



NHS PRACTITIONER HEALTH PROGRAMME

REPORT ON THE FIRST YEAR OF OPERATION

PRACTITIONER HEALTH PROGRAMME (PHP):
JANUARY 2010

PREPARED BY THE PRACTITIONER HEALTH PROGRAMME AND
THE LONDON SPECIALISED COMMISSIONING GROUP

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1 Executive summary

1.1 Headlines at 12 months

Figure 1: Headlines at 12 months

General		
<ul style="list-style-type: none"> • 184 practitioner-patients seen in the service • 53% men, 47% women • 91% doctors, 8% dentists, two other health professionals • Age range 24 – 65 years, more younger women and older men 		
Employment		
<ul style="list-style-type: none"> • 77% of practitioner-patients remained in or returned to work after contact with the service • 36/78 (46%) patients, who were not working whilst attending PHP, have returned to work • At presentation 107/184 (57%) working, 72/184 (39%) not working, five no information • 33% at presentation involved in some form of regulatory or disciplinary process 		
Problems seen – primary diagnosis		
<ul style="list-style-type: none"> • 114 (62%) presented with mental health problems • 67 (36%) presented with addiction problems • 3 (2%) presented with physical health problems alone, overall a total of 17 patients had some form of physical health problem 		
Mental health	Addiction	Physical health
<ul style="list-style-type: none"> • Depression 33/114 (29%) • Anxiety and depression 13/114 (11%) • Anxiety 24/114 (21%) • Undiagnosed psychosis 6/114 (5%) • Other 38 (34%), e.g. eating disorder, OCD, ADHD 	<ul style="list-style-type: none"> • Alcohol problems/dependence 51/67 (77%) • 27/51 men, 24/51 women • Substance misuse 16/67 (23%), including ketamine, heroin, cocaine, amphetamine, cannabis • 11/16 men 5/16 women 	<ul style="list-style-type: none"> • 17 patients: problems included cancer, deafness, MS, brain injury
Current snapshot of patients		
Mental health	Dependence on alcohol	Dependence on drugs
<ul style="list-style-type: none"> • 14/114 (12%) have needed inpatient treatment 	<ul style="list-style-type: none"> • 42/51 (82%) abstinent at current time and attending PHP regularly • Two patients currently in second stage rehab • 5/51 currently drinking • 4/51 lost to follow up 	<ul style="list-style-type: none"> • 14/16 (88%) abstinent as at 30 September 2009 • Two patients with multiple addictions are now abstinent • Two patients prescribed opiate substitute medication • 2/16 lost to follow up

1.2 Outcomes

We are able to report favourable outcomes with respect to:

- improvement in mental health and social functioning
- numbers returning to work or training
- reduction in potential risk to patients and the public
- regulatory involvement; for example, amendments to GMC/GDC conditions.

1.2.1 Health status of patients

Outcome measures, using validated questionnaires pre and post treatment, are being kept on all patients. Early analysis indicates good and sustained improvements in all domains being measured.

1.2.2 Reduction in risk to practitioner-patients and their patients

- Six patients advised to contact GMC/GDC
- Five patients removed themselves from the workplace on advice from PHP
- Three significant events analysed and resolved by the PHP team with learning shared as appropriate
- As of 30 September 2009, 24/174 patients were classified as high risk (red), 49/174 as medium risk, (amber) and 101/174 as low risk (green) (see Chapter 5 for explanation of risk assessment). The remaining 10 patients were discharged.

1.2.3 Positive outcomes in relation to the regulators and other disciplinary or legal processes

Patient involvement with PHP has been influential with the regulators and the legal system. For example, a patient who entered PHP through self-referral was given undertakings by the regulator, rather than conditions or suspension, as a direct result of their involvement with PHP. The regulator saw their engagement with the service as evidence of insight into their condition and commitment to treatment. In three cases, judges made reference to PHP support prior to handing out non-custodial sentences to practitioners who were attending PHP for treatment.

1.3 Commissioning highlights

1.3.1 Performance against contract

The London Specialised Commissioning Group (see Chapters 2 and 8) is content that PHP1 is performing well against contract. The number of contacts made with the service was lower than the number originally predicted, but the conversion of contacts to patients needing treatment was much higher than the service specification outlined. Furthermore the patients being treated tended to have multiple problems and were more complex than was expected.

The service remains within budget and meets its performance indicators. An annual review of the contract will aim to refresh and revise the performance indicators in the light of the experience gained during the first year of operation.

The PHP2 budget is under-spent. Approximately half the allocated budget for outpatient and inpatient care was spent in the first year. The spend per month has increased over time so the under-spend for the second year may not be so high. Due to the increasing complexity of presentation of PHP patients it may not be appropriate to use the first year baseline as the basis for subsequent funding.

Any under-spend will be used to extend the provision of the service beyond August 2010. It is hoped that the service will be able to continue until December of 2010 at least. New sources of funding are actively being sought at the time of writing this report.

1.4 Patient satisfaction

The improvement and satisfaction rates of the practitioner–patients receiving care are consistently high and increase over time the longer the patients are involved with the service.

2 Introduction

2.1 Report outline

This report has been prepared to give an overview of the first full year of the PHP service and provides a review of the service's activity, patient profiles, patient satisfaction and commissioning data. It also includes a review of activity that took place in September 2008 although PHP was not operational for the whole of that month. It is prepared by PHP and the London Specialised Commissioning Group (LSCG) for the Department of Health, London stakeholders and others interested in the progress of PHP.

The chapters in this report cover the following areas:

- a description of the service
- the volume of services provided
- the profiles of practitioner-patients in terms of demography, professional category etc
- service profiles in terms of morbidity and treatment
- the health status of patients
- patient satisfaction
- service costs
- the way forward.

2.2 Why do doctors and dentists need a specialist service?

The CMO report on medical regulation *Good doctors, safer patients* (2006) was the starting point for the development of PHP. Doctors and dentists (practitioners) can face a number of barriers when dealing with health difficulties, particularly mental health and addiction problems. For example:

- the insight of sick practitioners into their condition and the impact that it has upon their performance may be severely compromised
- illness in practitioners may be poorly managed and appropriate assistance may not be sought for a variety of reasons
- practitioners may be able to disguise their illness from others (perhaps through self-prescription)
- where illness is recognised to adversely affect performance, there may be a reluctance to refer a practitioner into a system that is perceived as "disciplinary", particularly where there is a lack of knowledge as to alternatives
- an excessively stressful work environment may have a significant impact on a practitioner's health and wellbeing.

In addition, practitioners may not access mainstream services for a variety of reasons, including an unwillingness to admit to illness, concerns about confidentiality, opportunities for self-medication and inappropriate treatment when they do access services (National Clinical Assessment Service (NCAS), 2007). Studies show high rates of depression, anxiety and substance misuse in healthcare professionals, especially doctors. Suicide is higher in doctors and dentists than in the general population (Harvey et al., 2009).

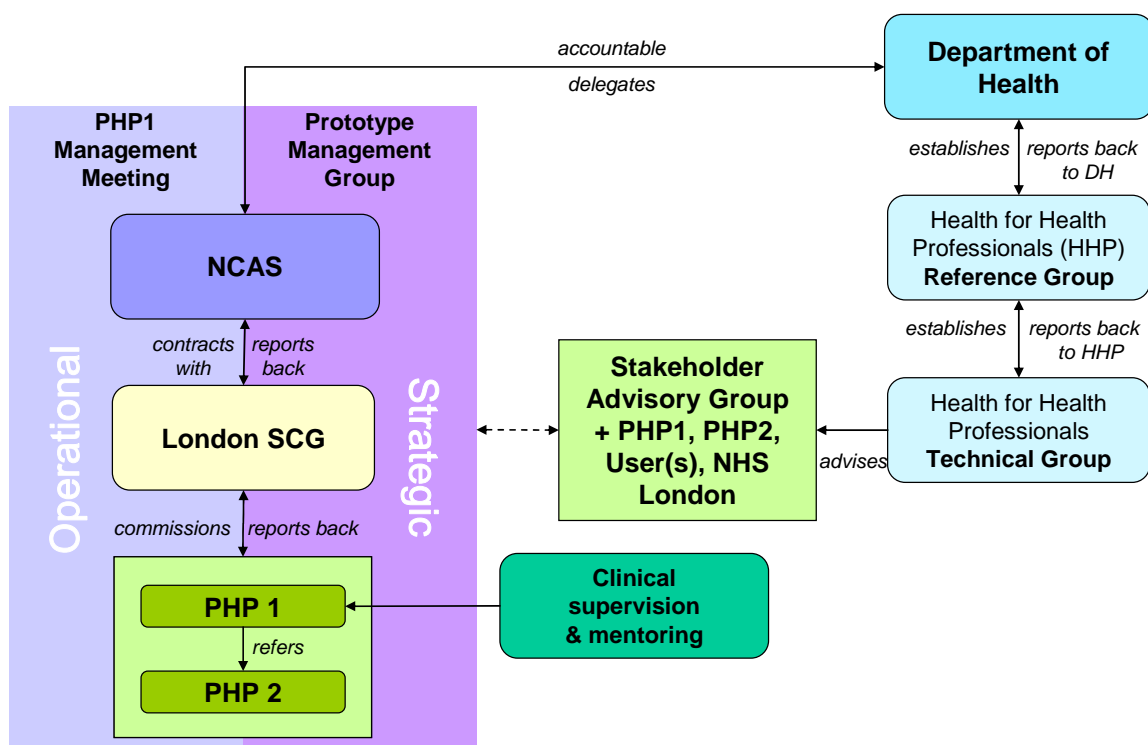
2.3 Commissioning and governance

NCAS worked with LSCG to commission the PHP1 service, selecting the Hurley Group from ten bids. The tender process was extensively publicised in trade press, by email and through one-

to-one meetings with key stakeholders. A competitive process identified the PHP2 specialist providers, who provide mental health and/or addiction services. PHP1 arranges for the specialist assessment and treatment of other health conditions on an individual basis.

PHP1 reports on the programme (though specifically not providing any identifiable patient information) through the Prototype Management Group chaired by NCAS to the Department of Health, and reports to the LSCG for contractual matters. A stakeholder advisory group provides expert advice on the development of the PHP to ensure that the service meets the requirements of key stakeholders including regulators, professional bodies, potential users of the service, the public and the Department of Health. The Prototype Management Group meets monthly to discuss progress, risk and future developments. This group includes representatives of PHP1, LSCG and the Department of Health, and has access to independent clinical advisors. Other contributions are sought according to need.

Figure 2: Commissioning/governance arrangements for the Practitioner Health Programme



2.4 PHP London prototype – features of the service

2.4.1 Overview

PHP provides healthcare services to around 30,000 doctors and dentists living or working in the London area with a mental health or addiction problem at any level of severity, or a physical health problem which may impact on performance. The service encourages effective use of occupational health, local primary care and other specialist services where these are available. It is designed to complement existing services and can be used as a specialist resource for clinicians treating doctors and dentists outside PHP, including occupational health physicians.

2.4.2 Accessing PHP

Practitioners with health concerns can contact the service directly for advice or for consultation and treatment. Patients are offered an appointment within two working days.

The PHP also provides advice to health care organisations employing or contracting with doctors and dentists, to Deaneries and Royal Colleges, also to colleagues, family and friends of practitioners with health problems. Employers or occupational health departments may make referrals with the knowledge and consent of the doctor or dentist concerned.

2.4.3 Confidentiality

Providing appropriate assurance to practitioners about confidentiality is key. Practitioners accessing the service ("practitioner-patients") can expect the same, or higher level of confidentiality as other patients accessing health services. Disclosure of information to another body will only be made in those rare circumstances where there is a serious concern about the safety of the practitioner-patient, their patients or the public, or where there is concern about criminal activity. The prototype service has benefited from a designated GMC contact through the London GMC Affiliate pilot to talk, in principle, about health cases where there may be fitness to practise issues. The PHP has memoranda of understanding with the GMC and GDC and these, along with its confidentiality policy, are posted on its website.

2.5 How the programme was developed

The Royal College of Psychiatrists and the London Deanery formed an expert working group assisted by NCAS to develop proposals for a Practitioner Health Programme during 2006 – 07. This was in response to CMO's 2006 report. Following the white Paper, *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century* published in February 2007, the Department of Health tasked NCAS with overseeing the commissioning and implementation of a prototype PHP.

2.6 Evaluation

A comprehensive programme of evaluation is measuring:

- patterns of use – self-referrals and referrals, demographics of those accessing the service and the range of health problems. The programme is using a dataset which should enable some comparison with physician health programmes in other countries
- service user satisfaction – seeking the views of users with regard to how far the service has met their needs and how it can be improved
- practitioner-patient outcomes – assessing impact and outcomes. This involves, for example, collection of information about health status through questionnaires at onset of treatment and intervals during treatment and follow-up. The possibility of some economic evaluation is being considered.

This first year evaluation report summarises the findings to date and will feed into the Health for Health Professionals work stream of the White Paper on reform of professional regulation, *Trust, Assurance and Safety*. It will inform decisions about possible extension of the service.

2.7 Funding and extension

Funding has been provided by the Department of Health for a two year London prototype service, for both PHP1 and PHP2. Funding officially ceases in August 2010, although savings made during the two year pilot will be used to keep the service running for longer. Initial cost benefit analysis shows that treatment through PHP is both safer and cheaper than traditional ways of dealing with sick doctors and dentists – the latter often involves long periods of time off sick on full pay with associated management and locum costs for their organisation.

The specification for the service has been circulated to Scotland, Wales and Northern Ireland and if the programme is successful we hope it may be extended to other parts of England, to undergraduates and to other health professionals. We submitted a paper to the Chief Medical Officer setting out options for extension to other parts of England. These include an additional PHP hub service, with a network of suitably trained and experienced GPs and occupational physicians working across England, supported by and able to refer to PHP. The Chief Medical Officer has given us the go ahead to consider how the extension might work in practice.

2.8 References

NCAS (2007). Proposal for a Practitioner Health Programme.

Harvey, S. B., Laird, B., Henderson, M., Hotopf, M. (2009). The mental health of healthcare professionals: A review for the Department of Health.

3 The service

3.1 Introduction

The PHP service was originally envisaged as two distinct services that would work closely together – PHP1 a first contact service offering assessment and limited therapeutic intervention – and PHP2 a secondary care service offering specialist outpatient, inpatient and day care services.

Since start-up in September 2008, PHP1 has developed a shared care model of service delivery based on the two distinct tiers, but offering many of the PHP2 outreach within the primary care setting of Riverside Medical Centre alongside PHP1. This enables clinicians to work as a team together, provide seamless care for the patients and share learning and expertise.

3.2 A brief description of the integrated PHP service at Riverside Medical Centre

PHP is led by Dr Clare Gerada, a general practitioner with expertise in mental health and addiction. The service is embedded within a “normal” general practice, though has its own administrative, medical, nursing and management team, computer server and consulting areas.

PHP is confidential, except where the practitioner-patient poses a risk to themselves or to their patients. Then PHP will disclose to relevant third parties (see paragraph 2.4.3 for further details).

PHP provides an integrated approach to care, with primary, secondary and third sector practitioners working alongside each other, sharing electronic records, consulting rooms, and learning events. Once a week all team members meet to discuss new patients and review complex patients. This integrated multidisciplinary, multi-professional team meeting allows for sharing of information and treatment planning, with each member of the team complementing other team members’ skills to bring about the best outcome for the practitioner-patient.

PHP is not an occupational health service, but does liaise with occupational health. The service provides assessments with respect to work place and supports return to work planning and implementation. PHP receives a number of referrals from occupational physicians.

PHP aims to be as accessible as possible, offering appointments within two days of first contact. Patients are offered an appointment time that best meets their needs (from 7.30 am – 6.30 pm Monday to Friday and 9.00 am – 1.00 pm on Saturday), and with the health professional that best meets their condition (assessed during the first telephone triage contact). There is no waiting list to see a PHP practitioner.

PHP offers the following:

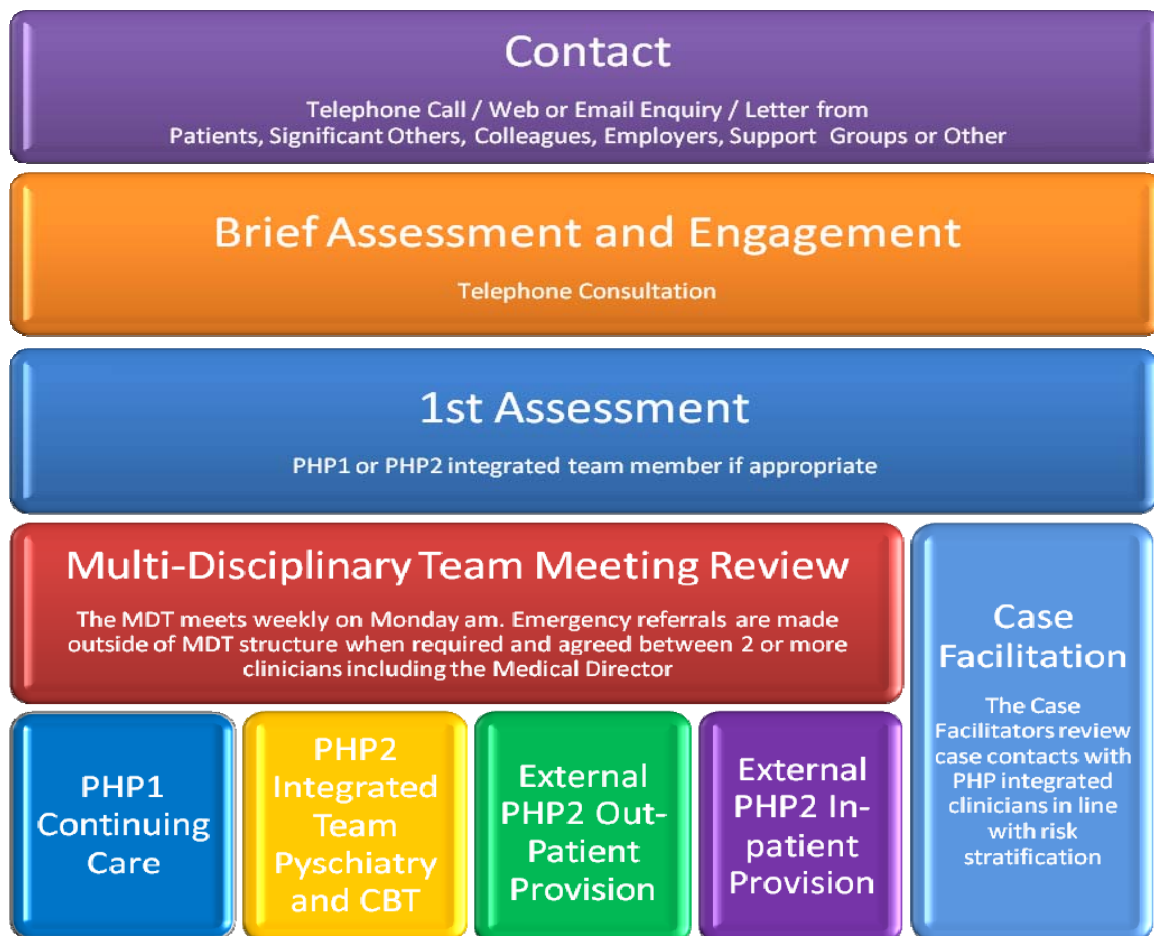
- first contact assessment, formulation and treatment planning
- multi-professional approach to care
- brief intervention, cognitive behaviour therapy, relapse prevention, psychodynamic psychotherapy, family therapy, couples-therapy, including NHS-Direct telephone Cognitive Behavioural Therapy (CBT)
- community based detoxification and access to inpatient alcohol detoxification
- substitute medication for opiate addiction
- therapeutic blood, urine and hair testing
- access to inpatient care
- access to inpatient rehabilitation
- massage and osteopathy

- work related CBT, with a focus on return to work strategies
- mentoring and specialist appraisal
- report writing
- case management
- contact with GMC / GDC supervisor
- support for attendance at GMC / GDC hearings
- attendance at employment tribunals or other work-related hearings
- direct liaison with defence organisations / Barristers / Solicitors / BMA representatives
- financial advice, via outreach from the Royal Medical Benevolent Fund.

3.3 PHP2

Patients may be referred from PHP1 to PHP2 services. PHP2 consists of specialist mental health and addiction services providing assessment and treatment for those who need outpatient, inpatient or rehabilitation care. These services are predominantly provided by South London and the Maudsley (SLAM) NHS Trust, the Tavistock and Portman NHS Trust, Catio Nightingale Hospital and Clouds House. Exceptions may be made when a practitioner-patient is already seeing a particular health professional or needs specialist treatment from a known expert or assessment and treatment for a physical health problem.

Figure 3: Movement through the PHP1/2 integrated service – first contact to treatment



4 How many patients have used the service?

4.1 Summary activity to the end of September 2009

A summary of the activity related to the service is shown in Table 1. Actual numbers are compared to the expected numbers outlined in the original service specification.

Table 1: Summary activity to the end of September 2009 – patient numbers

Service Provision (numbers of patients)	Actual	Expected
Initial contacts	338	510
Offered initial assessment	184	260
PHP1 in depth assessment	178	150
PHP2 outpatients including those within Integrated Team	136	80
PHP2 inpatient referrals	23	30
PHP1 ongoing treatment and case co-ordination as at the end of September 2009	153 (31 discharged)	50

338 individual contacts were made with the PHP1 service to end of September 2009 and 184 of these patients were offered initial assessments. These initial assessments resulted in:

- 178 practitioner-patients undergoing detailed assessment
- six patients not attending their first face-to-face appointment. These patients were offered follow up appointments and contacted a minimum of three times.

For the patients presenting in the first twelve¹ months, PHP1 was providing as at 30 September 2009 153 patients with ongoing treatment and case management / co-ordination – 31 patients were discharged. Of the 136 patients that were referred to PHP2, 23 attended as inpatients and 113 attended as outpatients. The 136 patients received their care through 256 PHP2 treatment episodes:

- 134 episodes were delivered at Riverside Medical Centre through the PHP2 staff working within the integrated team providing CBT and psychiatry, and
- 122 were delivered externally by PHP2 approved providers.

When the actual patient numbers are compared to the original service specification, it can be seen that:

- the number of initial contacts and initial assessments were lower than expected, but
- the level of care needed by patients has been higher than expected, resulting in more in-depth assessment and ongoing treatment than was originally envisaged.

4.2 Initial contacts

A total of 338 initial contacts were made with the PHP1 service from mid September 2008 to 30 September 2009.

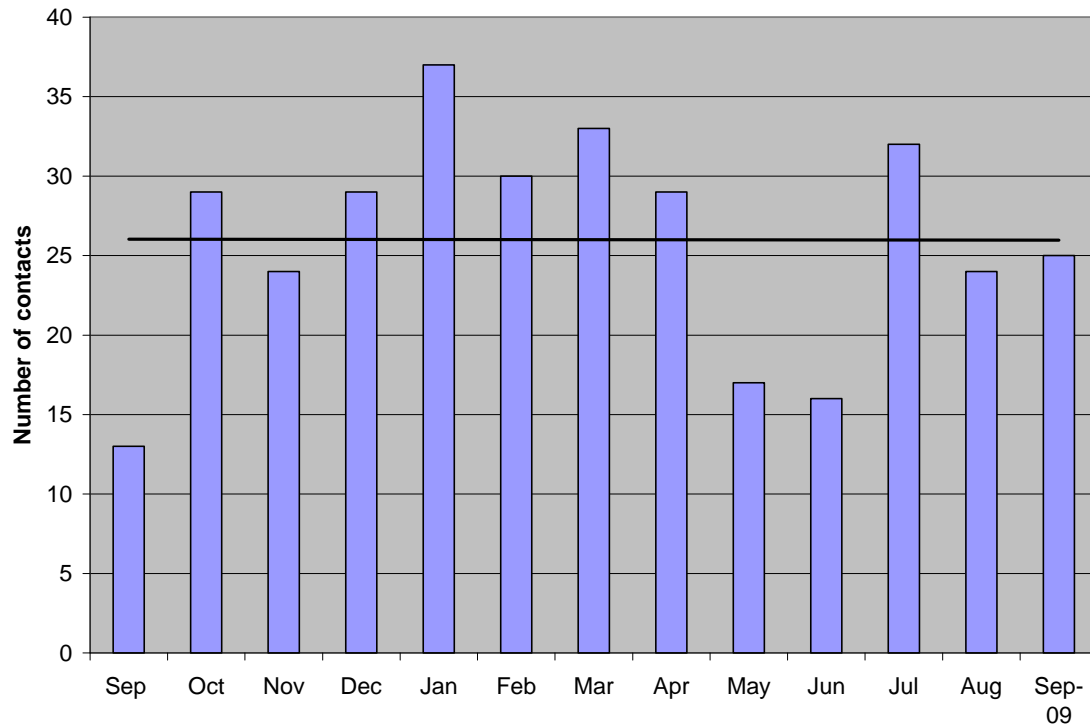
The monthly pattern of contacts is shown in Figure 4 below.

The graph shows that:

¹ In this report “twelve months” refers to the first full twelve months and the partial month of service in September 2008.

- the contacts for September 2008 were lower than other months as the service did not open its doors until half way through the month
- there was a marked increase in contacts in January. This had been anticipated due to recognised seasonal increases in mental health and addiction issues after Christmas and the New Year
- there was a dip in activity in the third quarter, April – June
- a linear trend line shows that the average number of contacts per month is 26.

Figure 4: Initial contacts made to the PHP1 service



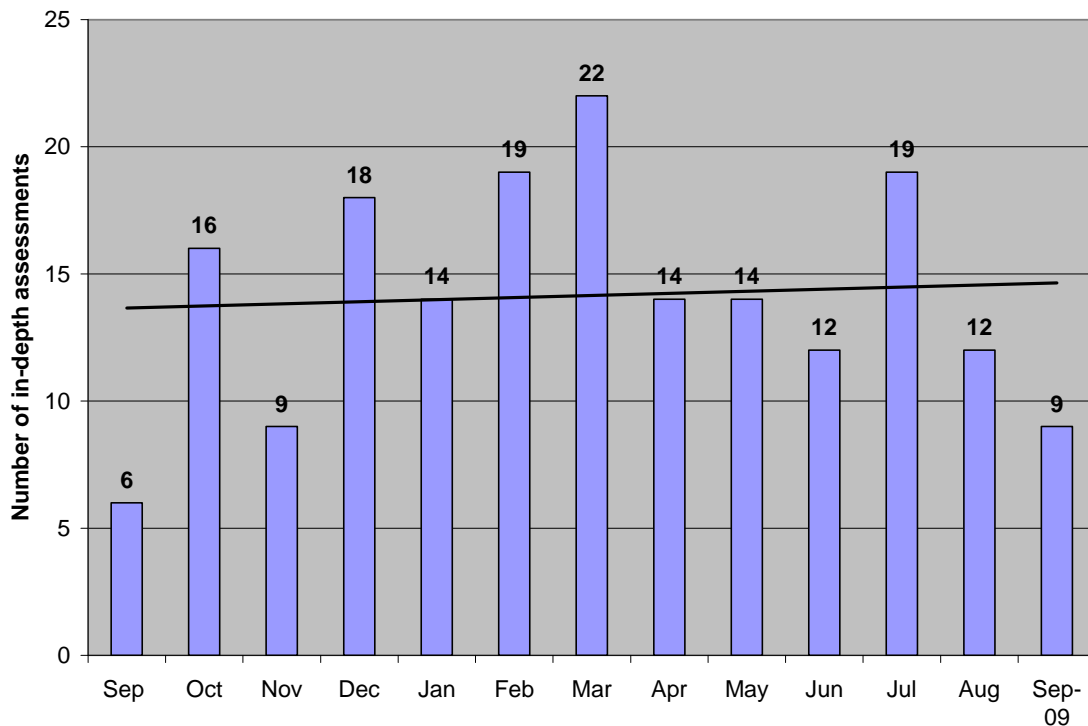
4.3 Initial assessments

After contacting the service 184 patients attended for initial assessments. The monthly pattern is shown in Figure 5.

The graph shows that:

- the number of assessments over the months is varied and has been as high as 22 and as low as six.
- a straight line trend (the black line) shows the average number of in-depth assessments is 14 per month although this number appears to be gradually rising.

Figure 5: initial assessments made by the PHP1 service



4.4 PHP2 referrals

PHP1 made 256 referrals to PHP2 services to the end of September 2009; the split between outpatient and inpatient, and episodes and individuals is shown in Table 2 below:

Table 2 shows that 136 patients have been referred to PHP2. These patients have been treated through 256 different treatment episodes – 219 outpatient referrals and 37 inpatient referrals. The average number of episodes of PHP2 treatment per patient is 1.9.

Table 2: Referrals to PHP2 – showing split between outpatient and inpatient

PHP2 referrals	Provision at 12 months
Outpatient referrals	219 (including 134 to the PHP integrated team and 85 to external PHP2 providers)
Inpatient referrals	37
Total (Episodes)	256
Total (Individuals)	136

Of the 256 treatment episodes:

- 134 referrals were to the integrated PHP2 team for CBT and psychiatry which operates from Riverside Medical Centre on site with PHP1
- 108 referrals were to preferred providers.

5 Patient and service profiles

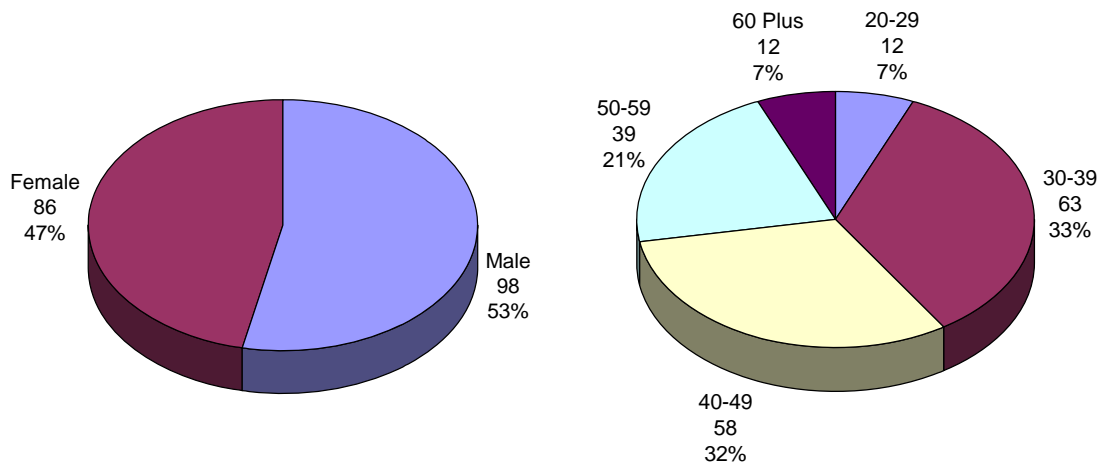
5.1 Demographics

5.1.1 Age and sex

The age and sex of PHP patients is shown in Figure 6. The graphs show that:

- more men have attended than women; the split is 53% : 47% – just over 40% of the London SHA medical and dental workforce are women, taking GP and Hospital and Community sectors and doctors and dentists together so this is not far from what might have been expected
- 7% are under 30, 33% fall into the 30 – 39 age bracket and 60% of patients are 40 or over – an age profile which approximately matches the medical and dental workforce in the London SHA area
- the service and associated awareness raising activities have reached a wide age range.

Figure 6: Age and sex distribution of patients attending for initial assessment

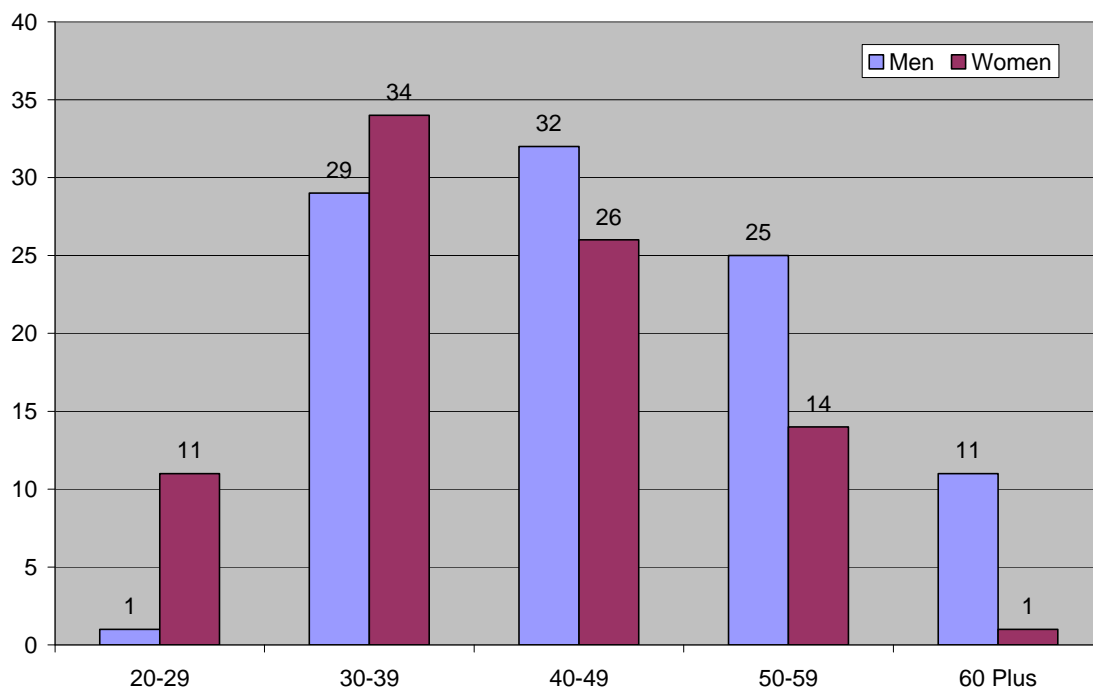


The age and sex distribution of the patients is broken down further in Figure 7.

This graph for male and female patients shows that:

- older men have accessed the service, with one third being over 50
- younger women appear to be more likely to access the service with 71 out of 86 being under 50. A significant number (11) of women aged 20 – 29 have been assessed whereas although more men access the service overall, the corresponding number of men in this age range is much lower at 1.

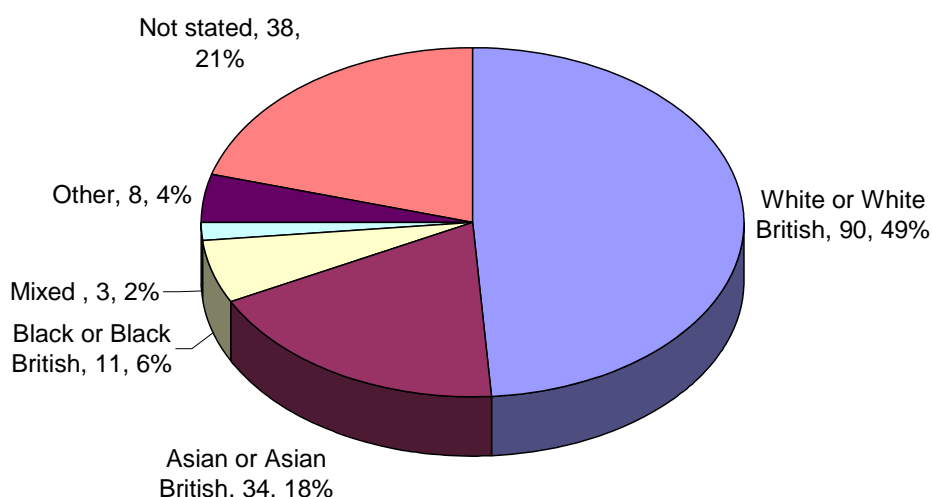
Figure 7: Age distribution shown separately for female and male patients



5.1.2 Ethnicity

The ethnicity for patients attending for initial assessments is shown in Figure 8. Since patient numbers are small the Office of National Statistics census categories for ethnicity have been grouped. The five groups shown in Figure 8 are those used by the NHS in classifying the Hospital and Community (though not yet GP) workforces. The graph shows that patients from a wide variety of ethnicities are attending the service. White or white British practitioners account for 62% of the 79% of patients with known ethnicity (146). Lack of GP comparator data rules out precise matching with the London workforce and data incompleteness means that these data should be treated with caution. But with white practitioners known to account for 54 – 60% of Hospital and Community doctors and dentists in England in 2008 (NHS Information Centre) PHP patients are probably reasonably representative of the London practitioner workforce.

Figure 8: Initial assessments: patient ethnicity



5.1.3 Ensuring PHP and its procedures support equality and diversity

PHP has seen a mix of referrals in the first twelve months of operation across ethnicity, gender and age.

As noted above, the ethnicity mix of PHP contacts is very varied with representation from all sectors. Comparison to London ethnicity data and evidence about the ethnicity of UK doctors shows that PHP is attracting patients for all ethnic backgrounds, and the patient split is in line with what might be expected. Similarly the gender mix is split fairly evenly between male and female. The age mix of PHP contacts appears to show a slightly higher distribution of younger woman and older men. The latter is representative of evidence related to performance concerns (NCAS, 2006). However, the younger woman category may also represent a positive finding of PHP accessibility and usage.

5.1.4 Geographical location

The PHP service is available to doctors and dentists who either live or work in the Greater London area. Figure 9 below shows the geographical spread of patients. The information is based on the postcode of the patient's registered address.

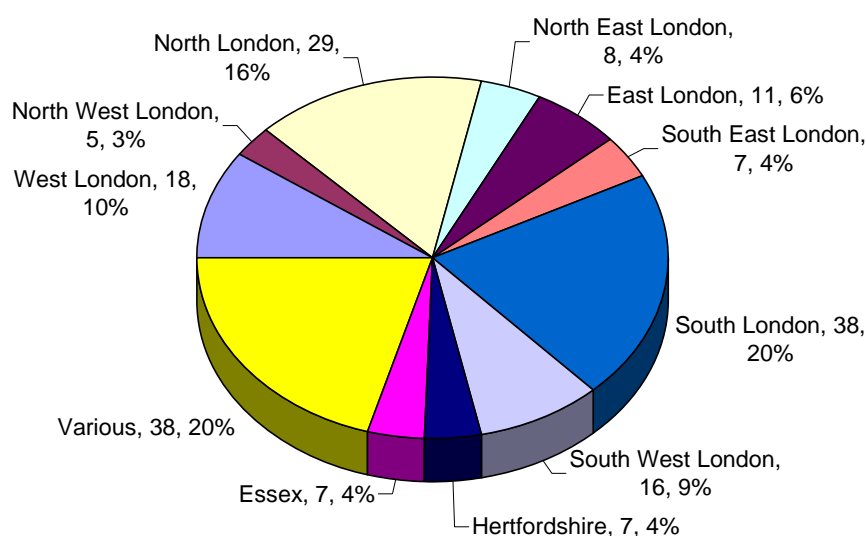
It can be seen that:

- 20% of patients do not live in London or did not disclose their address (various)
- the geographical distribution of patients providing a postcode is fairly evenly spread across London, with slightly higher numbers appearing to come from South and West London

Further analysis shows that:

- 27 of 31 London Boroughs have a practitioner-patient as a resident
- 28 of 31 London Boroughs have a practitioner-patient working within the borough.

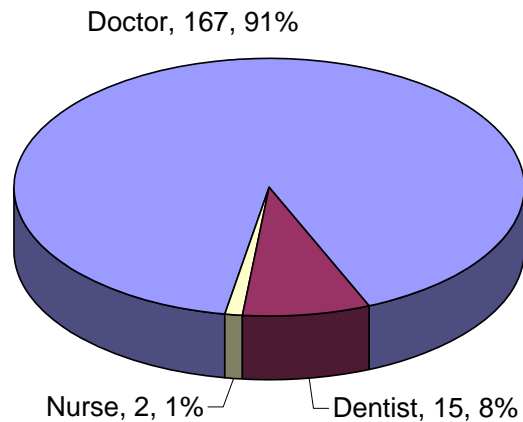
Figure 9: Location of practitioner-patients by postcode of registered address



5.1.5 Professional profile

To the end of September 2009, PHP1 undertook 184 initial assessments of doctors, dentists and nurses. The breakdown by profession is shown in Figure 10.

Figure 10: Initial assessment: professions seen



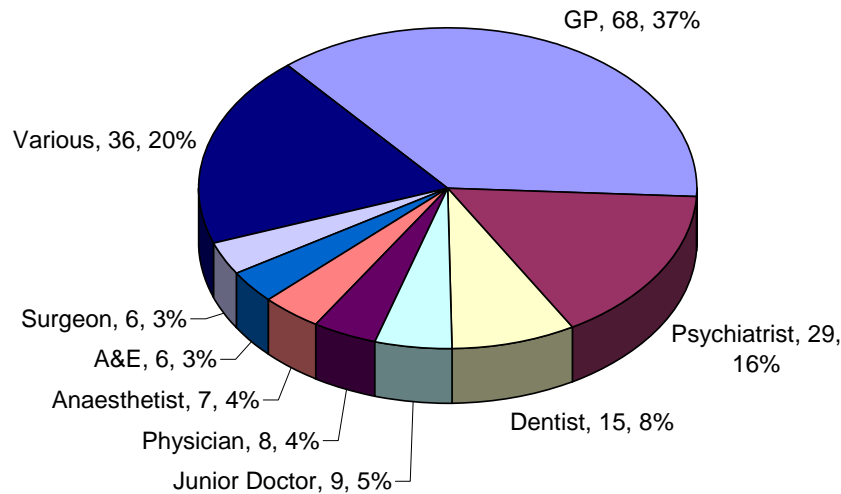
Doctors make up by the far the highest number of patients in line with expectations but make up more than their proportionate number of professionals working in London. Over the first year of operation the proportion of dentists has gradually fallen. During the first quarter of operation the number of dentists as a proportion of initial assessments stood at 17%; across the whole year this proportion has fallen to 8%. Additional awareness raising among dentists was initiated as a result of this drop in attendance rates. PHP1 agreed to see senior nurses on a strictly case-by-case basis as the service is not formally open to (and not set up to accommodate referrals from) this profession.

The patients attending for an initial assessment are split fairly evenly between primary and secondary care practitioners. To the end of September 2009 the professional split was:

- 37% GPs
- 8% dentists
- 30% secondary care practitioners
- 5% junior doctors
- 20% other (various, not shown for reasons of confidentiality).

A further breakdown showing key professional categories is shown in Figure 11.

Figure 11: Initial assessments: breakdown by professional category



NHS Information Centre statistics show that the London target population for doctors and dentists is around 30,000. Around one third of this population is made up of GPs and dentists; the other two thirds being Hospital and Community practitioners. Therefore the proportion of GPs and dentists attending PHP is greater than might be expected given the workforce population. This may suggest that Hospital and Community practitioners have better access to occupational health services.

In addition, it is interesting to note that over the first year:

- the proportion of GPs seems to have remained fairly constant at 37%
- the proportion of dentists and junior doctors fell over the year
- the other or various category rose to 11% of the assessments as opposed to 2% in the first quarter
- the proportion of psychiatrists was higher than any other secondary care professional category.

5.2 Morbidity and treatment

5.2.1 Presenting problem

Table 3: PHP1 presenting problems

Presenting problems	Total	% of total
Mental Health	114	62
Addiction	67	36
Physical Health	3	2
TOTAL	184	100

Table 3 shows the number of patients presenting with mental health, addiction or physical health problems. More than half PHP patients present with a mental health problem and 36% present with addiction problems. Please note that practitioner-patients may present with more than one category of problem. A further breakdown of the two main presenting problems is shown in Figure 12 below.

The results are based on the initial screening cohort of 184 patients where the relevant information was known.

Figure 12: A breakdown of mental health (left) and addiction diagnoses (right)

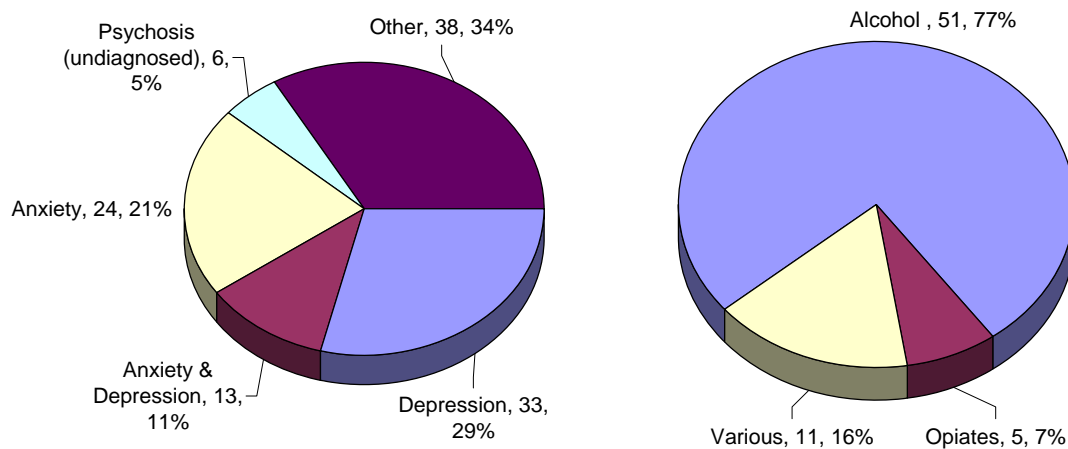


Figure 12 shows that:

- anxiety and depression account for 61% of all patients suffering mental health problems
- alcohol accounts for 77% of all addiction problems.

Under both diagnoses there are considerable percentages shown as 'Other' (34% of mental health diagnoses) or 'Various' (16% of addiction diagnoses). These diagnoses have been grouped together for purposes of anonymity. As patient numbers increase further disclosure of detail may become possible.

5.2.2 PHP treatment at Riverside Medical Centre

As shown in Section 3.2, both primary care and outreach secondary care consultations take place at Riverside Medical Centre. Consultations are used to provide:

- first contact assessment, formulation and treatment planning
- brief intervention, CBT, relapse prevention, psychodynamic psychotherapy, family therapy, couples-therapy
- community based alcohol detoxification
- psychiatry
- work related CBT, with a focus on return to work strategies
- mentoring
- case management.

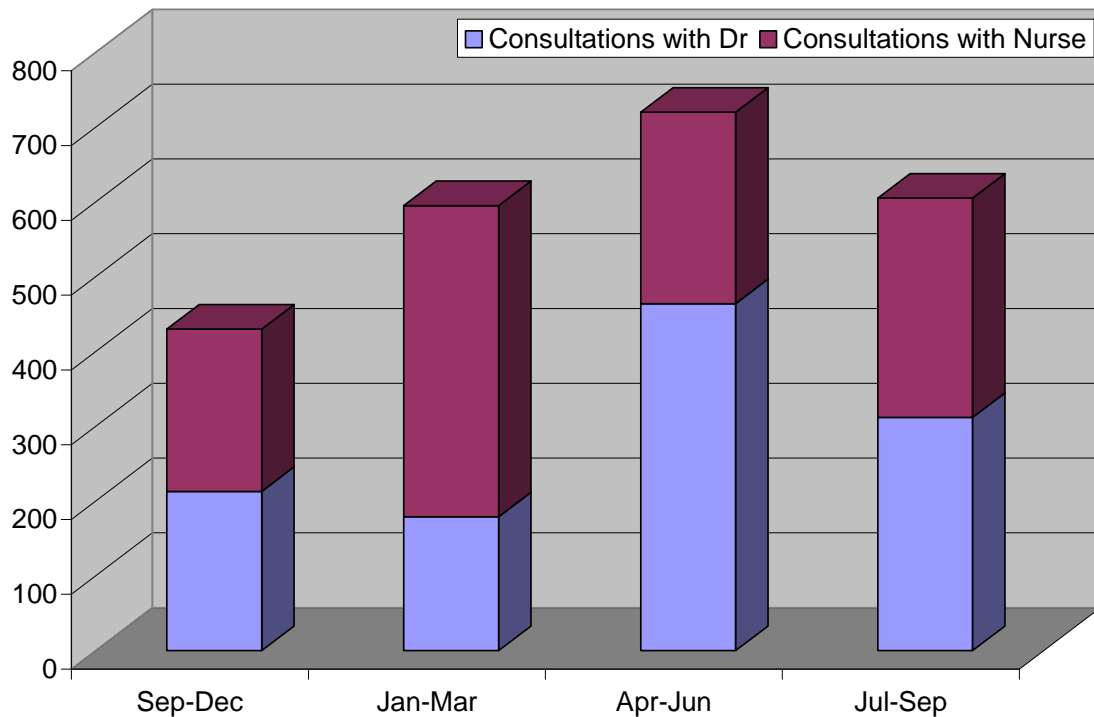
The number of consultations, broken down by quarter, is shown in Table 4 below.

Table 4: Number of PHP1 consultations provided by all doctors and the addiction nurse

PHP1 Consultations	Q1	Q2	Q3	Q4	Total
Consultations with Dr	213	179	464	312	1,168
Consultations with Nurse	217	416	256	293	1,182

These numbers are shown graphically in Figure 13 below.

Figure 13: Consultations at Riverside Medical Centre, by quarter



As at the end of September 2009, PHP1 was case managing 153 patients. Case management / case co-ordination includes organising referrals to PHP2 external services or to PHP2 clinicians in the integrated team, follow-up consultations, attendance at hearings, and liaising with professional bodies and professional carers.

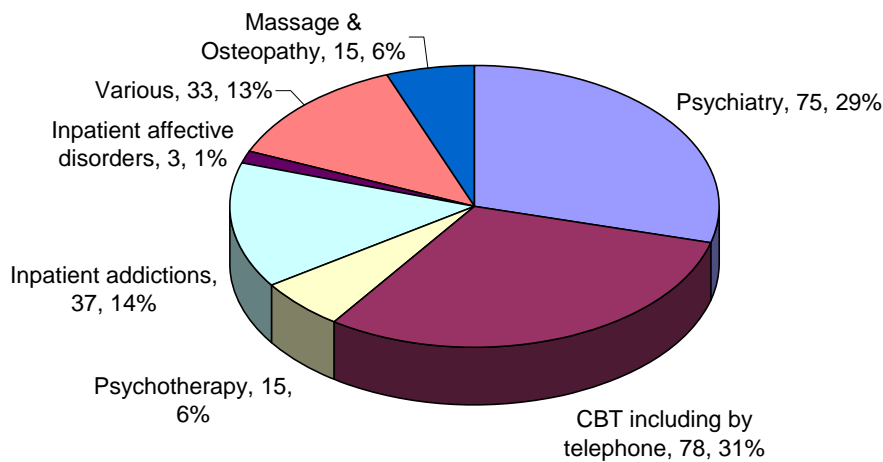
Patients are risk assessed as red, amber or green with regard to risk to the practitioner-patient, risk to their patients and risk to the reputation of PHP. Those patients assessed as high risk are reviewed weekly, medium risk fortnightly and others at least once a month.

5.2.3 Treatment in PHP2

Figure 14 below shows the breakdown of PHP2 referrals by treatment type. It shows that:

- 31% of all referrals to PHP2 are for cognitive behaviour therapy – this is the most used of all treatment modes
- 29% of referrals have been for psychiatry and 6% for psychotherapy
- inpatient referrals (for either addiction or affective disorders) account for 15%
- referrals for massage and osteopathy were part of a separate pilot paid for by the Hurley Group (host GP practice for PHP). These treatments were found to have a significant impact on levels of stress and improvement in wellbeing. They account for 6% of referrals.

Figure 14: PHP2 treatment by type



5.3 Awareness

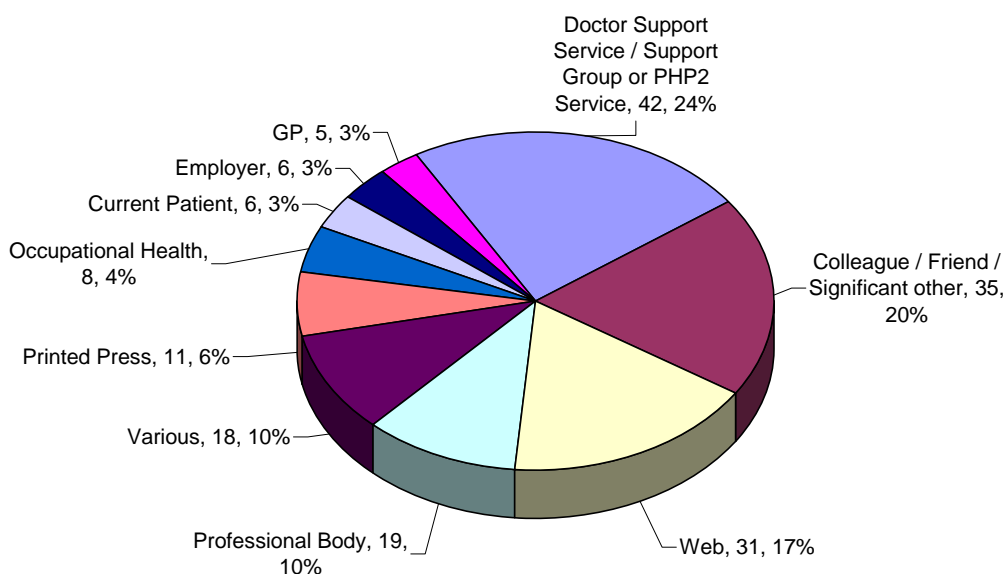
5.3.1 Awareness of PHP

Where appropriate practitioner-patients are asked how they heard of PHP and Figure 15 shows what was recorded for patients who provided an answer, to the end of September 2009.

- Other support services and groups for doctors, and clinicians from PHP itself, were a very significant source of information for patients, and a quarter of patients found out about PHP from these sources
- Colleagues and friends and the website were also very important information sources being pertinent in 20% and 17% respectively of self referrals to the service

It should be noted that only half the patients were asked about how they found out about the service. Data is only collected where the circumstances were appropriate. Information in this area is used to inform the Programme's communication strategy.

Figure 15: How those making initial contact heard of PHP



5.3.2 Awareness raising activities

During its first year of operation PHP has engaged in a number of awareness raising activities including:

- hosting a session at the RCGP annual conference in October 2009
- hosting a session at the International Physicians' Health Conference in November 2008 and attending the annual conference of European Association for Physician Health in October 2009
- meeting the Primary Care Medical Directors (BAMM) network
- providing articles for Chief Medical and Dental Officer updates
- meeting London Workforce Leads
- meeting London Dental advisors
- meeting SHA Medical Directors
- meeting with the Royal Medical Benevolent Fund to produce guidance for sick practitioners in financial difficulty
- attending the Medical Council on Alcohol AGM
- attending the GP registrars' event
- attending London Wide Associate In Training events
- meeting representatives from the MDU/MPS/GMC/GDC
- publishing articles, papers in academic and other journals
- participating in ongoing discussions with the Deaneries in London and surrounding areas e.g. Kingston, Surrey and Sussex.
- input into the Suicide Prevention Strategy Advisory Group.

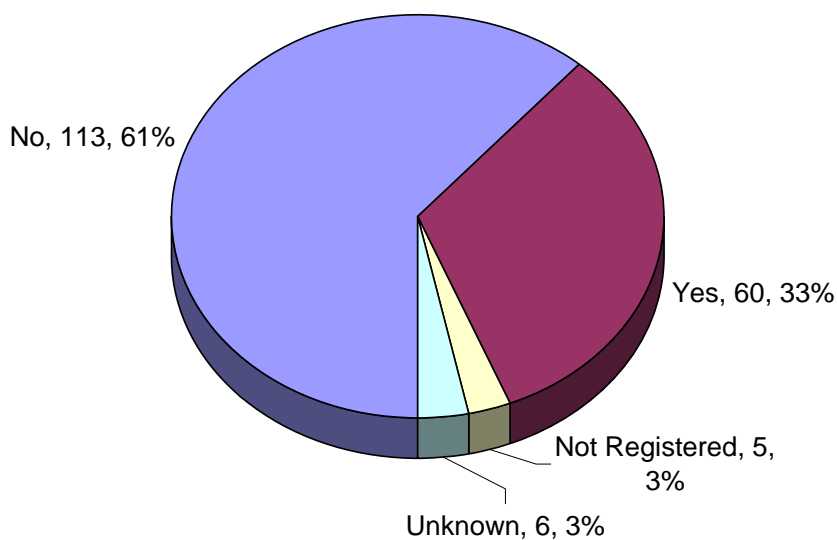
Speaking engagements include:

- the British Doctors and Dentist Group annual conference
- annual LMC conference
- Trent Occupational Medicine forum
- work and Mental Health conference
- Royal College of General Practitioners annual conference
- 2nd annual London trainee conference
- 14th national conference working with drug and alcohol users in primary care.

5.4 Involvement with the GMC or GDC

Figure 16 shows the numbers and percentages of patients who are involved, or not, with the GMC or GDC. It shows that one third of patients are involved with their regulatory body, whilst two-thirds are not. Small numbers of patients are either not registered or their position is not known.

Figure 16: Numbers of patients involved with the GMC or the GDC



5.5 References

NCAS (2006). National Clinical Assessment Service: analysis of the first four years' referral data. *National Patient Safety Agency*.

6 Monitoring the health status of practitioner-patients²

6.1 Clinical questionnaires and analysis

All PHP patients complete a number of self-report clinical questionnaires throughout their engagement with the service (see section 6.2 *Method* below for details). The questionnaires used by the PHP clinicians were chosen because:

- their reliability has been tested in other settings
- they are simple and easy to use
- they are clinically relevant to the health professional carrying out the assessment.

The PHP research team have undertaken a clinical audit of the first year of completed questionnaires. Highlights are included here to demonstrate how practitioner-patients have progressed during their time with the service. A more in-depth analysis is being prepared for peer review and, hopefully, publication in an academic journal at a future date.

Questionnaires are completed at their initial assessment (referred to here as “baseline”), after eight weeks, after 26 weeks and again after 52 weeks. Where there are particular concerns about substance use or cognitive functioning some patients are asked to fill out additional questionnaires. A global improvement questionnaire is used at patient follow-up appointments to see if the patients themselves feel that they are improving and to assess their satisfaction with the service.

The questionnaires form an integral part of the clinical consultation by helping to measure the severity of patients’ mental distress and their ability to participate in everyday life. They are an essential tool for PHP clinicians monitoring the health of practitioner-patients as well as providing a helpful measure of how patients are progressing in the service. Key findings from the PHP research team of the first year of completed questionnaires are:

- patients’ health is improving in all the areas that are measured the longer patients stay with the service, at each interval
- at baseline and eight-week follow-up patients show, on average, greater levels of distress than a non-clinical group but lower distress levels than a clinical sample (see section 6.2.2 for explanation)
- by 26-week follow-up patients score lower on risk than even the non-clinical group
- younger patients score higher than older patients on ‘wellbeing’ at baseline indicating more severe levels of distress with regard to subjective wellbeing
- younger patients also show greater levels of impairment on the Work and Social Adjustment Scale at baseline – in particular with regard to home management, social leisure activities and private leisure activities
- patients with co-morbid disorders score significantly higher on every questionnaire (i.e. show higher levels of distress/impairment) at baseline
- there are no significant age or diagnostic differences between scores at any follow-up interval, suggesting that all patients are improving regardless of age and diagnosis
- improvement and satisfaction rates are consistently high and improve at each interval

² Please note that data for this section was collated on 12 October 2009, at which point 191 patients had been registered with the service. Any patients registered after this date and any questionnaires received after this date have not been included.

- 77% of practitioner-patients remained in or returned to work after contact with the service
- 36/78 (46%) patients, who were not working whilst attending PHP, have returned to work.³

6.2 Method

6.2.1 Data collection

During the initial face-to-face assessment, each practitioner-patient's age, gender, profession and identified problem(s) are recorded by the PHP practitioner. Patients are also asked to complete their first self-report questionnaires at this point. For all questionnaire (except for Addenbrooke's Cognitive Examination – Revised; see below) a higher score means a higher level of distress or impairment in the patient.

6.2.2 Measures

Distress

All patients are asked to fill out the Clinical Outcomes for Routine Evaluation – Outcome Measure (CORE-OM) (Evans et al., 2002), a general measure of distress consisting of 34 items scored on a five-point scale, asking participants to rate how often the statements apply to them (from 'not at all' to 'most or all of the time'). Responses are split into four sub-scales to measure separately well-being, psychological problems, functioning and risk. The CORE-OM averages can be compared to a clinical group and a non-clinical group (as presented in the CORE system use manual). The clinical group come from 21 different treatment sites and the non-clinical group is a combination of a convenience sample and two groups of university students.

Social adjustment

All patients also complete a Social Adjustment Scale (Mundt et al., 2002), a simple five-question measure of impairment in day-to-day functioning. Patients respond to the questions about different aspects of impairment by selecting a number between 0 ('not at all') and 8 ('severely impaired'). Higher scores indicate a higher level of impairment.

PHP patients are also asked at the end of the Social Adjustment Scale to list how many days they have not worked during the previous six months because of their health problem.

Screening for alcohol misuse

The Fast Alcohol Screen Test (FAST) (Hodgson et al., 2002) is used to assess whether the patient has a problem with alcohol. The FAST consists of four questions designed to screen for hazardous/harmful drinking and alcohol dependence. Participants answer the questions about their drinking using a 5-point Likert scale ranging from 'never' to 'daily or almost daily'. If the assessor is concerned that the patient has a problem with an addiction or the FAST indicates a problem (i.e. the patient's total score for the FAST is 3 or higher) then the patient is asked to complete a further questionnaire.

Patients with alcohol problems complete the Severity of Alcohol Dependence Questionnaire, known as SADQ-C (Stockwell et al., 1994), a 20-item questionnaire measuring the severity of alcohol dependence. This questionnaire requires patients to respond to the questions using a 4-point scale, ranging from 0 ('almost never') to 3 ('almost always'). Their total score is then calculated, with higher scores indicating a more severe level of alcohol dependence.

Substance misuse

Patients with substance problems complete the Treatment Outcomes Profile, or TOP (Marsden et al., 2008), a simple questionnaire designed to assess the effectiveness of drug treatment. The TOP consists of four sections: substance use, injecting risk behaviour, crime, and health and social functioning.

³ Some of this summary information is taken from the in-depth analysis being prepared for peer review.

Cognitive screening

If the assessing clinician has concerns about a patient's cognitive function, an Addenbrooke's Cognitive Examination – Revised (ACE-R) cognitive screening test (Mioshi et al., 2006) is carried out during the assessment.

Follow-ups

During initial assessments, clinicians decide with patients an individual treatment plan, which may include CBT, inpatient detox, medical massage, psychotherapy or telephone CBT, for example. It is important to carry out the measures again during and after treatment in order to assess whether patients are improving. Therefore, the CORE-OM and the Social Adjustment Scale (as well as the SADQ-C where necessary) are repeated at eight-week, twenty six-week and fifty two-week follow-ups.

Global outcome

In addition to repeating the baseline questionnaires, patients fill out a brief measure of global outcome and satisfaction with treatment – the self-rated Clinical Global Improvement (CGI) questionnaire which has been used in randomised controlled trials to evaluate treatment outcome (see Fulcher & White, 1997). The first question asks patients to rate how much better they feel, on a scale of 1 (very satisfied) to 7 (very dissatisfied).

Satisfaction with treatment

The second question on the CGI asks patients to rate how satisfied they are with their contact with PHP, on the same scale of 1-7 (very satisfied – very dissatisfied).

The second question on the CGI asks patients to rate how satisfied they are with their contact with PHP, on the same scale of 1-7 (very satisfied – very dissatisfied).

6.3 Results

The review of the questionnaires is focused on the Work and Social Adjustment Scale, CORE-OM and FAST as these are the only questionnaires that all patients complete, as well as the SADQ-C, as a number of patients also complete this questionnaire.

150 patients (79%) handed in at least one complete questionnaire at baseline. Of those that did not, several had handed in incomplete questionnaires. Other reasons for not completing questionnaires at baseline include the patient being a telephone-only contact; the patient deciding not to engage with the service; the patient being inappropriate to collect data from (e.g. out of the London area); or the patient being newly-registered and not yet returning their forms.

At the time of writing this report:

- 65 patients had completed eight-week follow-up questionnaires and approximately 70 more patients had been sent questionnaires but not yet returned them
- 33 patients had completed twenty-six week follow-up questionnaires, and at the time of writing, we were awaiting a further 47
- five patients had completed fifty-two week follow-up questionnaires, and we were awaiting a further seven.

Table 5 gives a summary of the average (mean) scores for PHP patients for each questionnaire at each interval.

As described in the table, for each questionnaire, a higher score indicates a more severe problem. Therefore, we would hope to see scores getting consistently lower at each follow-up interval. The results for the CGI are included in Chapter 7.

The table shows that PHP is seeing lower mean scores on every questionnaire, and even every sub-scale of the CORE-OM, at every interval. This indicates that treatment within PHP is successful and effective across a range of measures.

Table 5: Summary of average questionnaire scores

Questionnaire	Maximum possible score	Clinical cut-off score *	Mean score baseline	Mean score 8 weeks	Mean score – 26 weeks	Mean score – 52 weeks
CORE-OM	136 (indicating high level of distress)	An average (per question) of: 1.19 for men; 1.29 for women	Overall: 51.2 Per question 1.45 (n=141)	Overall: 44.5 Per question 1.25 (n=65)	Overall: 32.2 Per question 0.91 (n=32)	Overall: 26.2 Per question 0.71 (n=5)
Subjective well-being (sub-scale)	16		2.00	1.75	1.23	0.95
Problems /symptoms (sub-scale)	48		1.90	1.62	1.20	0.98
Life functioning (sub-scale)	48		1.54	1.38	1.02	0.87
Risk/harm (sub-scale)	24		0.35	0.26	0.18	0.03
Social Adjustment	40 (indicating high level of impairment)	N/a	16.2 (n=143)	16.1 (n=64)	10.5 (n=33)	7.8 (n=5)
FAST	16 (indicating hazardous drinking)	3	2.81 (n=136)	-	-	-
SADQ-C	60, indicating severe dependence	30 for men; 25 for women	13.3 (n=23)	12.4 (n=12)	7.7 (n=6)	-

* “Clinical cut-off scores” refer to whether or not a score represents a clinical case. They have been established by asking a large sample of the UK population to complete questionnaires and comparing their scores with those for large samples of clients in therapy. We can examine the extent to which a patient’s score represents a ‘clinical population’ by comparing their score with the national cut-off score.

6.4 References

Evans, C., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J. & Audin, K. (2002). Towards a standardised brief outcome measure: psychometric properties and utility of the CORE-OM. *British Journal of Psychiatry*, 180, 51-60.

Fulcher, K.Y. & White, P.D. (1997). Randomised controlled trial of graded exercise inpatients with the chronic fatigue syndrome. *British Medical Journal*, 314, 1647-1652.

Hodgson, R.J., Alwyn, T., John, B., Thom, B. & Smith, A. (2002). The FAST Alcohol Screening Test. *Alcohol and Alcoholism*, 37, 61-66.

Marsden, J., Farrell, M., Bradbury, C., Dale-Perera, A., Eastwood, B., Roxburgh, M. & Taylor, S. (2008). Development of the treatment outcomes profile. *Addiction*, 103(9), 1450-1460.

Mioshi, E., Dawson, K., Mitchell, J., Arnold, R. & Hodges, J.R. (2006). The Addenbrooke's Cognitive Examination Revised (ACE-R): A brief cognitive test battery for dementia screening. *International Journal of Geriatric Psychiatry*, 21(11), 1078-1085.

Mundt, J.C., Marks, I.M., Shear, K. & Griest, J.H. (2002). The work and social adjustment scale: a simple measure of impairment in functioning. *British Journal of Psychiatry*, 180, 461-464.

Stockwell, T., Sitharan, T., McGrath, D. & Lang, E. (1994). The measurement of alcohol dependence and impaired control in community samples. *Addiction*, 89, 167-174.

7 Determining user satisfaction with PHP services and understanding the needs of users

7.1 Key messages

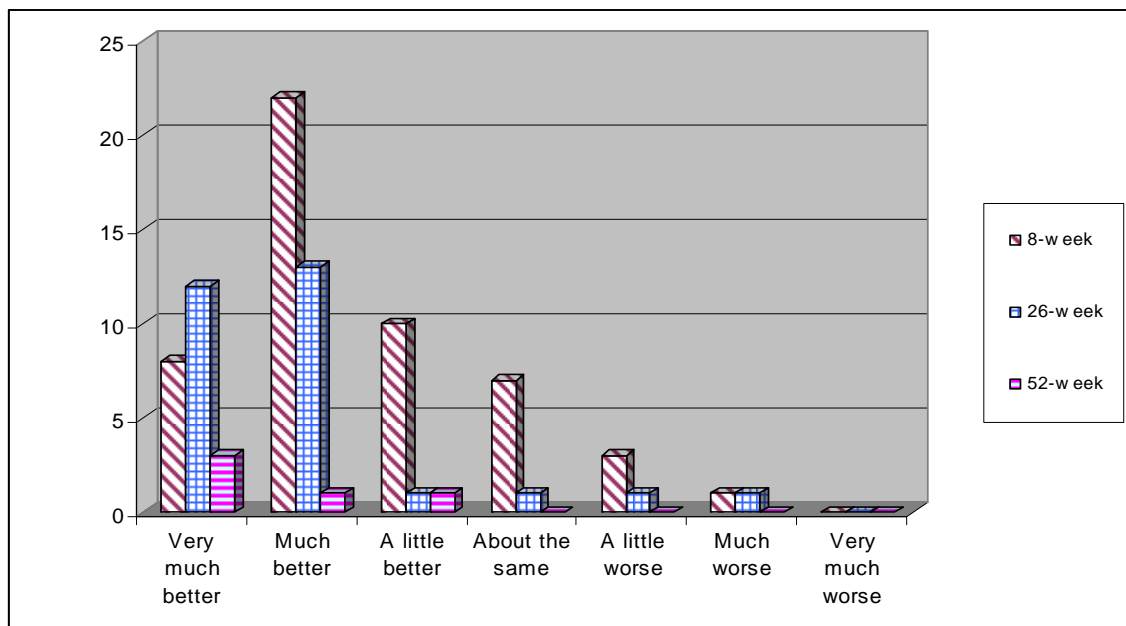
Improvement and satisfaction rates have consistently been extremely high, and are improving at each time practitioner-patients are asked their views through questionnaires. The majority of patients themselves are reporting that they feel better on the self-rated improvement questionnaire, and that they are satisfied with the treatment they have received from PHP. This report will be supplemented by an independent evaluation of the service currently being undertaken. Initial messages from the independent evaluation are consistent with this report.

7.2 Improvement and satisfaction

Patients are asked to fill in follow-up questionnaires at 8, 26 and 52 weeks (see Chapter 6). At each follow-up stage, patients are asked to fill in a brief questionnaire designed to assess both satisfaction with the service and global improvement. This questionnaire involves rating how they feel since engaging with service (very much better, much better, a little better, the same, a little worse, much worse or very much worse) and also how satisfied they feel with their contact with PHP (again, a 7-point scale, this time ranging from very satisfied to very dissatisfied).

The following graphs show the frequency of responses for the improvement and satisfaction questions at each interval.

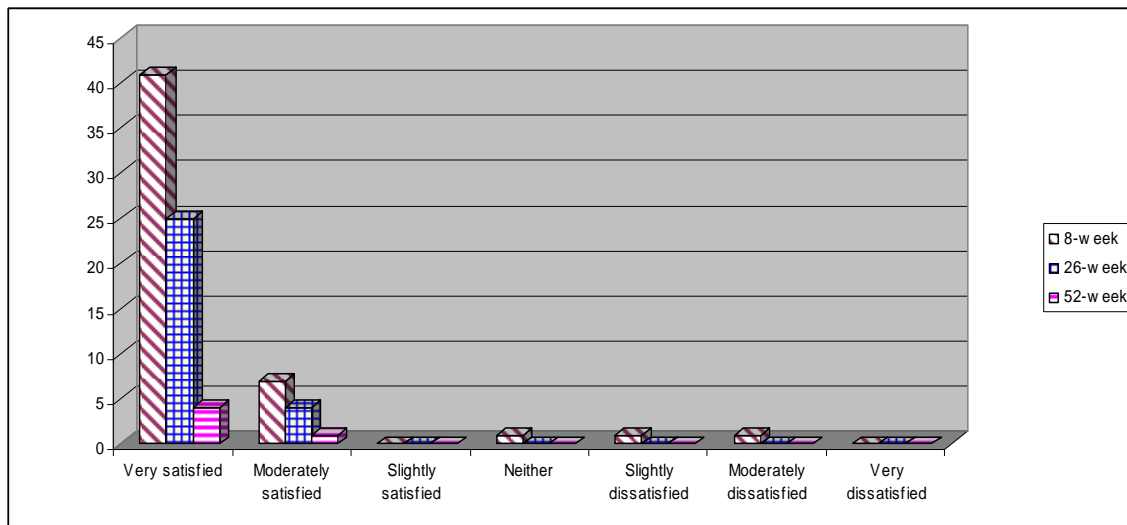
Figure 17: Improvement



It is important to note:

- at the eight-week interval, 78.4% of patients felt at least “a little better”, with the most frequent response (43.1% of patients) being “much better”
- at the twenty-six-week interval, 89.7% of patients felt at least “a little better”, with most feeling either “very much better” (41.4%) or “much better” (44.8%)
- at the fifty-two-week interval, 100% of patients felt at least “a little better”, although it should be noted that at the time of writing the number of patients who completed a fifty-two-week follow-up is still extremely small.

Figure 18: Satisfaction



Satisfaction with the service is high. Figure 18 shows that:

- at eight-week follow-up, 94.1% of patients were either “very” or “moderately” satisfied with their PHP treatment. The majority (80.4% overall) were “very satisfied”
- at the twenty-six-week and fifty-two-week intervals, 100% of patients were either “very” or “moderately” satisfied. The most common response at the twenty-six-week interval was “very satisfied” (86.2% of patients).

The graphs show that both self-rated improvement and satisfaction scores are extremely high, indicating that a vast majority of patients are feeling better than they did when they first contacted PHP, and that they also feel satisfied with their treatment.

The percentage of patients feeling “very much better” rose slightly from the eight-week interval and the twenty-six-week interval, as did the percentage of patients feeling “very satisfied” with their treatment, suggesting that improvement and satisfaction with the service get better over time.

7.3 Patient feedback comments

Table 6 below shows examples of patient feedback received by PHP.

The feedback has been anonymised and content has been omitted where this could allow identification of patients.

Table 6: Patient feedback

Patient Feedback
“I found our session incredibly helpful and you joined the very select group (of 2) health professionals that I like talking to!”
“Thank you for your concern and kindness. I do not have the words to describe what your guidance and support means to myself and my family. Thank you.”
“Thank you for giving of your time and expertise on Wednesday afternoon & evening I’m very grateful.”
“I am certain that the positive reference you supplied contributed to this favourable outcome and am indeed very grateful to you for this.”

Patient Feedback

"Thank you again SO much; I've been fortunate to "find" PHP, and blessed to have you as my care manager."

"I feel that I have been very lucky to have come across PHP in my life, Godsend! [The doctors] and the admin staff have been excellent, empathetic and supportive to my situation. I couldn't thank them any more. May God bless you all in grace for ever to continue with your life and work (excellent work) to the community."

"Very thorough; excellent support; superb management, not only from [the Medical Director] but also from [other clinicians]; every group thoroughly much needed and satisfying."

"Many many thanks – supportive help for problems."

"I am very grateful to [the doctors] and the staff for their excellent support and guidance. I could not thank you all any more."

"I think this is a marvellous service mainly related to the two excellent physicians that I saw... They are actively interested in the outcome of each individual case and want success for all of the patients. They try hard, follow up actively even if patients are not compliant and as individuals are extremely skilful. I do not believe I would have improved if not for them."

"I feel that PHP have filled an enormous therapeutic void in what otherwise would be a very daunting process for me as a doctor. PHP are a practical, supportive and unique service that encourages us to take the correct path of honesty and abstinence, instead of battling on alone with addiction and putting our patients at risk and our careers on the line. Thank you so much PHP."

7.4 Patient stories in their own words

7.4.1 A doctor

"I am a 46 year old medical practitioner, who referred myself to the Practitioner Health Programme at the beginning of 2009. I had been unable to get any meaningful on-going therapy for an addiction to opiate medication which I had been tackling in a haphazard fashion for many years.

The service provided has been invaluable, and has enabled me to re-structure my life, become established in recovery from my addiction, and continue to treat patients safely.

For many reasons, 'normal' mental health and addiction provision within the NHS is hardly ever appropriate for health practitioners as patients. Private treatment, particularly for addictive illness, is also fraught with difficulty. The PHP fills a gap in the care of health professionals which has been until now unfilled, with often desperate and tragic consequences.

I am sure that the outstanding level of therapeutic care which PHP provides could and should be offered to health practitioners throughout the country. Without their services I cannot say for certain that I would not have survived my illness, but I would certainly still be very unwell. To lose this unique facility would be in my mind unthinkable."

7.4.2 A dentist

"I would like to express how wonderful the above institute has been for me as a patient, a dentist dependent on tranquillisers. I was lucky enough to be referred to the above medical centre and even luckier that I found a therapist, a specialist nurse, who is very successfully helping me overcome my addiction on a weekly basis by appointment in counselling and monitoring my progress as I progressively reduce the dosage of Valium that I am reliant upon. Nothing is rushed or coerced in this reduction, yet the combined therapy is one of a gradual, gentle persuasion to reduce dosage when I feel I am able to. The specialist nurse instils confidence both in myself and in her as she does not restrict herself to treatment only at the Centre but can be called upon in between visits for advice, help and support as I have had to do many times. As well as treating me, she has managed to find time to make mandatory written reports about my progress when called upon by other professional bodies and people. The Centre is also associated with a regular group meeting of doctors and dentists to discuss their problems, addictions, treatments and recovery which I attend, all at the behest of the PHP.

An integral part of the PHP programme involves being sent to a Rehabilitation Centre in Wiltshire called "Clouds House" done by mutual agreement between patient and therapist when a certain level of reduction of dosage has been reached. "Clouds" will admit me for 6 – 8 weeks where I will continue to be treated until I am completely off Valium, while at the same time being counselled and taught coping skills like Cognitive Behavioural Therapy, relaxation techniques and exercises. The facility also allows visits from relatives and friends and in my case, visits from the specialist nurse herself to monitor my progress.

I have had the misfortune to be admitted for similar tranquilliser addiction in the past to ordinary hospitals, often with harsh time limits set for abstinence from addictive substances, including alcohol. In one case after my father died, I turned to Valium again and after admittance to a private hospital, I was forced to go 'cold turkey' and made to stop taking everything I was on which led me to having post traumatic stress disorder for which I had to be treated with anti-depressants. In stark contrast to these barbaric techniques, the PHP programme epitomises how addictions should be treated in the 21st Century and more funds should be made available for such modern Centres. I am very, very fortunate to be included in the PHP programme.

Yours sincerely,

A Dentist"

7.4.3 A General Practitioner

"I would like to take this opportunity to say how extremely helpful the PHP programme has been.

It is extremely useful to be able to access confidential help when you are a doctor. It can be a daunting task trying to access help through the usual NHS system, you often worry who will see your referral letter, who will be seeing you and how quickly you can get help.

It was great to be able to be assessed and have therapy provided so quickly.

I feel this has greatly improved my overall wellbeing which I no doubt has had a positive impact on my work, treating my patients.

I feel it is important to continue this service for future doctors in need of help. The fact that it is independent of other organisations is extremely helpful.

Many Thanks

A General Practitioner"

8 Monitoring the cost and performance of PHP services

8.1 Finance

8.1.1 PHP1 finance

PHP1 was financed through a block contract in the first year. The contract year ran from September 2008 to August 2009. The contract built in a transitional period from June 2008 to August 2008 to allow for service setup. The service specification allowed £800,000 for PHP1 in each contract year. PHP1 spent according to budget in the first contract year, having provided for three months set-up and transitional costs.

8.1.2 PHP2 services

The service specification allowed £800,000 a year for the purchase of PHP2 services. The total actual invoiced spend for completed patient episodes during the first year of the service is £405,535. This does not include spend on incomplete patient episodes: for instance the cost of patients referred to the Tavistock and Portman NHS Trust for 20 sessions who have only received 10 sessions will not be included in the figures.

The details are shown in Figure 19 below.

Figure 19: Split of PHP2 spend by provider

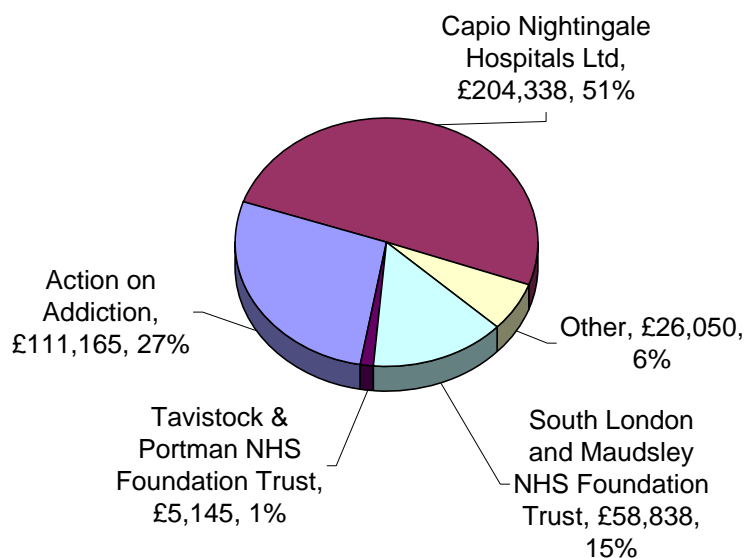


Figure 19 shows that about half the budget for PHP2 services was spent on care provided by Catio Nightingale Hospitals. This spending includes the costs of the clinicians that support PHP1 as permanent members of the integrated team, through outreach sessions at Riverside Medical Centre. Additionally outpatient, inpatient and day care services for mental health are provided at the hospital in central London. Action on Addiction runs Clouds House in Wiltshire which provides nearly all the service's inpatient treatment for addiction. South London and Maudsley NHS Trust provide outpatient mental health treatment for conditions such as chronic fatigue, affective disorders and neuropsychiatry.

Figure 20: Range of spend per patient on PHP2 services

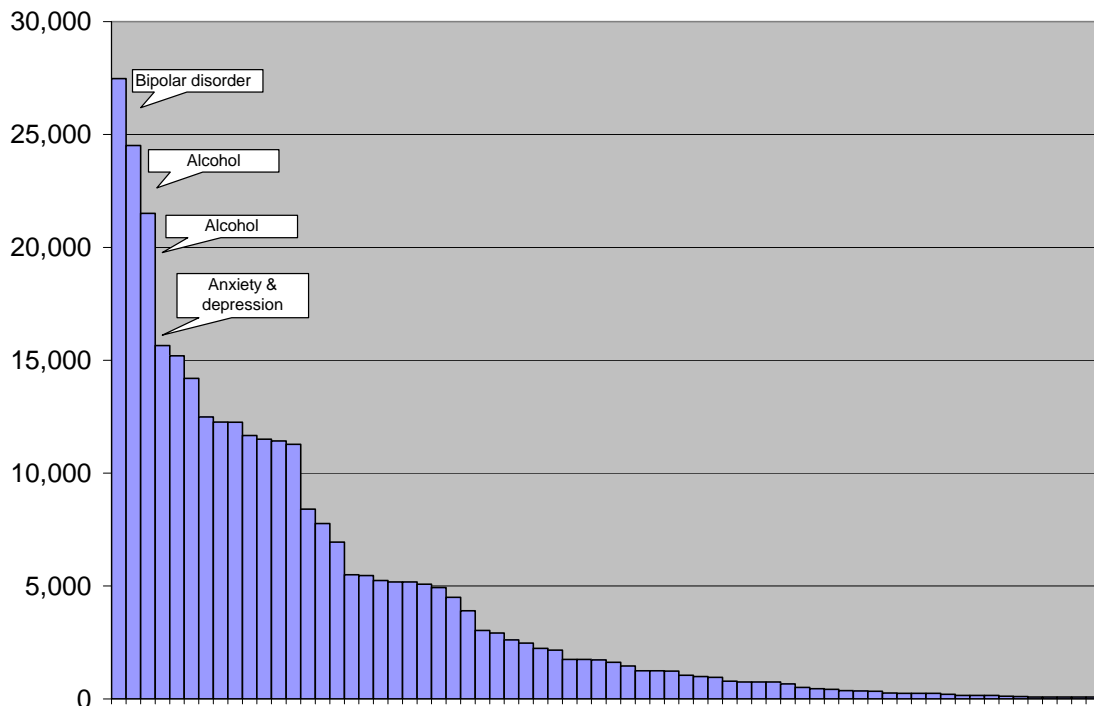


Figure 20 shows the spend on PHP2 services by patient. The graph shows only direct spend on services and excludes the £100,000 PHP spend on permanent PHP2 members within the PHP integrated team. The graph shows that the highest cost patients have suffered from bipolar disorder, addiction to alcohol and anxiety and depression. Further work has taken place to look at the treatment provided by the PHP integrated team to the most high cost (in terms of PHP2) patients, in order to get an overall view of the care pathways and total costs of these patients. The care provided is identified in Figure 21 below. Future work will take place to cost PHP integrated team consultations and allocate these costs to patients.

Figure 21: Complex PHP patients: use of PHP integrated team sessions

Patient		A	B	C	D	E	F	G	H	I	J
Diagnosis		Bipolar	Alcohol	Alcohol	Anxiety /Dep	Alcohol	Anxiety /Dep	Alcohol	Alcohol	Opiate/Dep	Alcohol
Consultation	Dr	20	23	7	21	11	7	3	9	23	5
	Nurse	7	51	16	12	11	1	25	8	12	32
	Total	27	74	23	33	22	8	28	17	35	37
Phone	Dr	0	4	0	0	0	3	0	0	0	1
	Nurse	0	0	0	0	0	0	0	0	0	0
	Total	0	4	0	0	0	3	0	0	0	1
MDT		7	0	1	1	3	9	0	0	0	0
Case review		3	0	0	1	0	0	0	0	0	0
Total clinical input		37	78	24	35	25	20	28	17	35	38
Months since presentation		8	11	8	11	9	3	11	8	7	12
Average input per month		4.6	7.1	3.0	3.2	2.8	6.7	2.5	2.1	5.0	3.2
Reports written						1	1	2	1	2	

8.1.3 Overall financial position

Overall PHP1 is performing as expected whilst PHP2 is considerably under-spent. This is interesting as although the total number of patients contacting the service is lower than expected, the number of those needing in-depth assessment and further treatment is higher than expected. The latter might lead one to expect that the PHP2 budget would be overstretched. The under-spend on PHP2 may be due to a number of factors:

- the original budget was too high – the split of the total budget between the PHP1 element and the PHP2 element was arbitrary, the total budget was split in two
- the introduction of the integrated team has been efficient and saved money as well as being a model of care that appears to be effective and well liked by practitioner-patients
- the case management model, in particular the use of a full time specialist addiction nurse with prescribing rights. Her presence within the team enables greater consistency, encourages patients to remain engaged in treatment and reduces the need to secondary care interventions
- this budget does not include commissioning and contracting costs.

8.1.4 Using the under-spend

The project runs for two years on the current funding stream from the Department of Health. If the spend on PHP2 continues the service is likely to be £600,000 to £800,000 under-spent at the end of the project. The Department of Health has agreed that this under-spend can be used to extend the length of the project. The Project Management Group is actively looking at how funding may be provided until March 2011 and beyond.

8.2 PHP performance against indicators

Performance indicators were set for PHP at the start of the project. There are a large number of indicators that attempt to ascertain whether seven core objectives are met. The objectives and a summary of the attainment of the associated indicators are shown in Table 7 below.

Table 7: Key performance indicators to end September 2009

Objective	Status after one year
To develop & maintain links with a wide range of stakeholders to ensure awareness of the service & what it offers.	Promotional material distributed at launch and at quarterly intervals. Large number of speaking and networking events across UK. In the region of 67,000 visitors to website.
To develop & maintain good working relationship with regulators & other statutory bodies.	Memorandum of Understanding with GMC, GDC and NCAS and confidentiality agreements in place. Regular stakeholder meetings and regular shared learning opportunities.
Clinical pathways & communication with PHP2 providers support patient treatment & recovery.	Referral pathways and data flow agreements in place with all providers. Shared learning events and clinical pathway planning events held between PHP clinicians.
To attract & engage with a wide range of patients.	338 initial contacts resulting in 184 case assessments across a wide range of professional groups and a variety of demographics.

Objective	Status after one year
To ensure patients receive appropriate treatment to support recovery & rehabilitation.	All patients requested to participate in baseline assessment and outcome evaluation.
To ensure that patients engage in case management to support their recovery & enhance patient safety.	All patients reviewed through multi-disciplinary case discussions. Risk status assessment made on all patients and case managers allocated.
The service is well managed & is proactive in maintaining & improving the service on offer.	Patients offered appointments to suit their schedule including evening and Saturday morning availability. Additional clinical and administrative support brought in to the team to meet demand.

9 Way Forward

9.1 Learning

PHP has now completed its first year of operation and this annual report provides a detailed description of the practitioner-patients who have been seen, their demographics, presenting complaints and treatment outcomes. We hope that during the next 12 months we will continue to offer support to doctors and dentists who are unable to receive the help they need through existing routes.

A number of emerging themes are becoming clear, for example:

- disproportionate numbers of psychiatrists are presenting and the PHP service believes that this reflects both the difficult position psychiatrists find themselves in with respect to accessing confidential treatment and that the nature of offering treatment to patients with mental health problems on a daily basis adds particular pressures to psychiatrists
- relatively large numbers of paediatricians are presenting and this may reflect the added pressures for this speciality group
- PHP has also identified a number of stressors that add to the mental health burden on doctors. This includes the current shift pattern of junior doctor training which means that young doctors rarely work with the same team and do not have the support that team working provides.

On a positive note, the working relationship with the GMC and GDC has enabled a smoother passage through the regulatory process for doctors that are engaged with PHP and more positive outcomes for some as well as identifying areas of learning for the GMC and GDC itself.

PHP has demonstrated in its first year that doctors and dentists will access a service of this kind and for many it is the first time they have sought help for longstanding ill health issues. PHP has also demonstrated that by offering help, support and treatment practitioner-patients can maintain a healthy working life and also can return to work after a long period of absence. PHP offers value for money and should reduce costs related to performance and regulatory processes. Most importantly, according to patient testimony, the service can save lives.

9.2 Next steps

The task ahead for PHP is to build on the positive outcomes and identify the added value and benefits a service of this nature can bring to individual doctors and dentists, the organisations and teams in which they work and to ensuring safe, effective care to patients and the public. Further data collection and service evaluation will assist in this process but perhaps the most valuable evidence is the experience of the practitioner-patients and healthcare organisations that have accessed and experienced the service offered.