

Care Under Pressure

A realist review of interventions to tackle doctors' mental ill-health and its impacts on the clinical workforce & patient care

 [@care_under](https://twitter.com/care_under)



Disclaimer

The project is ongoing. The findings presented are a work in progress

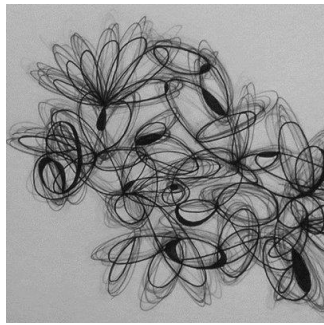
This research was funded by the NIHR Health Services and Delivery Research (HS&DR) Programme (project number 16/53/12)

The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care

Relevance

- ‘Astonishingly high levels’ of stress and burnout in HCPs – **‘public health problem’** (Limb 2015)
- Recruitment, absenteeism, presentism, retention issues
- Potential for impaired HCPs to cause harm to patients
- Financial implications of HCPs ill health
- Tendency to focus on workplace interventions aimed at increasing HCPs’ **‘productivity’** and **‘resilience’**, placing responsibility with individual HCPs. This can potentially **aggravate** the pressures

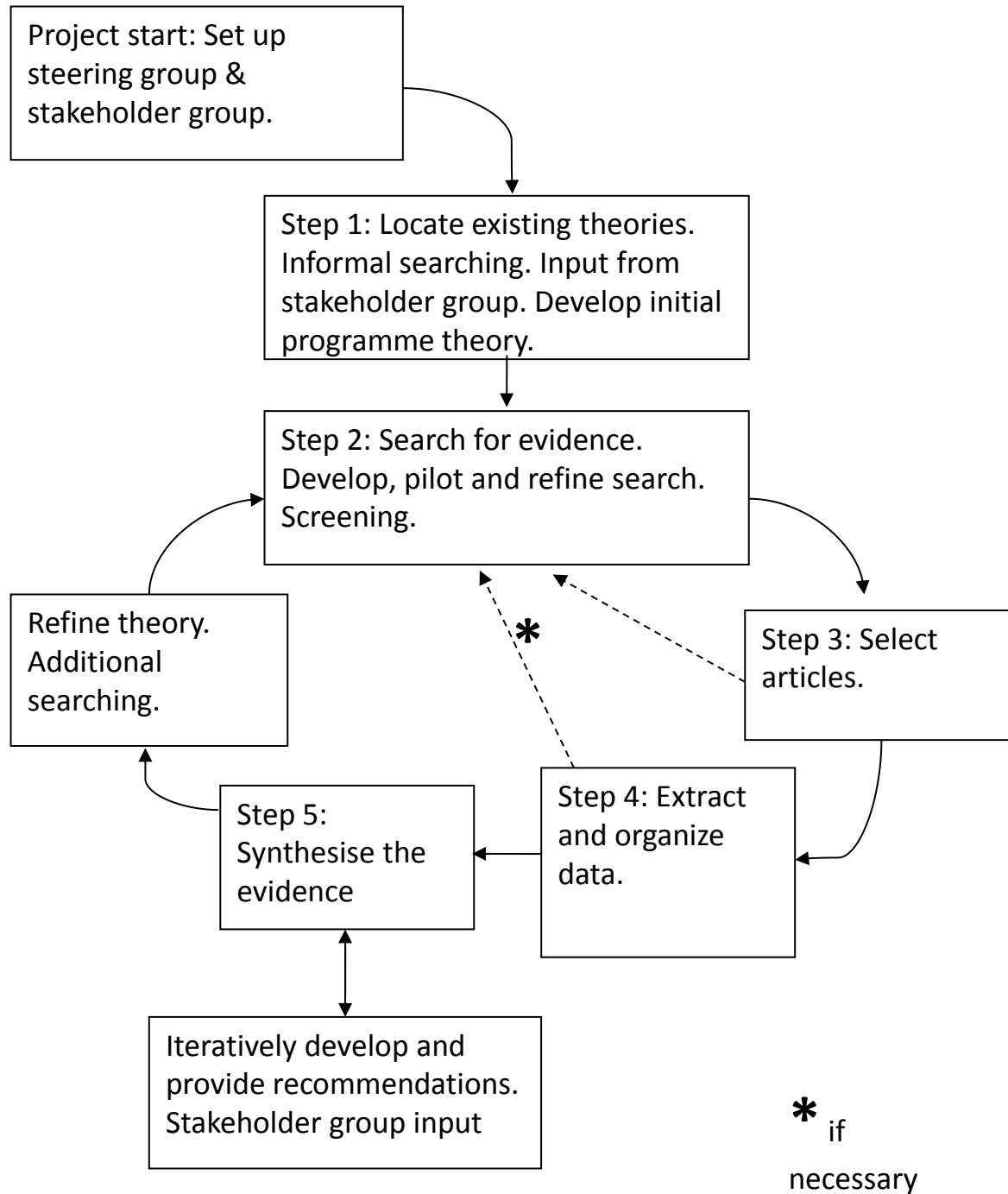
“The failure to implement a comprehensive long-term strategy to secure **appropriately skilled, well-trained and committed workforce** that the health and care system will need is, **the biggest internal threat to the sustainability of the NHS**” (Lord Select Committee 2017, my emphasis)

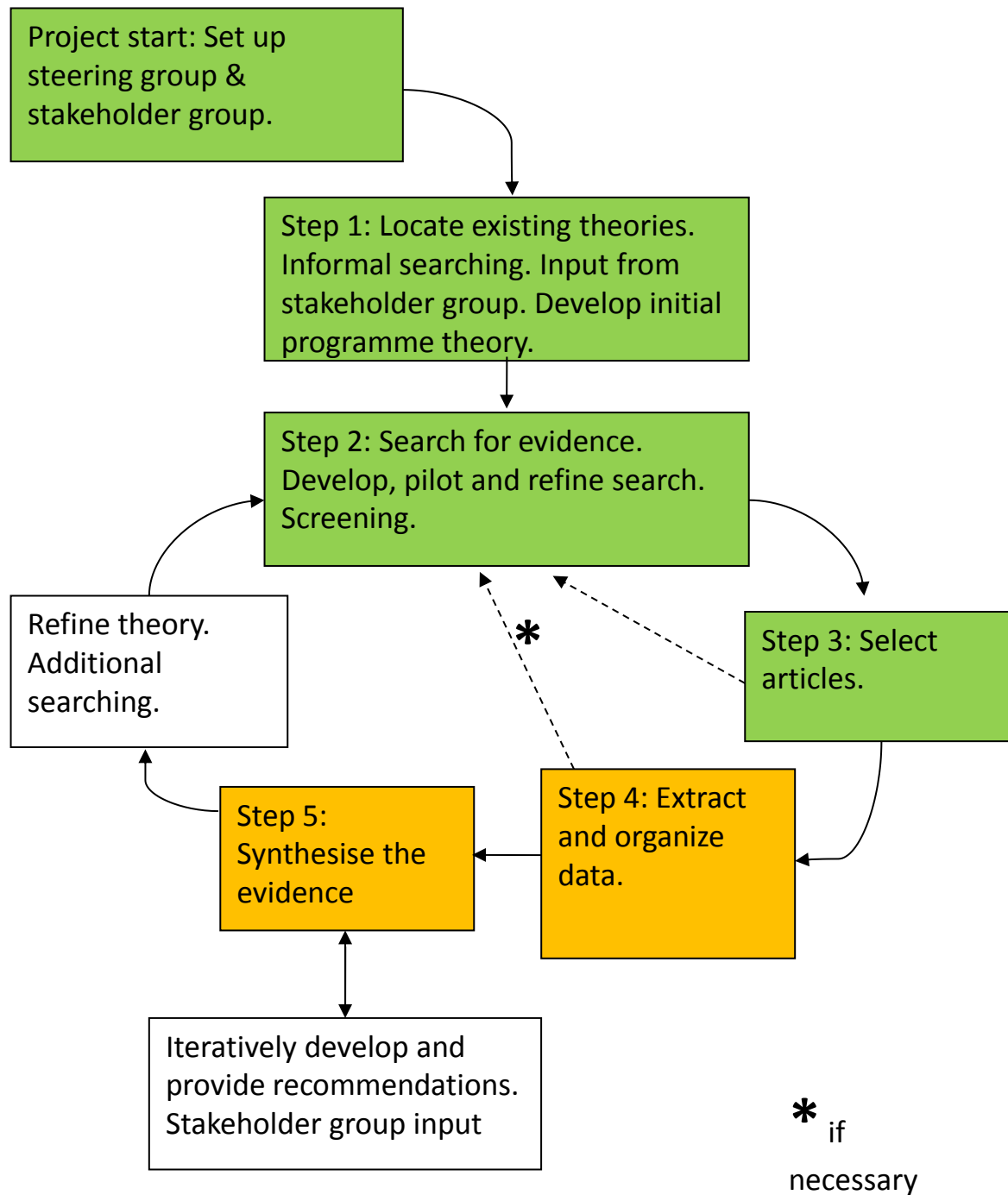


Our Realist Review (doctors)

To improve our understanding of how, why and in what contexts mental health services and support interventions can be designed, to minimise the negative impacts of providing care on doctors' mental ill-health.

1. What are the *processes* by which mental ill-health develops, and where are the gaps not addressed by interventions currently?
2. What are the *mechanisms* by which interventions result in their intended **outcomes**?
3. What are **the contexts** which determine whether different mechanisms produce intended outcomes?
4. What *changes* are needed to existing and/or future interventions to make them more effective?





BMJ Open 'Care Under Pressure': a realist review of interventions to tackle doctors' mental ill-health and its impacts on the clinical workforce and patient care

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Summary of included studies to date (work in progress)

- N=183 empirical studies, conceptual pieces, policy documents, all relating to interventions
- Mostly since 2010 and from the USA
- Mostly 'doctors/physicians' rather than specialty-specific (general practice; oncology; and medical students++).
- Prevention +++, treatment ++, screening +

Levels of intervention

Individual (n=+) e.g. mindfulness, CBT, therapy, training

Structural (n=++) e.g. rotas, support, processes

Mixed (n=+++) e.g. individual but explicitly endorsed and embedded

An exemplar draft CMOC (work in progress)

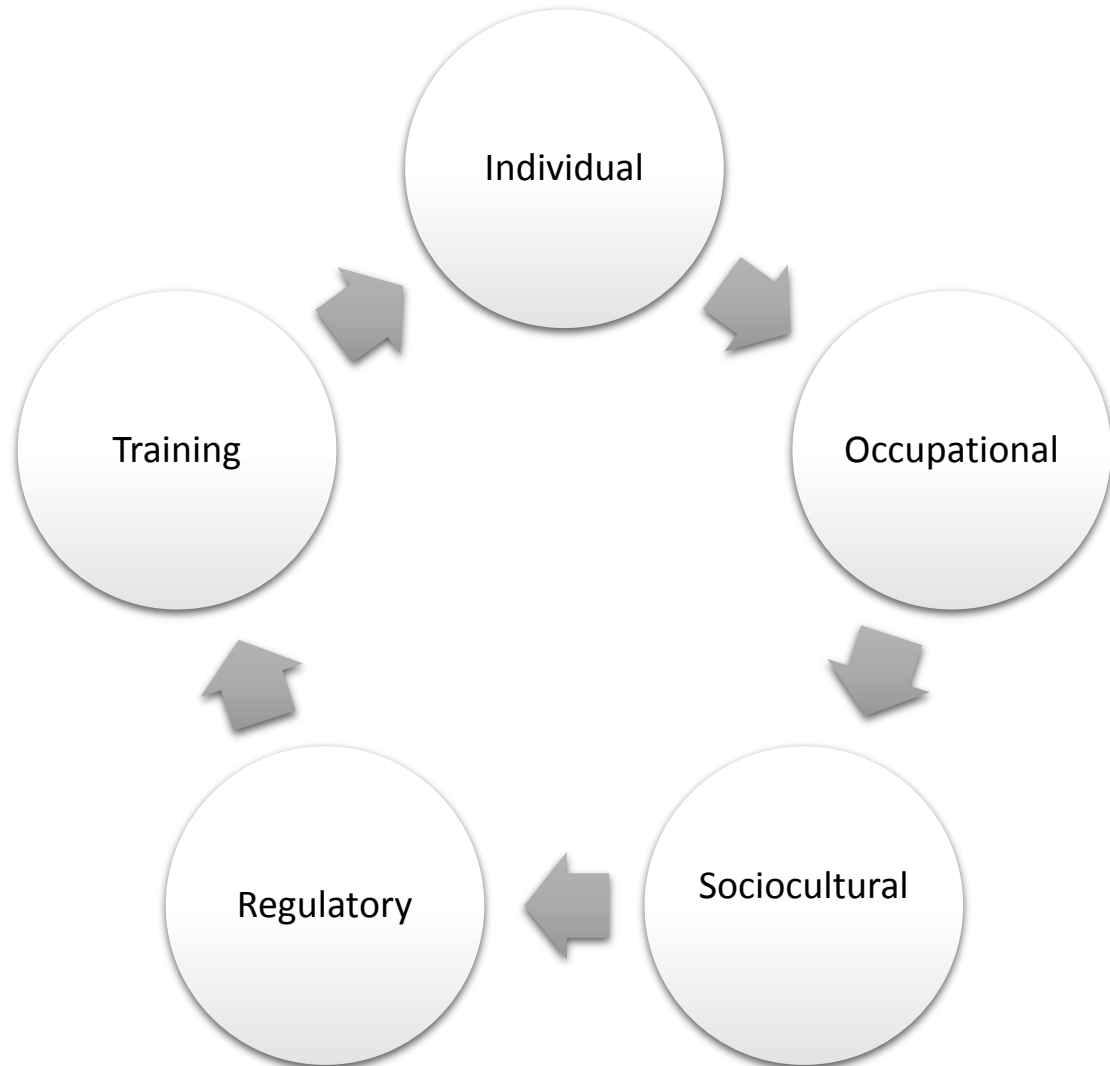


In a context where working time is reduced and teams may be more fragmented (*context*), doctors and trainees feel more disconnected from the profession of medicine, from their peers and from patients (*mechanism*), leading to isolation and unhappiness with work, which may lead to outcomes associated with mental ill-health (e.g. presenteeism, absenteeism, and loss from the profession) (*outcome*).

Implications

- Aim to prioritise connection (with colleagues, patients etc.) to build a sense of belonging within teams, programmes, organisations, professions.
- Aim to focus less on the competition between work and life, and more on making work a functional and enjoyable part of doctors' lives.

Complexity: it's not what you do...



- Each dimension is complex.
- Diverse Drs (career stages, professional context).
- Need prevention, support and treatment, tailored to context and needs of different groups.
- Evidence syntheses cannot usually take this into account.
- Our findings suggest that HOW we convey interventions is critically important.

Dissemination plan: outputs and impact

- **Academic forms.** (NIHR report, publications, conference presentations)
- **More innovative forms.** Animations and/or information graphics that might be distributed more widely (e.g. for notice boards on wards, inductions, teaching sessions) to raise awareness and normalise mental health issues
- **Measures/indicators.** Use of the Evidence Integration Triangle to inform our interpretation/dissemination strategy. It would be offered in existing systems to monitor and evaluate the impact of changes made based on our research findings
- **Plain English summaries tailored to different audiences** (e.g. doctors, patients, health service managers, medical educators, policy makers) to increase their recognition and understanding of the issue and how evidence can inform actions they can take

Thank you for listening

PROSPERO registration number: [CRD42017069870](https://doi.org/10.1136/2017/069870).

Webpage: <http://clahrc-peninsula.nihr.ac.uk/research/care-under-pressure>

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<input type="radio"/> Clear coherent roles responsibility clinical pathway		36	90
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<input type="radio"/> individual level		29	61
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Search

Initial Inclusion criteria

- Mental ill-health and its impacts (e.g. presenteeism, absenteeism, workforce retention) – all studies that focused on one or more of these aspects. Note, generic occupational health services targeting whole populations of doctors, rather than doctors suffering mental ill-health, would not be included.
- Study design – all study designs.
- Types of settings – all healthcare settings.
- Types of participants – all studies that included medical doctors.
- Types of intervention – interventions or resources that focus on improving mental ill-health and minimizing its impacts.
- Outcome measures – all mental health outcomes and measures relevant to its impacts (e.g. absenteeism, presenteeism, retention).

Figure 1

