In association with NHS Practitioner Health Programme

UK Physician Health Summit 2017
Supporting the health of health practitioners

Wednesday 29 March 2017    De Vere West One Conference Centre, London

Supporting Organisation

The Cameron Fund
Good Governance Institute
Litigation Authority

De Vere West One Conference Centre, London
10.00  Chairman’s Introduction: The State of Physician Health in the UK

**Dr Clare Gerada**
Medical Director
NHS Practitioner Health Programme

- what are the key issues facing sick doctors in the UK
- who is presenting for help and why
- what can physician health services do help those who present
- what can we do to prevent doctors becoming unwell

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10.45  The Case for Change

**Louisa Dallmeyer BA, CPFA**
Commissioner
Office of London CCGs

- are physician health services worth the investment?
- what is the economic case for investing in physician health?
- who should pay and why?

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11.00  Introduction of the New National Mental Health Service for GPs

**Lucy Warner**
Chief Executive
NHS Practitioner Health Programme

- update on NHS England’s new mental health service for GPs
- looking ahead and the new service and how it will work

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11.15  Question and answers, followed by tea, coffee and exhibition at 11.35

12.00 CONFERENCE CONTINUES & SPLITS INTO BREAKOUT STREAMS

- **MASTERCLASS 1** Dealing with Addiction
- **MASTERCLASS 2** Retaining the Older Doctor
- **MASTERCLASS 3** The Power of Groups

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12.50 LUNCH & EXHIBITION

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13.55 CONFERENCE CONTINUES & SPLITS INTO BREAKOUT STREAMS

- **MASTERCLASS 4** Thorny Issues: Performance & Regulation
- **MASTERCLASS 5** Supporting IMG & Refugee Doctors
- **MASTERCLASS 6** Workshop for doctors in training grades and those supporting them

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Final Joint Sessions

14.45  How mental health issues can cause financial hardship

**David Harris**
The Cameron Fund

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15.00  Surviving Work

**Dr Elizabeth Cotton**
Founding Director
Surviving Work

- understand what are the issues that really affect Drs at work
- understand the causes and resources needed to survive at work
- understand how to get help and improve relationships with those around you at work

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15.15  Question and answers, followed by tea, coffee and exhibition at 15.20

15.40  Mindful Medics Programme with Mindfulness Techniques

**Dr Reena Kotecha**
Medical Doctor & Mindfulness Meditation/Pranayama
Mindful Medics

- tips and techniques
- group demonstration exercise

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16.10  Panel Discussion: What is the Future for Physician Health

An opportunity to ask a panel of experts about the issues with doctors suffering with ill health

**Dr John Smyth**
Interim Assistant Director (Case Examiners) General Medical Council

**Dr Elizabeth Cotton**
Founding Director Surviving Work

**Dr Clare Gerada**
Medical Director NHS Practitioner Health Programme

**Lucy Warner**
Chief Executive NHS Practitioner Health Programme

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16.40  Question and answers, followed by close at 16.50
### Case Study: How we did it

**Rory O’Connor**  
Psychiatric Nurse Clinical Advisor NHS England & Clinician NHS Practitioner Health Programme

### Masterclass 1: Dealing with Addiction

**Jane Marshall**  
Consultant Psychiatrist South London and Maudsley NHS Foundation Trust & Clinician NHS Practitioner Health Programme

### Masterclass 2: Retaining the Older Doctor

**Dr Naureen Bhatti**  
Associate dean for return to practice schemes Professional Support Unit Health Education England  
& **Dr Rebecca Viney**  
Rebecca Viney Associates

### Masterclass 3: The Power of Groups

**Dr Sharon Kalsy**  
Independent Consultant Kalsy Consulting

12.50  
Question and answers, followed by lunch and exhibition

### Masterclass 4: Thorny Issues: Performance & Regulation

**Andrew Long**  
Consultant Great Ormond Street Hospital

### Masterclass 5: Supporting International Medical Graduate & Refugee Doctors

**Mr Richard Jones**  
Cognitive Behaviour Therapist Specialist Nurse and an Independent Prescriber NHS Practitioner Health Programme

### Masterclass 6: Workshop for doctors in training grades and those supporting them

**Dr Elinor Hynes**  
Psychiatrist and Clinician NHS Practitioner Health Programme  
& **Dr Claire Gallagher**  
GP & Clinician NHS Practitioner Health Programme

14.45  
Back to main closing session
Self-assessment Record

To be completed by those wishing to record further learning and knowledge enhancement for Continuing Personal and Professional Development (CPD) purposes

SUBJECT/FORMAT/DATE: ........................................................................................................................................

1. What were the key issues covered and the learning benefits noted?

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2. What can I put into practice by way of action points?
   A) Immediately?

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B) Medium/long term?

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3. What further reading/research do I need to do?

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4. Approximate study / further learning time achieved.................................................................

NB: This form may be photocopied and retained amongst your personal CPD records. Completed photocopies might also be submitted by those required to forward documentary evidence of CPD activity to their professional association or institute.
Chairman’s Introduction:  
The State of Physician Health in the UK

Dr Clare Gerada  
Medical Director  
NHS Practitioner Health Programme  
clare.gerada@nhs.net

Dr Clare Gerada has become the first female Chair of the Royal College of General Practitioners in 50 years. She is also the first Chair to come from Malta!

Clare is the daughter of Dr Anthony Gerada and Mrs Josephine Gerada. Anthony arrived in the UK in 1964 and worked as a singlehanded, then dual handed GP in Peterborough. Clare vividly remembers accompanying him on home visits and him inspiring her with his tremendous commitment to medicine and general practice. He taught her that to be a good GP you have to be a good listener and to give something back to your community, something he did for nearly 40 years.

Clare studied medicine at University College London, qualifying in 1982. She trained in medicine, then psychiatry and then followed her fathers foot steps and became a general practitioner in South London, where she has stayed every since, just about to celebrate her 25th anniversary at the practice. The practice started life in 1969 – and remains on its current site – on the ground floor of a 19-storey housing estate in Lambeth. The practice has now expanded becoming one the largest GP group practices in London. Her training in psychiatry led her to a life long interest in managing drug users – and in fact represented the Department of Health (England) advising the Maltese Government on their drug policy.

Over the years, Clare has held a number of local and national leadership positions, including Director of Primary Care for the National Clinical Governance Team and Senior Medical Advisor to the Department of Health. In 2008, she won the contract to run the Practitioner Health Programme (www.php.nhs.uk), which is a pioneering programme providing confidential services to doctors and dentists with mental health or addiction problems.

Clare has published a number of academic papers, articles, books and chapters, the most recent, in 2011 on gambling and her first, in 1986 on periodic psychosis and the menstrual cycle. In-between she has published papers on wide ranging topics such as smoking and psychosis: random drug testing in schools and practitioner-health.

Clare has strong links to three Royal Colleges: Fellow of Royal College of General Practitioners and psychiatrists, was awarded an honorary Fellowship of Royal College of Physicians in 2008.
Clare was awarded an MBE in the Millennium Birthday Honours for services to medicine and substance misuse.

Clare is married to a psychiatrist and has two sons – one of who is desperate to change his nationality from British to Maltese and Clare is helping to get the necessary paper work together so he can fulfil his wish. She re-gained her Maltese citizenship in 2017.
The Case for Change

Louisa Dallmeyer BA, CPFA
Commissioner
Office of London CCGs
Louisa.Dallmeyer@nhs.net

Louisa has worked in the health care field for 26 years. Having begun her career in finance in the NHS, she was given the opportunity to work as a consultant, specialising in health care, for KPMG. This enabled her to realise that what she was really interested in was strategic performance improvement, and she took part in and led projects in this field in the UK and in developing countries. Louisa returned to work in the NHS - first setting up a comprehensive acute benchmarking programme in NW London - then going on to work with Department of Health and the National Clinical Assessment Service to develop and commission the Practitioner Health Programme.

Louisa has commissioned the Practitioner Health Programme since 2008. She is particularly interested in understanding the costs, benefits and outcomes of the service, and in developing appropriate long term funding models.

Abstract

The Practitioner Health Programme was developed in 2008 by the Department of Health and the National Clinical Assessment Service. It was developed in response to growing evidence that a significant number of doctors and dentists did not seek help for certain conditions due to perceptions of stigma and lack of confidentiality. A prototype service was developed in London with the intention to expand it nationwide, if the case for investment was proven. The prototype provided a confidential service for doctors and dentists in London who had mental health or addiction issues. The service was, and continues to be successful in terms of outcomes for patients and value for money. Eight years later, a similar service, the GP Health Service has recently been commissioned by NHS England for all GPs in England. This presentation will explore if these services are value for money and if they are, who should pay for them?
Physician health services: are they worth the investment?

Louisa Dallmeyer
Commissioner
Office of London CCGs

Physician health services worth the investment?

Why are we investing in physician health services?

• To overcome the obstacles that stop doctors accessing healthcare like the rest of the population:
  – Stigma of being ill and potential impact on career
  – Perceived lack of confidentiality
  – Inability to refer out-of-area due to restrictions of NHS financial regime
• To impact on the suicide rates amongst the profession
• To protect patients

Patient safety

"We need a system that understands the pressures and strains under which all professionals operate and shows understanding, compassion and support where these are appropriate.

It also means a system that is better able to identify people early on who are struggling – perhaps with personal problems of mental health or addiction – and supporting them, showing the same care to them that they have shown to their patients, so that they have a fair chance to improve and return to practice, if that is possible."


Stigma

Are physician health services worth the investment?
What is the economic case?

The cost of ill health

- Sickness absence costs the NHS £1.7 billion each year and presenteeism has been estimated to cost at least £2.55 billion
- The costs of London doctors and dentists who fall ill to the NHS is estimated to be at least £28m a year
  - sick leave of hospital medical and dental staff is estimated to cost an annual £16.8m
  - suspensions owing to ill health cost £5.5m
  - GP sick leave approximately £1m
- Presenteeism is estimated to cost at least £25m for hospital doctors and dentists alone
- It is estimated that the average cost per completed suicide for those of working age only in England is £1.67m (at 2009 prices)
  - includes intangible costs (loss of life to the individual, the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals

How much does PHP cost

- PHP for London residents costs circa £1m p.a.
- 32 CCGs in London
  - £31,250 each p.a.
  - The cost of excluding one doctor from work for seven weeks is £29,000 (Invisible Patients, 2010)
- c.35,000 registered doctors living in London
  - £26 per doctor

How does PHP save money?

- gets patients back to work
- supports patients to continue working wherever possible
- a one-stop-shop
- refer patients quickly & appropriately
- earlier, less costly interventions

Outcomes

- Remaining in work
  - In past year 77% of patients have remained in work, with the remainder being off sick, unemployed, suspended or retired
- Abstinence rates
  - In the past year 66% of patients are consistently abstinent, with the remainder being on maintenance or controlled drinking as part of their care plan
Who should pay and why?

How are services funded now?

• PHP currently commissioned in London by 32 CCGs via the Office of London CCGs
  – Based on all doctors being a “hard to reach” patient group
• NHS GP Health Service funded for all GPs, and GP trainees, in England by NHS England
  – Based on a performers list, quasi employer responsibility to reduce stress and burnout
• Elsewhere in world many different models...

International examples

• US e.g. Pennsylvania PHP
  – State medical society
  – Malpractice insurance companies
  – Hospital and private contributions
  – Participant fees
  – Charity contributions
• Canada e.g. British Columbia
  – Co-funded and governed by the BC Medical Association & the Ministry of Health
• Australia
  – Funded by the Medical Board of Australia (regulator)
  – Doctors' Health Services Pty Ltd & the state advisory & referral services are independent organisations operating at arm's length from regulatory authorities. The privacy & confidentiality is paramount.

Who should pay and why?

• Anyone!
• Future in UK?
  – Regionally via 210 CCGs / STP areas/ Regions?
  – As a specialised commissioned service?
  – As a directly commissioned service of NHS England? Alongside military health?
• Any solution must facilitate anonymity, confidentiality & ability to be treated out of area
• Issues around who should pay stifles service develop!
Introduction of the New National Mental Health Service for GPs

Lucy Warner
Chief Executive
NHS Practitioner Health Programme
lucy.warner@nhs.net

Lucy has over 20 years NHS experience ranging across many aspects of health care, working with practices, local and national teams and including a stint in Gibraltar. She is Chief Executive of the NHS Practitioner Health Programme, a confidential primary care led service for doctors and dentists which has seen more than 800 practitioner-patients since its launch in September 2008.

Lucy has previously worked with NHS England as the Responding to Concerns Lead, focusing on concerns in the medical workforce and with the NHS Revalidation Support Team supporting the implementation of appraisal and revalidation for doctors in England. She also works as an independent advisor on Clinical Governance.
Jane has been a Consultant Psychiatrist in the Addictions at the South London and Maudsley NHS Foundation Trust (SLaM) since 1994. She currently works with the NHS Practitioner Health Programme (PHP), a dedicated London-based service for doctors and dentists with mental health and addiction problems; with Equinox, a local voluntary sector detoxification unit; and as Consultant Advisor to the Civil Aviation Authority (CAA). Through her clinical work at PHP (which includes the full range of mental health disorders as well as substance use disorders) she sees the organisational and systemic issues facing medical staff at first hand, and also the personal toll.

Abstract

Dealing with Addiction

The prevalence of alcohol problems in doctors is no higher than in the population as a whole, whereas higher rates of prescription drug use are recognised as an occupational hazard. This practice of self-treatment with controlled drugs is a ‘unique concern’ for doctors.

The development of substance misuse problems in doctors is multi-factorial. Anxiety and depression, work-related and family stress, physical health problems, personality difficulties, pain and a non-specific drift into drinking have all been implicated. Early diagnosis is critical because doctors are often reluctant to seek help and colleagues are reluctant to intervene.

Medical schools and continuing medical education programmes must give greater emphasis to addiction and substance misuse in doctors with a view to reducing the incidence of ‘impaired physicians’ and promoting and encouraging early treatment and rehabilitation.
Case Study: How we did it

Rory O’Connor
Psychiatrist Nurse Clinical Advisor, NHS England
Clinician, NHS Practitioner Health Programme
roryoconnor@nhs.net

MSc Addictions, BA Psychology, Registered Psychiatric Nurse, Diploma in Counselling. Rory has worked for 40 years in mental health and addiction and has extensive experience in managing programmes for health professionals, dentists and veterinary surgeons with mental illness and addictive disorders. Currently Clinical Advisor to NHS England who act as commissioners to the Practitioner Health Programme and National Coordinator for the Dentists’ Health Support Programme.
Dealing with Addiction in Healthcare Professionals

Dr Jane Marshall
UK Physician Health Sunmmit
29 March 2017

Distress in Doctors and Dentists

• Multifactorial:
  – Loss of control
  – Excessive workload
  – Experience of suffering
  – Poor self-care
  – Maladaptive coping strategies
  – Stressful life events
  
  Shanafelt et al, 2002; 2003; Spickard et al 2002; West et al 2006

Stressful Work Environment/Overwork

• Excessive and demanding workload
  – Emotionally draining
  – Experience of suffering
• Working patterns
  – Shift and night work
  – Working in isolation
  – Loss of control
• Poorly functioning teams
• Poor communication
• Bullying and harassment
• Poor levels of support

Consequences

• Poor patient care
  – Anger
  – Inability to be compassionate
  – Burnout
  – Fatigue, errors
• More time off work
• Sick leave, early retirement, suicide
• Reduction in morale of work force
• Impact on families

Managing Stress

• Minimise stress
  – Improve the working environment
  – Become less isolated
  – Share problems with colleagues
• Workplace
  – Work sensible hours
  – Take holidays
  – Learn how to handle patient anxiety and hostility
  – Exercise
  – Be kinder and less critical to oneself

Substance Use Disorders in UK Doctors

1999: “Some 1 in 15 doctors in the UK may suffer some form of dependence” BMA Working Party
• 1998: 7% of GPs admitted to using alcohol frequently to cope (Firth Cozens)
1998: 60% of sample of junior doctors exceeding safe limits and 10% drinking at hazardous level (Birch et al)
• 2007: Postal survey of hospital consultants -17% drinking at hazardous levels (Taylor et al)
1998: 25% of junior doctors using cannabis and 10% using hallucinogens (Birch et al)
### Specialities at Risk
Hughes et al, 1992

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>• Genetic predisposition</td>
</tr>
<tr>
<td>Accident and Emergency Physicians</td>
<td>• Psychological vulnerabilities</td>
</tr>
<tr>
<td>Anaesthetists</td>
<td>• Stressful work environment/overwork</td>
</tr>
<tr>
<td>General practitioners</td>
<td>• Knowledge and accessibility of drugs in the workplace</td>
</tr>
<tr>
<td></td>
<td>• Self-medication</td>
</tr>
<tr>
<td></td>
<td>• Need to maintain image of competence (also a risk factor for isolation)</td>
</tr>
<tr>
<td></td>
<td>• Need to maintain image of “healer” → compulsion to spend long hours at work</td>
</tr>
</tbody>
</table>

### Risk Factors for Alcohol or Drug Use

- Genetic predisposition
- Psychological vulnerabilities
- Stressful work environment/overwork
- Knowledge and accessibility of drugs in the workplace
- Self-medication
- Need to maintain image of competence (also a risk factor for isolation)
- Need to maintain image of “healer” → compulsion to spend long hours at work

### Individual Vulnerability

- Individual defences and self-esteem challenged
- Psychotropic drugs easily available
  - Self-medication
- Ambivalent attitudes towards alcohol

### Prescription Medication

- Doctors are at increased risk of using prescribed medication especially:
  - Opiates and benzodiazepines
- Ease of access
- Knowledge about drugs
- Ability to prescribe/inject

### Prescription Medication

- Doctors are advised not to treat themselves but...
- Forsythe et al (1999) found that:
  - 77% self-prescribed
  - 10-15% admitted prescribing antidepressants, anxiolytics, opiates and hypnotics

### Barriers to Seeking Help

- **Work-related**
  - Difficulty taking time off
  - Heavy workload

- **Fear and shame**
  - Fear of lack of confidentiality (and punitive response)
  - Fear of stigma
  - Concerns about professional future

- **Lack of knowledge about what to do**
  - Insufficient knowledge about services
  - Experience about how other colleagues have been treated
Key Treatment Issues for Addicted Healthcare Professionals

They present late
They have usually been “found out” and reported → shame
They usually have multiple problems
  • Addiction: alcohol/drugs
  • Mental health problems
  • Social/family problems
  • Physical health problems
Stigma still a major problem

Assessment of the Individual

Health Issues
  • Context - Duration
  • Personality - Resilience
Competence Issues
  • Related to substance use
  • Unrelated to substance use
Conduct Issues
  • Work-related incident (+/- substance use)
  • Criminal or Civil Conviction

What does addiction look like in the workplace?
• Coming to work with a hangover:
  – e.g. after a weekend of heavy drinking: “headaches”; “can’t concentrate”; “don’t work at usual pace”
• More serious problems:
  – Deteriorating skills/Interpersonal difficulties
• Indices
  – Sickness absence: especially on Mondays
  – Productivity rates
  – Accidents
  – Disciplinary issues

Effects of Alcohol and Drug Use in the Workplace
• Effect on work performance
  – Absenteeism, inefficiency; poor decision-making; impaired customer relations
• Productivity problems
  – Inconsistent performance; poor quality of work; lower productivity (slower); more mistakes and accidents
• Alcohol impairs:
  – Thinking
  – Concentration
  – Judgement
  – Mood
• Up to 40% of accidents at work involve or are related to alcohol

Working situations associated with drug and alcohol problems

<table>
<thead>
<tr>
<th>Working situations associated with drug and alcohol problems</th>
<th>Factors in workplace culture that present an increased risk for use of substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shift and night work</td>
<td>Availability</td>
</tr>
<tr>
<td>Travel away from home</td>
<td>Work pressures</td>
</tr>
<tr>
<td>Working remotely</td>
<td>Peer group pressure</td>
</tr>
<tr>
<td>Business meals</td>
<td>Co-worker collusion</td>
</tr>
<tr>
<td>Poor communications</td>
<td>Lack of supervision</td>
</tr>
<tr>
<td>Job stress</td>
<td>Financial hardship</td>
</tr>
<tr>
<td>Financial independence</td>
<td></td>
</tr>
<tr>
<td>Longer hours (international evidence)</td>
<td>Physical danger</td>
</tr>
<tr>
<td>Interface with demanding or aggressive public</td>
<td></td>
</tr>
</tbody>
</table>

From BMA Report: 2014

Highest mortality from alcohol-related diseases and injuries (1991-2000)

| Highest mortality from illicit drug dependence and accidental poisoning by illicit drugs (1991-2000) |
|---|---|
| Those working in the drinks industry, including publicans and bar staff | Literary and artistic occupations |
| Construction industry trades |

1960-1980s: Doctors had high levels of alcohol-related deaths
2001-5: Premature mortality rate of only 58

Coggon et al, 2009

South London and Maudsley NHS Foundation Trust
**Substance Misuse among Healthcare Workers: National Survey of Occupational Physicians**

Substance misuse cases categorized by profession presenting to OHPs in the preceding 12 months (N= 107 - 79% of OHPs participating in this study)

<table>
<thead>
<tr>
<th>Professional group presenting with a SUD</th>
<th>Number (%) of OHPs who reported at least one presentation in the preceding year</th>
<th>Number (%) of presentations to OHPs in the preceding year, by profession</th>
<th>Mean (SD) of presentations OHPs in the preceding year, by profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>69 (54%)</td>
<td>134 (18%)</td>
<td>2.63 (2.70)</td>
</tr>
<tr>
<td>Nurses</td>
<td>78 (73%)</td>
<td>260 (34%)</td>
<td>2.63 (2.70)</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>6 (5%)</td>
<td>9 (1%)</td>
<td>0.10 (0.47)</td>
</tr>
<tr>
<td>Nursing/Medical Assistants</td>
<td>44 (41%)</td>
<td>94 (12%)</td>
<td>1.01 (1.61)</td>
</tr>
<tr>
<td>Allied Health care Professionals</td>
<td>34 (22%)</td>
<td>62 (9%)</td>
<td>0.68 (1.12)</td>
</tr>
<tr>
<td>Non-Clinical Staff</td>
<td>62 (58%)</td>
<td>141 (19%)</td>
<td>1.57 (1.61)</td>
</tr>
</tbody>
</table>

Reported only the total number of HCWs presenting 2 (2%) 57 (8%) 28.5 (23.3)

**All professional groups**

102 (95%) 758 (100%) 7.08 (7.07)

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**Principles of Clinical Care for Doctors and Dentists (1)**

- Doctors who are ill should be treated as patients, not colleagues
- Rules on confidentiality should be strictly observed
- Additional safeguards to ensure privacy should be in place
- Doctors should be registered with a local GP

Department of Health, 2008

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**Principles of Clinical Care for Doctors and Dentists (2)**

- Doctors treating doctors should have appropriate expertise and seniority
- Out-of-area care should be arranged unless local care is specifically requested
- Doctors should receive the same care and risk management as other patients

Department of Health, 2008

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**Principles of Clinical Care for the Addicted Doctor/Dentist**

- Confidentiality should be strictly observed
- The treating doctor should have appropriate expertise
- Doctors/dentists should receive the same care and risk management as other patients
- Supervision and monitoring are critical
- Whether or not to refer to the GMC/GDC
- Mutual aid groups (AA, BDDG)

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**Role of Occupational Health**

- Health promotion
- Coordination of care of the healthcare professional
  - Organisation of assessments
  - Arrangement of tests
  - Further referrals where appropriate
  - Recommendations re: return to work, work patterns, or work areas, in agreement with the relevant manager

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**PHP: 3-Year Results**

- 574 patients in 36 months
- 92% doctors; 5% dentists; 3% others
- 53% men; 47% women
- Increasing numbers of younger doctors
- 77% remained in or returned to work
- 20+ advised to contact regulator
- 25+ advised to remove themselves from workplace

**Work outcomes**

- Complex problems/present late
- Social and professional isolation
- Excellent uptake and outcomes

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South London and Maudsley NHS Foundation Trust

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South London and Maudsley NHS Foundation Trust
PHP: 3-Year Diagnoses (n=574)

3-Year Mental Health Diagnoses

3-Year Alcohol and Drug Diagnoses

PHP: 5-Year Results

Regulator involvement: 2008-2013
Registrations by year: 2008-2013

New registrations: 2008-2013

<table>
<thead>
<tr>
<th></th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
<th>YEAR 4</th>
<th>YEAR 5</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>105</td>
<td>122</td>
<td>95</td>
<td>111</td>
<td>99</td>
<td>532</td>
</tr>
<tr>
<td>Female</td>
<td>90</td>
<td>110</td>
<td>94</td>
<td>109</td>
<td>143</td>
<td>548</td>
</tr>
</tbody>
</table>

New registrations per month: 2011-14

Practitioner patients by grade

Presenting problem by year
Practitioner patients by speciality

Recommendations

- Access to information
- Designated care pathways and services
- The role of Occupational Health Services
- Tackling stigma and discrimination
- Healthy working practices
- Reducing stressors in the workplace
- Supporting staff with mental ill health
- Looking after one’s own health.

5-Year Follow-up of 904 doctors
McLellan et al, 2008

- Consecutively enrolled in 16 physician health programs (USA)
- 87% male; average age 44 years; 63% married
- Primary substance used:
  - Alcohol 50.3%; Opioids 35.9%; Stimulants 7.9;
  - Other substances 5.9%
- Multiple substances 50%
- Intravenous use 13.9%
- Specialties: mainly Family Medicine; Anaesthesiology; Emergency Medicine; Psychiatry
- 78.7% licensed and working at 5-year follow-up

Substances Used (n=904)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Count (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>30%</td>
</tr>
<tr>
<td>Opioids</td>
<td>97%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>97%</td>
</tr>
<tr>
<td>Others</td>
<td>2%</td>
</tr>
</tbody>
</table>

South London and Maudsley NHS Foundation Trust

Physicians Enrolled in 16 State Physician Health Programs: 5-year Follow-up McLellan et al 2008

<table>
<thead>
<tr>
<th>Variable</th>
<th>Completed contract (n=515)</th>
<th>Contract extended (n=132)</th>
<th>Failed to complete contract (n=155)</th>
<th>Followed sample (n=802)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed or practising medicine licensed or working (not clinical)</td>
<td>477 (94)</td>
<td>67 (52)</td>
<td>15 (10)</td>
<td>569 (73)</td>
</tr>
<tr>
<td>Retired or left practice voluntarily licensed or working (not clinical)</td>
<td>10 (2)</td>
<td>12 (9)</td>
<td>17 (11)</td>
<td>65 (8)</td>
</tr>
<tr>
<td>Licence revoked</td>
<td>7 (1)</td>
<td>3 (2)</td>
<td>18 (12)</td>
<td>41 (5)</td>
</tr>
<tr>
<td>Died</td>
<td>5 (1)</td>
<td>0 (0)</td>
<td>27 (17)</td>
<td>30 (4)</td>
</tr>
<tr>
<td>Unknown</td>
<td>6 (1)</td>
<td>6 (1)</td>
<td>14 (9)</td>
<td>26 (3)</td>
</tr>
</tbody>
</table>

South London and Maudsley NHS Foundation Trust

Occupational Status at 5-year Follow-Up McLellan et al 2008

<table>
<thead>
<tr>
<th>Variable</th>
<th>Completed contract (n=515)</th>
<th>Contract extended (n=132)</th>
<th>Failed to complete contract (n=155)</th>
<th>Followed sample (n=802)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed or practising medicine licensed or working (not clinical)</td>
<td>477 (94)</td>
<td>67 (52)</td>
<td>15 (10)</td>
<td>569 (73)</td>
</tr>
<tr>
<td>Retired or left practice voluntarily licensed or working (not clinical)</td>
<td>10 (2)</td>
<td>12 (9)</td>
<td>17 (11)</td>
<td>65 (8)</td>
</tr>
<tr>
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<td>6 (1)</td>
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<td>14 (9)</td>
<td>26 (3)</td>
</tr>
</tbody>
</table>

South London and Maudsley NHS Foundation Trust
### Drug testing during monitoring period for 647 physicians who completed their contracts

<table>
<thead>
<tr>
<th>Variable</th>
<th>Completed contract</th>
<th>Contract extended</th>
<th>Both groups</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average duration of contract (months)</td>
<td>54</td>
<td>64</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Mean no. of drug tests per physician</td>
<td>82</td>
<td>121</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>No (%) with at least one positive drug test result</td>
<td>57 (11)</td>
<td>69 (52)</td>
<td>126 (19)</td>
<td></td>
</tr>
<tr>
<td>No (%) with a repeat positive result*</td>
<td>8 (14)</td>
<td>25 (38)</td>
<td>33 (24)</td>
<td></td>
</tr>
</tbody>
</table>

### References


Ipsos MORI. Fitness to practise: The health of health care professionals. 2009 [www.dh.gov.uk](http://www.dh.gov.uk)


MASTERCLASS 2: Retaining the Older Doctor

Dr Naureen Bhatti
AssociateDean for return to practice schemes, Professional Support Unit
Health Education England
naureen.bhatti@nwle.hee.nhs.uk

Naureen has worked as a GP at the Limehouse Practice in Tower Hamlets since 1998 and alongside has been involved in medical education for many years. As well as being a trainer she was initially a GP tutor for sessional GPs working flexibly, including those on the old Retainer Scheme, before becoming Programme Director for the GP Induction and Refresher Scheme in 2006. From 2013-2016 she took on the role of Associate Dean for Inducting, Returning and Retaining the Workforce in the Professional Support Unit, London, before moving to be the North Central and East London Head of School for General Practice last year. She is passionate about flexibility to ensure working equilibrium for doctors as their needs change through their working life, ensuring retention of good doctors in the workforce.

Dr Rebecca Viney
GP & Appraiser
Rebecca Viney and Associates
rebecca.viney1@gmail.com

Rebecca’s passion is in unleashing the workforce potential of the NHS.

Her latest roles were as Primary Care Advisor to Health Education England and Deputy Head of Education and Quality for Primary and Community Care, Health Education East of England.

She was the Associate Dean for the London Deanery for 15 years, representing Sessional GPs, and creating the award winning Coaching and Mentoring Service for doctors and dentists across London.

Other senior positions in the health sector included: chair of GPC’s Sessional GP sub-committee. NED for HENCEL Board and board member of Haringey’s CCG.

Rebecca is currently a GP and appraiser in Cambridgeshire and London. She continues to roll out a coaching culture in organisations. Her new passion is in unleashing the potential of those in the expert stage of their lives, 50+.
Retaining the Older Doctor

We are the baby boomer generation, the postwar, drugs, sex, and rock n' roll set who grew up during a time of idealistic visions that served to energise a generation who were simultaneously culturally and socially revolutionised. We are a workaholic generation, passionately concerned about participation in the workplace, motivated by vision, mission and strategy.

So where does that leave the “baby boomer” doctors? We have worked hard and been committed to our roles, often at great personal sacrifice. But as we have got older many are in senior positions with added responsibilities, some have health issues, many are sandwiched between caring roles for elderly parents and children - 80% report stress and contemplate leaving early.

But we have a workforce crisis in primary and secondary care that needs them to stay. We know we face a major and imminent problem in respect of GP workforce capacity with data to show number of GPs leaving has almost doubled in 10 years and those aged 55 – 59 are now leaving at a similar rate to those over 60. And worryingly several surveys highlight that the intention to quit direct patient care in the next 5 years in GPs over 50 has increased from 54% in 2012 to 60.9% in 2015. The average age of retirement for consultants has fallen from 65 to 62 and surveys show high levels of stress here too with many considering an early exit too.

GPs describe that they were doing an (almost) undoable job, with reduced morale and emotional resilience coming through strongly. Survey data from consultants and GPs highlight burnout, poor mental health, addiction and “compassion fatigue” are all increasingly prevalent and the GMC found doctors over 50 are most likely to be the subject of formal complaints. Teams and services, and ultimately patients, lose hard won wisdom and expertise. But, most importantly, doctors don’t all want to retire with many reporting they still enjoyed the practice of medicine and using their clinical skills to help patients, and it wasn’t that that made them retire or contemplate retiring early. What they want is a change of pace or role, a move to less than fulltime working, being nearer home, more time with family and friends, social hours and to continue to add value. But many feel the only clinical option is “all or nothing”.

What is being done to give this valuable and essential workforce the flexibility they need? The workshop will cover what is being done to retain GPs including details of the new GP Retention Scheme and the GP career Plus Scheme. Other initiatives are badly needed. Coaching and mentoring is highly evaluated by senior doctors. We need meaningful appraisals with less onerous paperwork and more supportive discussion. We need confidential health services for everyone, not just doctors in London or GPs across England. And initiatives for increased peer support, reduced partnership stresses for GPs, greater educational initiatives and flexible working and part-time options for established doctors.
The word retirement is anathema to most baby boomers, whose high powered careers have been core to their whole identity. Leaving doctors apply their skills to a host of other activities. We need to harness and leverage the skills and energy of doctors at the expert / mastery stage of their careers. Retirement is the beginning, not the end. The Japanese do not have a word for retirement, they have the word ‘ikigai’ - ‘the reason you wake up in the morning’. Those with ‘ikigai’ live longer and healthier lives. Life transitions are renowned for being uncomfortable and after acknowledging this we want older doctors to have an opportunity to think, experiment and explore, to engage in pursuits they value and leverage their skills, knowledge and talent to continue to make a difference. With people retiring earlier and living longer we need to change the culture.

References
Regus Work-Life Balance Index 2013
HSCIC General and Personal Medical Services, England 2005-2015, as at 30 September – HSCIC provided a data extract for this analysis which enables a count of unique individuals and analysis of part-time workers.
HSCIC General and Personal Medical Services, England 2004-2014, as at 30 September. Leavers data for 2015 are not available due to the new collection methodology.


[https://www.ted.com/talks/mihaly_csikszentmihalyi_on_flow](https://www.ted.com/talks/mihaly_csikszentmihalyi_on_flow)
Retaining the older Doctor

Dr Naureen Bhatti
Head of School General Practice – HEE NCEL
National HEE Lead for new GP Retention Scheme - 2017

Dr Rebecca Viney
GP – Educator – 50+ in transition

The baby boomer generation

• Idealistic
• Competitive
• Results drive
• Stay for the long-term
• Sense of identity/value tied to their career
• Sacrifice family/personal wellbeing for work
• Senior level/ elderly parents/ children/ grandchildren/ health
• 80% report stress
Increasing numbers GPs leaving

- Percentage of practitioners who have left GP practice
  - Female
  - Male

Which GPs left 2013 -2014

- GP leavers 2013-2014 - Age Profile
  - Males
  - Females

Intention to leave – survey data

- 54% GPs >50 “high” likelihood of leaving in 5 years
  (Seventh National GP Workforce Survey)
- 63% of those with 20+ years in GP intend to retire in next 5 years
  (BMA National Survey of GPs – 2015)
- 64% aged 50-59 intend to quit direct patient care within 5 years
  (University of Exeter survey – unpublished)
Hospital consultants – “Who cares for the Carers?”
- 8/10 respondents “re-evaluating retirement plans”
- average age retirement 65-62
- longer to recover - evenings and weekends on call
- workload expansion as leadership roles accumulated
- burnout
- poor mental health
- addiction
- compassion fatigue
- Increased complaints (GMC data)

GP - an (almost) undoable job
- Increased managerial and administrative workload
- high workload/work pressures, eg long working hours
- high patient expectations
- a desire for more family/leisure time
- reduced job satisfaction
- disillusionment with the NHS
- ill health
- insufficient financial incentives to stay at work
- Revalidation
- partnership working arrangements

What do older doctors want
- change of pace
- a new role
- to work less than fulltime
- social hours
- “recovery time”
- Reduced workload (GPs)
- less bureaucracy
- less burden of paperwork for revalidation
- a chance to enjoy life while well
GP retention scheme

- The scheme is aimed at those GPs who are seriously considering leaving or have left general practice due:
  - to personal reasons
  - approaching retirement
  - or require greater flexibility
- Used as an incentive for both the GP and practice to enable the GP to remain in clinical practice
- Maximum four clinical sessions - protected time for CPD and educational support.
- Practice payment – £76.92 per session
- Salary supplement – £1000/session worked per annum up to a maximum of four. (e.g. 4 sessions per week results in £4000 pa)

GP careers plus scheme - pilot

Review range of models to employ pool of GPs that support a local health system to:
- Provide clinical capacity for practices to cover vacancies, annual leave, parental leave and sick cover.
- Carry out specific types of work e.g. long term conditions, access hub sessions, home visits.
- Provide leadership through: clinical training, individual mentoring and coaching, innovation and change leadership, support for practices in crisis.

What else?

- Coaching and Mentoring
- Less onerous appraisal/revalidation paperwork
- Confidential health services – PHP for all
- Increased peer support
- Reduced partnership stresses for GPs
- Educational initiatives through the new Educator Provider Networks
- Flexible working and LTFT options for all
What is Flow?

• “Of all the virtues we can learn no trait is more useful, more essential for survival, and more likely to improve the quality of life than the ability to transform adversity into an enjoyable challenge.”
• — Mihaly Csikszentmihalyi, *Flow: The Psychology of Happiness*

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Ikigai

• According to the Japanese, everyone has an *ikigai*. They have no word for retirement.

• An *ikigai* is essentially ‘a reason to get up in the morning’. A reason to enjoy life.

• It includes joy, a sense of purpose and meaning and a feeling of well-being.
Dr Sharon Kalsy is a Consultant Clinical Psychologist. In a career spanning over twenty years, she has worked across a variety of sectors and patient groups which include: forensic mental health, HIV and sexual health, people with learning disabilities, older adults, children and families, neurorehabilitation, severe and enduring mental health, community, outpatient and inpatient services. As well as applying her skills to patient groups, Sharon has also spent many years in the development and delivery of training for medical, nursing and psychotherapy staff: her training has focussed on helping healthcare staff improve communication with and reduced resistance in patients, managing common mental health problems, conducting mental health risk assessments, and developing brief interventions skills using cognitive behavioural therapy and motivational interviewing. The success of these training programmes gained recognition at national conferences in the UK and abroad.

Sharon’s passion for the wide application of psychological approaches has led her to work in the NHS, prison service, charity and private sectors. Her skills in team and service development led to her progressing quickly into executive management and she has led two national charities – GamCare and the Institute of Group Analysis - improving systems and processes to enable these organisations to develop nationally and to meet clinical and commissioning expectations through the design and implementation of comprehensive transformational change programmes. Sharon’s ability to conceptualise the psychological impact of organisational change has also led her to offer executive coaching and leadership development programmes in the corporate sector to multinational companies.

Aside from these experiences, Sharon is committed to the development and fair treatment of workers and has previously been a workplace representative in the NHS with UNITE the Union and was Vice Chair of UNITE’s Occupational Advisory Committee for Psychological Practitioners. She was Interim Chair of the British Psychological Society’s (BPS) cross divisional Work and Health Group and is now a Committee Member of the BPS’s Work and Health Working party.

Sharon now offers various psychological services – from therapy, training, mentoring, medicolegal assessment, supervision and coaching – via her company Dr Sharon Kalsy Independent Consultant Kalsy Consulting drsharonkalsy@kalsyconsulting.co.uk
Kalsy Consulting which allows her the freedom to continue working across a range of sectors, supporting people to achieve improvements in their professional and personal lives.

Abstract
This will be an interactive session during which the audience will be invited to consider the usefulness of group interventions and the unique contribution they make to the development of individuals and organisations.
The Power of Groups
Dr Sharon Kalsy
Consultant Clinical Psychologist
Kalsy Consulting
29th March 2017

Forming, Storming, Norming?
• Video clip

The experience of groups
• What is your experience of groups?
• How does it compare?
• What challenges you about being in a group and what excites you?
What is a group?

"two or more individuals who are connected to one another by social relationships"

Donelson R. Forsyth (2006)

Research into group dynamics

- Charles Horton Cooley (1909): the "looking glass self"
- Frederic Thrasher (1927): gang culture - "partially intelligible codes"
- Elton Mayo (1933): the "Hawthorne Effect"
- Kurt Lewin (1947): "group dynamics", "interdependence" and change

Bion (1961) - Tavistock Model
Yalom (1975) - Interpersonal School

Foulkes (1970s) - Group-Analysis

Yalom’s Group Factors

- Existential
- Install hope
- Universality
- Impact information
- Altruism
- Corrective recapitulation of the primary family group

- Catharsis
- Group Cohesion
- Interpersonal Learning
- Impulsive behaviour
- Develop socialising techniques

- Dynamic Administration
The dangers of groups

Group Think (Irving Janis, 1972)

- When a group makes faulty decisions leading to a deterioration of “mental efficiency, reality testing, and moral judgment”.
- Affected groups ignore alternatives and tend to take irrational actions that dehumanize other groups.
- Vulnerabilities to groupthink:
  - Group members have similar backgrounds
  - Insulated from outside opinions
  - No clear rules for decision making
  - Poor leadership and authority

Group exercises - 1

- A new part-time GU Consultant joins a long-established GU/HIV clinic at a cash-strapped London PCT. She is tasked with setting up the service’s first GU Clinic for young people based on NICE recommendations which focus on behavioural interventions, which she has never delivered. The GU/HIV nursing and medical teams are overworked and there is an undercurrent of resentment that money has been invested in a new area rather than in existing services. The Consultant needs to create a new team to help her.
- The GU and HIV nursing and health advising teams, the two full time HIV/GUM consultants and a clinical psychologist who provides therapy and staff training generally get on well and are dedicated to their patients.
- What groups might the new consultant try and influence and how?
- Where might the new consultant face challenges in terms of group-dynamics?
- How might she overcome these challenges?
- What alliances might she focus on first?
Group exercises - 2

A group of GPs who have recently qualified are invited to attend a 6 week training programme on the development of CBT skills, after which they attend once a month Balint groups run by a psychologist and family therapist, both experienced in running groups.

During a case presentation on a patient who complains of feeling worthless and depressed after losing his job and fix marriage, the presenting GP stops and talks of his own burnout and how similar his feelings are to his patient’s. He wonders whether he is capable of helping this patient. Some of his fellow GPs look uncomfortable, others look concerned.

• What are the risks in this group?
• Where are the opportunities and how can these be maximised?
• How might you respond as the Balint group leader?

What is the value of groups?

• To individuals?
• To clinical practice?
• To organisations?
• To society?

www.kalsyconsulting.co.uk

drsharonkalsy@kalsyconsulting.co.uk
Dr Andrew Long has been a consultant in general paediatrics within the UK for 25 years and was appointed to Great Ormond Street Hospital in February 2011 to support the development of the new team of general paediatricians. He became Specialty Lead for the general paediatric team in May 2013 and was appointed as Associate Medical Director and Responsible Officer in 2016 with a brief for managing revalidation and medical affairs. He has recently been appointed as a Lead Assessor for the National Clinical Assessment Service.

His clinical interests include care of the newborn infant, child growth and nutrition but he has a passion for medical education and training. He was elected as Vice President for Education at Royal College of Paediatrics and Child Health in July 2013 having previously held several senior College roles including Officer for Overseas Examinations; Officer for Assessment and Assistant Registrar to the College. He is a Fellow of the College and has been a senior examiner in the UK and overseas. His current portfolio includes CPD, revalidation, career progression and professional development.

Andrew has been involved in the work of the Academy of Medical Royal Colleges where he leads the work on remediation for doctors in difficulty. He has a longstanding interest in mentoring and careers support and completed a Masters in Interprofessional Education in 2008. He is also committed to the concept of ‘blended learning’ and has been interested in the development of eLearning and distance learning methodology for a number of years. He has developed expertise in assessment methodology and has published work on leadership, multi-professional education, mentorship and managing doctors in difficulty.

In April 2014 Andrew completed a term of five years as Head of School for Paediatrics and Child Health at the London Deanery, where he had been an Associate Dean since 2006. He was Director of Medical Education and Associate Medical Director in his previous role in Bromley and has been a mentor for trainees and consultants over many years. Andrew trained in London at St Mary’s Hospital Medical School, London and was appointed Honorary Senior Lecturer at University College London in February 2013.
Abstract

This workshop will rely on delegate participation to enable discussion of the impact of regulation on the performance of doctors and their physical and mental health. As a current Responsible Officer and previous Head of School for paediatric training, the facilitator will use his experience and understanding of the issues that cause difficulty in training through to career progression. Recognition of the individual stresses and challenges of working within healthcare services will hopefully facilitate group discussion and look at both the emotional responses as well as organisational pressures that can either support or hinder professional development. As much as possible, this workshop will rely on ‘Chatham House rules’ (https://www.chathamhouse.org/about/chatham-house-rule) to engender free-flowing discussion and the ability to share experiences.
MASTERCLASS 4
Thorny Issues: Performance & Regulation

Dr Andrew Long
Great Ormond Street Hospital
Royal College of Paediatrics and Child Health

Regulation – Why?

July 2001
January 2005

Regulation – Who?

"...recent events have dented public confidence in the quality of clinical care...the challenge is for the professions to demonstrate that self-regulation can continue to enjoy public confidence."

Doctors must:
- make patient care their first concern
- respect the patient’s right to be fully informed in decisions
- keep skills up to date
- protect patients if they believe they or a colleague, is unfit to practice

Systems must be:
- Open to public scrutiny
- Responsive to change in clinical practice
- Publicly accountable for standards and action taken to maintain them

Regulation – how?

4 domains of GMP
- Safety and performance
- Training and education
- Conduct and reputation
- Discipline

Performance - Tackling concerns

Identifying potential concerns

Complaints
Concerns from patients and colleagues
Indicators including death monitoring
Information sharing
Performers List arrangements
NCAS (Doctors and Dentists)
GMC Affiliates (Doctors only)

Local action/remediation
Referral to national regulator

Tackling Concerns Locally, DH 2009
**Thorny Issues: Performance & Regulation**

- is/are the current system(s) Fit for Purpose?
- does it treat doctors fairly?
- does it protect the patient?
- does it work for teams?
- what/where does it need improvement?

**Trust processes**

- Has there been an SUI/patient/colleague complaint?
  - Investigate appropriately (no blame culture)
  - Judgement determines action
- Is it capability or conduct?
  - Trust disciplinary policy
- Is it individual or team?
- Is it a training issue?
  - Involve College/Clinical Tutor (DME)
  - Involve School/HEE as appropriate

**Judith**

- Orthopaedic surgeon
- prolapsed intervertebral disc
- discectomy
- cauda equina syndrome
- exclusion
- investigation
- NCAS

**Support doctor**

- Bank holiday cover
- Teamworking
- Inexperienced staff
- Delayed recognition
- Poor communication
- Out-of-hours MRI
- Questionable practice
MASTERCLASS 5:
Supporting International Medical Graduate & Refugee Doctors

**Mr Richard Jones**  
Cognitive Behaviour Therapist Specialist Nurse and an Independent Prescriber  
NHS Practitioner Health Programme  
[richard.jones@nhs.net](mailto:richard.jones@nhs.net)

Richard is the Clinical Director of the Practitioner Health Programme and the new General Practitioner Health Service. He is an RMN, and independent prescriber and a cognitive behaviour therapist working exclusively in the field of practitioner health.

**Abstract**  
Richard’s session will briefly present some PHP/GPH figures on IMG and refugee doctors, and then open a discussion around improving access to treatment and support for this often overlooked group.
MASTERCLASS 6:
Workshop for doctors in training grades and those supporting them

Dr Elinor Hynes MBBS MRCPsych
Psychiatrist and Clinician
NHS Practitioner Programme
elinor.hynes@nhs.net

Elinor did her undergraduate training at University College London and her Core Psychiatric training with the South London and Maudsley NHS Foundation Trust.

Elinor has been working in a combination of in-patient and community drug and alcohol services for the last year and a half. She has a particular interest in group psychotherapy and runs a weekly drop-in doctors group on a Thursday at PHP. She is also working with the Dragon Cafe in Borough, a mental health service user organisation who have started a project, Recreate Psychiatry which explores bringing creativity into psychiatry and the therapeutic relationship.

Currently she is also studying for her MA in Psychosocial studies at Birkbeck.
Claire has been a GP at PHP since 2011 and provides initial assessments, follow up appointments and cognitive behavioural therapy (CBT) interventions. Claire qualified from University College and Middlesex School of Medicine in 1989. After GP training in Portsmouth she then became a GP partner in Muswell Hill, North London for 7 years. She then lived abroad for 18 months and did CBT training and a Diploma of Occupational Medicine (via University of Manchester).

From 2005-2016 she combined GP work with working in a Regional Eating Disorders Unit providing CBT for people with Primary Eating Disorders and for the last 7 years she was the Clinical Lead for psychological assessments for Homerton Bariatric Service. In 2012 she completed a Diploma of CBT at Royal Holloway University of London.

Abstract

This workshop will be space to discuss the issues faced by doctors in training.

Attendees and facilitators will collaboratively explore common challenges and the strategies people find helpful to cope with them. We will be focusing on 2 areas, what the individual can do for themselves and the importance of team relationships.
Dr Elizabeth Cotton is a writer and educator working in the field of mental health at work. She teaches and writes academically at Middlesex University about employment relations, precarious work, business and management, solidarity and team working and has worked as a psychotherapist in the NHS. Elizabeth worked as an organiser and educator for the Miners’ International and has worked with activists from 35 developing and transition economies. In 2012 she set up www.survivingwork.org to offer support to working people and in 2016 set up an online resource specifically for healthcare workers with the Tavistock & Portman NHS Trust for healthcare workers www.survivingworkinhealth.org. Her current book Surviving Work: Helpful stuff for people on the frontline is published by Taylor & Francis/Routledge in March 2017.

Surviving Work in Healthcare
www.survivingworkinhealth.org

This session will look at the experience of healthcare workers in managing working life in the context of crisis and change. Taking the experience of different professional groups and organisations, Dr Elizabeth Cotton will make a proposal about the politics, processes and practices that health workers are able to use to survive work and to deliver care. This proposal rests on walking the line between coping and hoping, setting and holding the ethical battle lines and building relations with the people around us. This session does not offer any magic solutions to the systemic failings in healthcare, but it does offer the experience of the people who are really surviving working in healthcare.
Mindful Medics Programme with Mindfulness Techniques

Reena Koetcha
Medical Director & Mindfulness Meditation/Pranayama
Mindful Medics
Reenarocks@gmail.com

Reena is a medical physician trained at Imperial College London. After spending the early part of her career in the NHS as a hospital doctor, Reena expanded her practice to focus on evidence-based approaches that enhance productivity and resilience at work as well as improve the health and wellbeing of the individual. Following on from this she developed the ‘Mindful Medics’ programme; an eight-week course designed to improve the health and wellbeing of healthcare professionals. Reena also works in corporate education and organisation consulting capacities. She is European Lead for Wisdom Labs; a leading global provider of evidence-based wellbeing solutions in the workplace.

Abstract
Stress accounts for a significant proportion of work related ill health cases and working days lost in the NHS. There’s an inherent irony or paradox that here is a sector that’s charged with promoting the health and wellbeing of the population but is damaging the health and wellbeing of staff in the process ¹. Staff ill-health and related absence is linked to an increased risk of unsafe care, worse experiences of care for patients and poorer outcomes ². It can be difficult to strike a work life balance in this current climate. Having experienced the positive mental and physical effects of mindfulness meditation and related personal development enhancing practices first hand, Dr Kotecha has developed ‘Mindful Medics’; a programme designed to improve the health and wellbeing of all healthcare professionals.
The programme is currently being offered to a group at Milton Keynes University Hospital NHS Trust. The feedback is promising, and here are the thoughts of a current healthcare professional undergoing the course:

‘I am so grateful to Reena and the NHS for affording me the opportunity to attend this course, it has been informative and enjoyable. The topics discussed have motivated me to think differently. I have practiced the tasks shown to me and can honestly say they have helped lift my mood and change my outlook, making me start to enjoy life again...I would say that this is a new way of thinking, and some people will not take to it, however I would urge anyone and everyone to give it a try... If this course is available to other colleagues, I feel it would have a huge benefit on their health and wellbeing, and potentially reduce sickness levels. This would then impact positively on the NHS as a whole’.

1)Michael West (Head of Thought Leadership, The King’s Fund)
2) Boorman, 2009
Mindful Medics

A programme designed to improve health and wellbeing of healthcare professionals.

mindfulmedics@outlook.com

The current climate: All Sectors

- 37% of all work related ill health cases
- 45% of all working days lost due to ill health
Staff ill-health and related absence is linked to an increased **risk of unsafe care, worse experiences** of care for patients and **poorer outcomes** (Boorman, 2009)

“Oh the Irony...”

“There’s an inherent irony or paradox that here is a sector that’s **charged with promoting the health and wellbeing of the population** but is **damaging the health and wellbeing of staff** in the process,”

Michael West (Head of Thought Leadership, The King’s Fund)
‘PAID’ Reality

Attention Economy

‘Understanding and managing attention is now the single most important determinant of business success’ – Accenture Institute of Strategic Change
Mindfulness

“paying attention in a particular way; on purpose, in the present moment, and non judgmentally” Jon Kabat-Zinn

• Focused Attention
• Open Monitoring
• Formal vs Informal Practice
It is fascinating to see the brain’s plasticity and that, by practicing meditation, we can play an active role in changing the brain and can increase our well-being and quality of life...

- Dr Britta Holzel, researcher, Harvard Medical School
Mindfulness All Party Parliamentary Group

‘Government departments should encourage the development of mindfulness programmes for staff in the public sector – in particular in health, education and criminal justice - to combat stress and improve organisational effectiveness’

(Mindful Nation UK Report 2015)

Importance of prioritising staff health and wellbeing

NHS organisations which prioritise staff health and well being:

- achieve enhanced performance
- improve patient care
- are better at retaining staff
- have lower rates of sickness absence

(DoH Boorman Review 2009)
The Mindful Medics Course

- An 8 week programme incorporating:
  - Mindfulness Meditation
  - Cognitive Circuit Training
  - Techniques to improve Positive Index
  - The Happiness Advantage
  - Gratitude and Compassion Exercises
  - Growth Mindset Development
  - Resilience Enhancement Tools

What your colleague says...

- I am so grateful to Reena and the NHS for affording me the opportunity to attend this course, it has been informative and enjoyable. The topics discussed have motivated me to think differently. I have practiced the tasks shown to me and can honestly say they have helped lift my mood and change my outlook, making me start to enjoy life again... I would say that this is a new way of thinking, and some people will not take to it, however I would urge anyone and everyone to give it a try... If this course is available to other colleagues, I feel it would have a huge benefit on their health and wellbeing, and potentially reduce sickness levels. This would then impact positively on the NHS as a whole.
Panel Discussion:
What is the Future for Physician Health?

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