- Is the health condition work related?
- Are conditions at work affecting the practitioner?
- Is the condition self limiting, recurrent, chronic, progressive?
- What is the prognosis if the condition is treated? What is the prognosis untreated? What sort of timescales apply? What is the likelihood of relapse (if relapsing condition)?
- What is the functional importance of the health conditions?
- What restrictions need to be imposed to protect patient safety?
- What reasonable adjustments could be made?
- What specialist medical opinion needs to be sought/has been sought and how far do the answers to other points draw on that opinion?
- How is the condition being monitored and what are the plans for follow-up and monitoring (including management of the range of conditions/co-morbidities)?
- Current fitness for work – full duties or partial. If partial, what hours, and what changes to the responsibilities / job plan will be required?
- How should any potential risks to patient safety caused by the practitioner's condition be assessed, managed and minimised?
- Are there any disability requirements for reasonable adjustment under the Equality Act 2010 legislation?
- How should any return to work programme be managed?
- How might the occupational physician provide further guidance on managing the case (and would a case conference be helpful)?
- What information has the occupational physician provided to the practitioner and is there consent to disclosure of information?
- Can the occupational physician provide an indication of likely compliance/cooperation from the practitioner?
- What are the likely side effects of any treatment and/or medication?

Resource C - Security planning

This is a template for a responsible manager to develop a signed agreement with a practitioner who has a relapsing illness. Part 1 is worked out with the practitioner to identify early warning signs and Part 2 is given to close colleagues so that they know what to do if the illness recurs.

The template for this plan can be found on the NCAS website. It can be downloaded and, if necessary, adapted. It is reproduced here in compact form but the downloaded document can be stretched as much as necessary for a particular episode of recovery with support. See Chapter 7 for further discussion of security planning.

Part 1 Relapse prevention – security plan made with:	
	Practitioner's name
'Relapse signature'	
Mental illness comes in many forms, and everybody's experience of mental illness is different. The term 'relapse signature' refers to the specific thoughts, feelings and behaviours that you experience when you are becoming unwell. Recognising the 'signature; will give you time to get the help you need when you need it.	
I know I am becoming unwell when:	
1	
2	
3	
4	
5	
Staying well	
It is now widely accepted that unwanted stress can contribute to mental illness, and therefore stress needs to be managed and limited. Identifying stressors is the first step to managing them.	
My stressors are:	
1	
2	
3	
4	
5	
What I can do about them:	
If illness recurs:	
If I begin to feel unwell, I will:	
1	
2	
3	
4	
5	
	Practitioner's signature
	Date

Part 2 Relapse prevention – plan to be held by close colleagues of:		
		Practitioner's name
Diagnosis		
Brief description of the condition and how you can tell that this person is experiencing its effects:		
IMPORTANT POINTS TO NOTE:		
Alerts		
What might happen because of this condition?		
Who should notice these signs?		
Who should they notify/be in touch with?		
Actions to be taken		
1		
2		
3		
4		
5		
Training related to this plan		
Who needs to be trained	Training topic(s)	Date completed
		Colleague's signature
		Date

Resource D - Use of formal NHS procedures

Formal disciplinary procedures usually make reference to health and the procedure to be followed when dealing with concerns about a practitioner's health when their capability to work comes into question. This resource provides an overview of the use of Primary Care Organisation (PCO) contractual or Performers List powers, Trust procedures under Maintaining High Professional Standards and, for pharmacists, NHS (Pharmaceutical Services) Regulations or Agenda for Change. The resource considers these procedures in England and, while similar procedures are in place in Wales and Northern Ireland, different arrangements apply in Scotland. Please check the relevant procedures for each of the four countries of the UK on the 'resources' section of the NCAS website.

GPs involved in the provision of NHS primary medical services in England

GPs who hold a contract or are part of a contractor

Where a PCT has concerns about the health of a medical contractor (i.e. a medical practitioner who is a signatory to a GMS, PMS or APMS contract or is part of a contracting entity), it may request that the contractor (who may also be a contract performer) undergo a medical examination.

Paragraph 113(2)(o) of Schedule 6 to the NHS (GMS Contracts) Regulations 2004 (as amended) ("the GMS Regulations") confers a discretionary power on the PCT in GMS arrangements that allows the PCT to terminate the contract where a contractor or member of a contracting entity has refused to comply with a request by the Primary Care Trust for him/her to be medically examined on the grounds that it is concerned that he/she is incapable of adequately providing services under the contract.

Paragraph 105(3)(l) of Schedule 5 to the NHS (PMS Agreements) Regulations 2004 (as amended) ("the PMS Regulations") confers a similar discretionary power on PCTs under PMS and APMS arrangements.

Regulation 27 of the GMS Regulations states that the Local Medical Committee's functions include:

> *(c) the making of arrangements for the medical examination of a medical practitioner specified in paragraph (2) [in summary contractors or members of contracting entities],), where the contractor or the Primary Care Trust is concerned that the medical practitioner is incapable of adequately providing services under the contract and it so requests with the agreement of the medical practitioner concerned [our emphasis]; and*
>
> *(d) the consideration of the report of any medical examination arranged in accordance with sub-paragraph (c) and the making of a written report as to the capability of the medical practitioner of adequately providing services under the contract to the medical practitioner concerned, the contractor and the Primary Care Trust with whom the contractor holds a contract.*

While no such express provision exists within the PMS Regulations, where an examination arranged by the LMC only takes place where the contractor has consented, approaching the LMC for assistance in cases involving APMS or PMS agreements would be reasonable.

GP Performers

In order to perform NHS primary medical services, a GP must appear on a Performers List. PCTs have powers to manage their Performers Lists including the power to:

- suspend a performer where to do so is necessary for the protection of the public;
- remove or contingently remove a performer from the Performers Lists on efficiency grounds; and
- remove a performer from the Performers List on grounds of unsuitability.

While there are no health specific provisions within the NHS (Performers Lists) Regulations 2004 ("the PLR"), it may be appropriate for a PCT to consider the exercise of one or more powers when managing a GP performer who has health issues, particularly where they lack insight into their condition. PCTs are required to notify NCAS where they have suspended a practitioner on the Performers List.

General dental practitioners providing NHS primary dental services in England

Contractual provisions, similar to those discussed above in relation to GP contractors, exist for dental contractors. See for example:

- Paragraph 71(2)(m) of Schedule 3 to the NHS (General Dental Services Contracts) Regulations 2005; and
- Paragraph 69(2)(l) of Schedule 3 to the NHS (Personal Dental Services Agreements) Regulations 2005.

Dentists performing NHS primary dental services must also be on a Performers List. The principles discussed above in relation to GPs will also be relevant to the formal management of general dental practitioners.

Employed doctors and dentists

Maintaining High Professional Standards

This document provides a framework for processes to use where there are serious concerns involving health, conduct or capability for doctors and dentists who are employed by NHS bodies. Many NHS bodies have incorporated MHPS into their local procedures for dealing with medical and dental staff.

Part V of MHPS provides guidance when handling concerns about a practitioner's health. Note especially paragraph 4 (mislabelled 3 in the document) which deals with the duty to make reasonable adjustments.

Paragraph 5 refers to ill health retirement. Note the DH guidance on this issued in 2008.

Paragraph 8 refers to occupational health convening a meeting to discuss their recommendations and to agree a timetable of action and rehabilitation.

Part II of MHPS sets out how to use Restriction of Practice and Exclusion from Work provisions to ensure patient (and staff) safety. If you are considering excluding a practitioner under MHPS framework, you should contact NCAS to discuss the situation before any move to formal exclusion.

Pharmacists involved in the provision of NHS community pharmaceutical services in England

The framework for the provision of NHS community pharmaceutical services by independent contractors differs from those for primary medical services and primary dental services. The regulations state that a PCO must maintain a pharmaceutical list of contractors whose application to be included has been granted. A pharmaceutical list will include bodies corporate and partnerships as well as individual pharmacists. The relationship of the PCO with a pharmacy contractor is not, in the majority of cases, with an individual pharmacist and pharmaceutical lists are not therefore the equivalent of a performers list for pharmacists.

PCOs have powers to manage their pharmaceutical list where a contractor breaches their terms of service under the appropriate regulations. Where a PCO becomes aware of a health concern about an individual pharmacist that might impact on a contractor's ability to comply with their terms of service, the PCO should assure itself that the contractor is appropriately managing the health concern particularly where the concern may directly impact on patient safety.

Employed pharmacists

Pharmacists employed by the NHS, be that in primary or secondary care, are subject to Agenda for Change (AfC). Subsequently their management is informed by AfC terms and condition. Those pharmacists employed in community pharmacy will be subject to their individual employment contracts and the 'health procedures' of their employer.

Resource E - Additional sources of help

As organisations and managers become more aware of practitioner health concerns, new support services are evolving, some of which are listed here. Please check the websites because the resources available may change.

Specialist health services for health professionals

A range of specialist, self-help and peer support resources are available for doctors, dentists and pharmacists.

Resources for doctors are listed on the BMA Doctors for Doctors website, which also includes resources for dentists

Contact details for Doctors for Doctors and BMA Counselling can be found at www.bma.org.uk

Dentists can access healthcare services through the Dentists' Health Support Programme (020 7224 4671).

Pharmacists can access a range of services through Pharmacist Support (www.pharmacistsupport.org). This organisation provides a number of programmes for pharmacists and their families who find themselves in times of need, including health support services.

There is a small number of specialist services, mainly for doctors. Services are provided, for example in Newcastle, Cornwall, Leeds, Manchester, London and Oxford.

Local resources

The occupational physician may be able to identify local resources to assist the practitioner (for example, counselling services, general practitioner support and self-help and peer support networks).

Early retirement

Details on early retirement from the NHS on the grounds of ill-health are provided by NHS Pensions. A FAQ section on the NHSBSA website outlines how the ill-health retirement rules work (www.nhsbsa.nhs.uk/1308.aspx).

The National Clinical Assessment Service (NCAS) works with health organisations and individual practitioners where there is concern about the performance of a doctor, dentist or pharmacist.

We aim to clarify the concerns, understand what is leading to them and support their resolution. Services are tailored to the specific case and can include:

- expert advice and signposting to other resources;
- specialist interventions such as performance assessment and back-to-work support.

NCAS uses evaluation, data analysis and research to inform its work and also runs a programme of national and local educational workshops. Employers, contracting bodies or practitioners can contact NCAS for help. NCAS works throughout the UK and associated administrations and in both the NHS and independent sectors of healthcare.

Contact NCAS

In England **call 020 7062 1655**

In Scotland **call 0131 220 6411**

In Northern Ireland or Wales **call 029 2044 7540**

www.ncas.npsa.nhs.uk

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