

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

Occupational health  
practice in the NHS  
in England

A national clinical audit: round 2

## Executive summary



Royal College  
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# Executive summary

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

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

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

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

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

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

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

## How to interpret your trust's results

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

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

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

### Key findings and recommendations

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

#### *Participation*

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

#### *Sickness absence*

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

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

#### *Depression assessment*

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

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

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

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

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

#### *Fitness for work*

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

#### *Treatment services funded by the employer*

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

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

#### *Type of trust analysis*

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

#### *National dissemination conference and regional implementation workshops*

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

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

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

## Conclusions

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

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

## Next steps

### *OH providers*

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

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

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

### *HWDU*

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

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

Copies of the full audit report are available from the  
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