

Depression screening and management of staff on long-term sickness absence

Occupational health
practice in the NHS
in England

A national clinical audit



Royal College
of Physicians
Setting higher medical standards

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Faculty of Occupational Medicine

NHS
Plus

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Prepared on behalf of the Occupational Health Clinical
Effectiveness Unit Audit Development Group by:

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January 2009



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NHS Plus

The NHS Plus Project aims to improve the quality and delivery of occupational health services to NHS staff and in turn increase the availability of NHS Plus services to small and medium employers. In addition to commissioning the Occupational Health Clinical Effectiveness Unit to produce evidence-based guidelines and conduct national audits, the Project has work strands to improve the delivery of services, provide an improved trading model and improve the strategic leadership of occupational health services in the NHS.

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Occupational Health Clinical Effectiveness Unit

The Occupational Health Clinical Effectiveness Unit at the Royal College of Physicians aims to measure and raise standards, and to reduce variability, of occupational health care through the development of evidence-based guidelines and conduct of national clinical audits.

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- maximising people's opportunities to benefit from healthy and rewarding work while not putting themselves or others at unreasonable risk
- access for everyone to advice from a competent occupational physician as part of comprehensive occupational health and safety services.

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Foreword

Dear Colleagues

These two national comparative audits represent the next step towards improving the quality of occupational health care in the NHS and I am delighted to commend them to you.

They are the first of their kind. This report covers the findings of the audit of depression screening in occupational health for NHS staff on long-term sickness absence. Its sister report describes the audit of back pain management. Back pain and depression are common causes of sickness absence in the NHS workforce, and so these are two very important areas in which to measure the quality of occupational health care.

The findings reported here suggest that the Occupational Health Clinical Effectiveness Unit audit programme is following the success of national clinical audits in other areas, such as stroke care and care in heart disease. I am very impressed with the sheer application necessary to assess the entries and omissions of case notes, one of the most discerningly critical ways of examining the quality of practice against demanding standards; and I admire the enthusiasm with which occupational health professionals took part. It is taking part that counts at this early stage in the audit cycle. Participants now have a baseline against which they can measure improvements in performance in future audit rounds. This is a major step, not only because it provides a detailed picture but because it also signals a beginning, reinforcing the proper place of these services in the NHS.

Chief Executive Officers will be aware that audits such as these reveal variations in practice that influence the quality of service. I hope that trusts will now support their occupational health departments as they make the changes necessary to raise standards further.

The vision of Lord Darzi's Next Stage Review is of a health service driven by continuing quality improvement. It is only through audit, conducted according to agreed standards, that we can determine how well we do, or not, and where and how we can do better.

I congratulate the Occupational Health Clinical Effectiveness Unit and NHS occupational health services on their achievement which I know they will now build on.



Dame Carol Black
National Director for Health and Work

On behalf of NHS Plus, I would like to congratulate and thank all the trusts that supported this audit and the occupational health staff who have worked so hard to contribute data. These audits are part of a drive by NHS Plus to improve the quality of occupational health services in the NHS and beyond. The high participation rates across the country are fundamental to the audit's success and provide an excellent foundation as we progress through the audit cycle.

The next step is to review our national and local results, and to identify areas where practice can improve. NHS Plus will host a national conference in Spring 2009 to disseminate the audit results. This will be followed by regional workshops to identify barriers to change and the tools needed to overcome these barriers. Additionally, NHS Plus will continue to fund the Occupational Health Clinical Effectiveness Unit (OHCEU) in 2009 to support tool development and implementation.

At NHS Plus, we are dedicated to supporting the NHS as it seeks to lead the way in improving the quality and provision of health, work and well-being services. These audits represent a major step towards this aim. Audit participation is an essential component of quality improvement, service accreditation and, for doctors, revalidation. NHS Plus looks forward to continuing to support health, work and well-being professionals in meeting these requirements and to raise standards of occupational health care in the NHS.



Dr Ira Madan
Director of Clinical Standards
NHS Plus

Executive summary

The first national clinical audits in occupational health were coordinated by the Occupational Health Clinical Effectiveness Unit (OHCEU) in 2008. Two comparative clinical audits were conducted, providing a starting point for the occupational health community to raise standards and reduce variability of occupational health care in the NHS.

This report describes the findings of one of these first audits: the national audit of screening for depression measures how well occupational health professionals are assessing and managing depression in staff of NHS trusts in England¹ on long-term sickness absence.

We chose to audit depression screening in staff off sick for at least four weeks (for any health problem) as we know that many people with chronic physical symptoms also develop depression. We also know that the longer an employee is off sick, the greater the risk of depression; and the less likely they are to make a successful return to work. Long-term sickness absence has repercussions for the individual, their family, their employer, the benefit system and the wider economy and society as a whole.

The Audit Leads, supported by the multidisciplinary Audit Development Group, developed an audit tool based on the National Institute for Health and Clinical Excellence (NICE) Guideline on the Management of Depression.² Occupational health doctors and nurses used the tool to audit case notes. The audit included only first occupational health consultations with employees who had been absent from work for at least four weeks (for any health-related reason). The anonymised data were analysed by the OHCEU. In addition to the national results presented below, each participating trust received its own local confidential results.

These audits offer a unique opportunity for all occupational health providers to focus on quality. The overall results form a baseline relevant both to trusts that participated and those that were unable to. Local results (provided to all participants) will enable occupational health services to compare themselves against best practice and to benchmark against other occupational health services across England. Each trust can use the results to identify areas in which improvements are needed, supported by the OHCEU. Future rounds of audit will measure performance against the baseline and identify further areas in which improvements could be achieved.

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 cases is considered large enough to reliably indicate local practice. Trust results based upon a small number of cases may not accurately represent local practice.

¹ NHS Plus, the commissioner of the OHCEU, is funded by the Department of Health for England.

² National Institute for Health and Clinical Excellence (2004) *Depression: management of depression in primary and secondary care (CG23)*.

- 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 in the Introduction 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 trusts. Those that participated now have a baseline from which they can measure improvements in performance through future audit rounds. An occupational health service that has taken part in this early stage in the audit cycle indicates a willingness to improve its practice.
- This audit measures a very specific area of occupational health practice. The results cannot be extrapolated as a measure of the full range of diverse activities undertaken by occupational health services. Each occupational health service will operate under different local circumstances. We also note that results could be heavily influenced by local policies and practice.
- The OHCEU has not ranked trusts. The local results should be interpreted by each trust itself, taking into account knowledge of its service.
- The report is a tool for reviewing the occupational health care provided to the staff of a trust. It should be used by each trust for facilitating dialogue between occupational health 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 guideline available. However, we recognise that the exact nature and number of questions required to screen for depression and assess its severity will vary depending on the presentation of the case. The NICE Guideline states that ‘The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.’

Key findings and recommendations

Participation

- National clinical audit of occupational health practice in the NHS in England is achievable, with 69% of trusts participating in this first depression screening audit round. Many of the remaining trusts will be able to share the results obtained by their occupational health provider, as many services provide care for the staff of more than one trust (see *Section 2*).
- A fifth of trusts entered fewer than ten cases and will need to interpret their local results with caution as they may not be truly representative of local practice. We suggest these trusts pay particular attention to the national findings.

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

- We found wide variation in practice. There were very high levels of compliance with the NICE Guideline on the Management of Depression in some consultations (regardless of the severity of the case), and low levels of compliance in others.

This finding shows that the NICE Guideline can and is being followed in some occupational health departments and that further work is needed to achieve a higher and consistent standard of care nationally. Documentation in the case notes should be comprehensive.

- 58% of all cases were screened for depression. However, screening occurred in a much higher proportion of cases referred for a psychological problem (83%) than those with a different diagnosis (15%).

This finding shows that many more consultations need to include screening for depression, particularly where the presenting problem is a physical one.

- In 18% of cases with evidence of distress, the OH professional asked about six core symptoms of depression. 11% of cases were asked about none of the six symptoms.

These findings suggest that occupational health professionals need to include more questions about the core symptoms of depression in their consultations, to avoid missing depression in staff on long-term sickness absence.

- 31% of cases with evidence of distress were asked about thoughts of suicide or deliberate self harm. This figure was slightly higher (37%) for cases with a diagnosis of depression. Of those who reported thoughts of this nature, two thirds were asked further important questions about their plans and half were asked about any previous acts.

The management of employees with distress and depression could be improved if appropriate questions about suicide were more frequently asked by occupational health professionals.

- Over 60% of cases with distress were asked about family members. 33% were asked about alcohol and 9% were asked about drugs.

A better understanding of potential barriers to recovery would be gained by asking about aspects of home and family life more often. Importantly, more consultations should include questions about alcohol and illicit drug use.

Variations between occupational groups

- A higher proportion of nurses and a lower proportion of doctors were entered into this audit than would be expected from the demographics of the NHS workforce.

It is important that trusts ensure that all staff groups have full access to occupational health services and are encouraged to seek advice.

- Few other differences between occupational groups were seen in the results for the other audit questions, which is reassuring.

Type of trust analysis

There were few differences found in the results between types of trust, although compliance was slightly poorer in Mental Health trusts than in the other types of trust.³

Conclusions

We found wide variation across England in meeting the criteria we chose to audit.

For all staff on long-term sickness absence, regardless of their presenting problem, OH professionals need to consider the possibility of depression. Where there is a suggestion of depressed mood, individuals should have a more thorough assessment of depression including suicide risk. Additionally, many more cases should be asked about alcohol and drug use.

The audit showed evidence of constructive communication with line managers. OH professionals were good at recording the contribution of workplace factors to any depression and assessing whether to discuss this with the employer. Another encouraging finding was the high proportion of cases with depression who were asked about contact with other healthcare professionals.

Next steps

Occupational health providers

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

Where consultations do not meet the standards set in the NICE Guideline, 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;
- developing tools to facilitate improvement, for example algorithms and action plans;
- developing systems to support comprehensive documentation of consultations.

OHCEU

- NHS Plus will host a national conference for OH professionals in Spring 2009. At the conference we will disseminate the findings of the audit and facilitate sharing of good practice. We will begin the process of developing materials and mechanisms for improving OH provision for NHS staff nationally.
- The OHCEU will hold regional workshops and focus groups during 2009. These events will enable participants to share their experiences of using the audit to change practice, barriers to such change, and how these can be overcome.
- 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.

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

³ 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.

1 Introduction

This national comparative clinical audit measures how well NHS staff in England⁴ on long-term sickness absence are screened for depression by occupational health doctors and nurses. This is one of two audits the Occupational Health Clinical Effectiveness Unit (OHCEU) carried out simultaneously during 2008. The other audit assessed consultations with NHS staff with back pain and is described in a separate report.⁵

Sickness absence and depression

OH doctors and nurses frequently see employees who have been on long-term sickness absence. Most staff are referred by their managers. While some of these staff will already have been diagnosed with a psychological illness, others will be off sick with a physical problem.

It is well documented that many people with chronic physical symptoms also develop depression. We also know that the longer an employee is off sick, the more likely this becomes; and the less likely they are to make a successful return to work.⁶ Long-term sickness absence has repercussions for the individual, their family, their employer, the benefit system and the wider economy and society as a whole.

To facilitate optimum management of staff on long-term sickness absence, it is important that any clinicians involved in their care screen regularly for depression; and this includes OH professionals. While there are no specific guidelines for such screening by OH professionals, there is a relevant NICE Guideline on the Management of Depression in primary and secondary care.⁷ We used this national guideline to develop standards against which the care provided by OH doctors and nurses looking after NHS staff in England could be measured.

Clinical audit

The purpose of clinical audit is to measure compliance with standards and to identify areas where practice should be improved. The audit process should compare actual performance against a standard: data are collected to determine whether the standard is met. Where a standard is not met, interventions can be designed to improve practice. A further round of audit monitors the effect of the intervention activities, and identifies new priorities for change.

⁴ NHS Plus, the commissioner of the OHCEU, is funded by the Department of Health for England.

⁵ OHCEU (2009) *Back pain management – Occupational health practice in the NHS in England: A national clinical audit*.

⁶ Department for Work and Pensions (2002) *Pathways to work: Helping people into employment*.

⁷ National Institute for Health and Clinical Excellence (2004) *Depression: management of depression in primary and secondary care* (CG23). The Guideline specifies that it is intended for use by various groups including: 'Professional groups who share in the treatment and care for people with a diagnosis of depression, including psychiatrists, clinical psychologists, mental health nurses, community psychiatric nurses, other community nurses, social workers, counsellors, practice nurses, occupational therapists, pharmacists, general practitioners and others... Professionals in other health and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those diagnosed with depression...' (Paragraph 1.2.2) The NICE Guideline can also help OH professionals to assess the severity of depression, allowing them to facilitate the appropriate level of care.

A good example of effective national clinical audit is MINAP (Myocardial Infarction National Audit Project), which has collected data for the last eight years. It has shown a year on year improvement in the proportion of heart attack patients who received timely access to thrombolytic treatment.

Aims of the national audit

The principles of clinical audit can be applied to the OH setting. Our audit examines clinical aspects of occupational health care in screening for depression, and communication between the OH professional and other health professionals and the employer. The aims are:

1. To improve detection of depression in NHS staff on long-term sickness absence.
2. To assess variations in practice in the occupational health care of staff on long-term sickness absence across trusts in England.
3. To enable NHS trusts to compare the quality of their depression screening for staff on long-term sickness absence against evidence-based criteria.
4. To produce 'baseline' measures of aspects of occupational health care, against which future progress, both locally and nationally, can be measured.
5. To develop an audit methodology appropriate to the specialty of occupational health and demonstrate that national clinical audit of occupational health care in the NHS is achievable.

Documentation

Our case note audit required the relevant information to have been documented. Full and accurate documentation of a consultation is an essential part of patient care. Clinical records demonstrate that an appropriate assessment has taken place, allow progress between appointments to be assessed, and facilitate continuity of care where more than one clinician is involved in the case. The General Medical Council Guidance for doctors states that 'you must keep clear, accurate and legible records'.⁸ The Faculty of Occupational Medicine Guidance on ethics describes the maintenance of OH clinical records as 'the foundation of a high standard of professional care. Such records ensure good communication for inter-professional working and aid assessment of employee health'.⁹

The following chapters report the process and results of the depression screening audit. As this is the first round of our audit, we have provided an explanation of the topic choice, design and data collection process as well as a detailed results section.

⁸ General Medical Council (2006) *Good Medical Practice*, paragraph 3(f).

⁹ Faculty of Occupational Medicine (2006) *Guidance on ethics for occupational physicians*, 6th Edition, paragraph 4.1.

2 Occupational health services in the NHS in England

OH care for staff is provided by NHS trusts in England in a range of different ways. In carrying out our audit, we observed that there is a certain level of flux as services are re-tendered and reorganised. Of nearly 400 NHS trusts, just under half have an in-house service. The remaining trusts contract their service from another provider (or, for a small number, more than one provider), usually a different (local) NHS trust. Approximately 20 trusts commission their OH service from a private provider. Some OH providers therefore serve multiple NHS trusts.

The unit for reporting this audit was the trust. We therefore asked OH services to enter data separately for staff of each of the trusts to which they provide services.

We asked participating trusts for their annual budget, head count¹⁰ and budget for OH provision.¹¹ The results are shown below:

National data

2007–08	Head count	Total annual trust budget	OH annual budget	Proportion of budget spent on OH	Annual OH budget per head
<i>Valid trusts</i>	257	239	242	230	240
<i>Missing</i>	10	28	25	37	27
Median	2,576	£201,000,000	£205,480	0.13%	£69.93
IQR	1,600–4,300	£117,000,000– £380,000,000	£106,016– £331,421	0.04%–0.18%	£50.82–£92.97

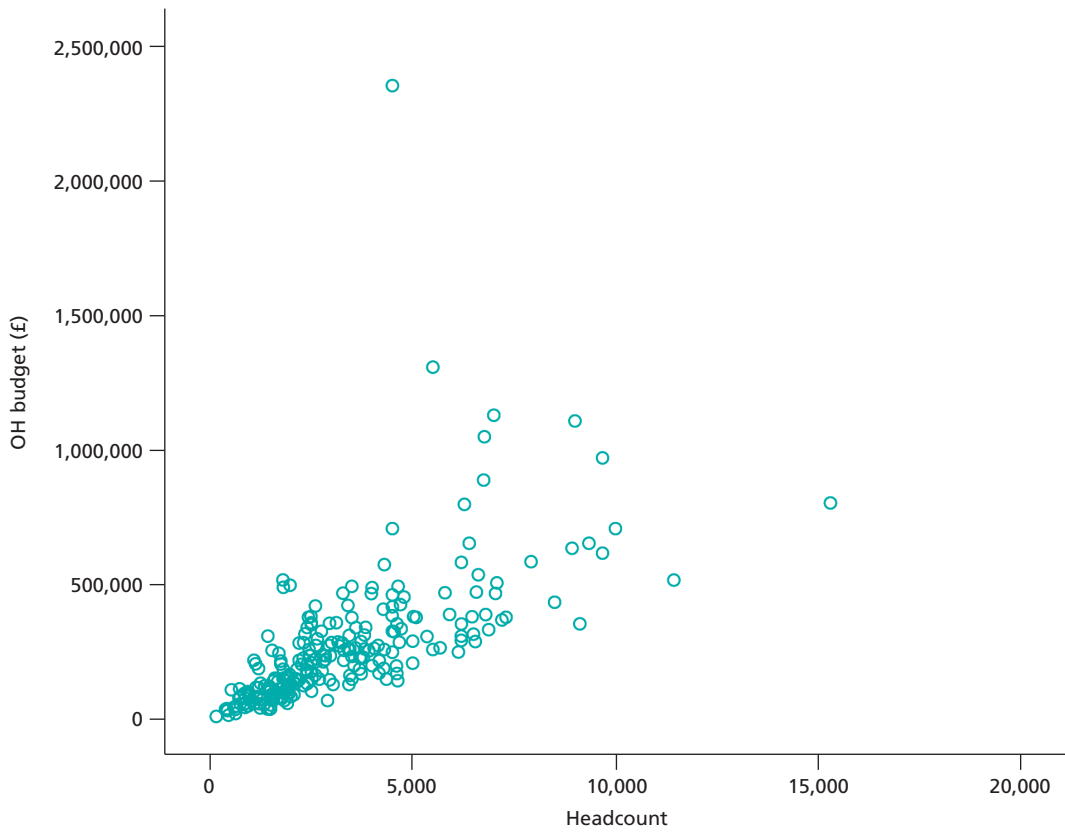
The association between headcount and OH budget is shown in Fig 1 (overleaf) (each point is one trust).

¹⁰ Total headcount, not the whole time equivalent.

¹¹ The question we asked was:

What budget does your Trust allocate for Occupational Health Service provision to your Trust staff for 2007/08? Please include core occupational health services, manual handling and counselling budget but exclude safety budget. Please exclude any income from outside (income generating) contracts – we only need to know Trust contribution to Occupational Health Care of its employees.

Fig 1 The association between headcount and OH budget



3 Methods

Notes on terminology

Sites

Trusts either have their own in-house OH service or commission it from another provider. Because some trusts use more than one OH service and some OH services provide to more than one trust, we used the term 'site' for each combination of an OH provider and trust. There was a unique login code for each site for data collection on the webtool.

Unit of audit - trusts

Because NHS OH is organised and funded at trust level, we analysed results and produced local reports for individual trusts rather than individual OH services.

Types of trust

Trusts were allocated into type of trust according to the lists available on the NHS Choices website.¹² Those trusts which fell into multiple categories and groupings made up of very small samples, were not included in the type of trust analyses.

Case notes

A case note refers to the entry referring to a consultation in the OH record.

Case

A case is a member of staff from a participating trust who was seen by their OH department and whose consultation was audited.

Audit Development Group

The audit tool was developed by practising clinicians supported by the OHCEU Audit Development Group. The Group includes specialists in OH (nurses, doctors and academics), psychiatry, physiotherapy, management and human resources, audit and clinical standards, and medical statistics.

Choice of topic

The audit topic was selected by the OHCEU Steering Group using a structured approach. We prioritised according to:

- Its importance in OH practice, especially in the NHS, but also more widely.
- The existence of national evidence-based guidelines to use as standards for practice to measure against.

¹² www.nhs.uk/aboutnhs/HowtheNHSworks/authoritiesandtrusts/Pages/authoritiesandtrusts.aspx, accessed October 2008.

- Whether the topic has been a focus for previous audits and, if so, where and how recently.
- The amenability of the topic to audit, and especially to the assessment of relevant outcome measures.
- Evidence about the extent to which practice in this area is amenable to change.
- Potential barriers to both data collection and improvement based on audit findings (in particular beliefs of patients/workers about the value of interventions or their consequences).
- Variability of practice.

Audit tool design

Rationale

People on long-term sickness absence are at high risk of depression and it is a common co-morbidity, whatever the presenting diagnosis.¹³ 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.

Depression screening is designed to identify people with depression beyond those with an established diagnosis of the condition. Management of depression in the OH setting does not necessarily involve treatment; the focus is on optimisation of care to expedite recovery so that the employee is able to return to work. The audit questions were designed to identify whether consultations had covered the following aspects of management of depression:

- identification (primary and co-morbid);
- assessment of severity and risk in order to guide management decisions;
- assessment of psychosocial and workplace factors (and hence barriers to recovery);
- recording of any current treatment; and
- communication with other appropriate healthcare professionals, patients themselves and employers/line managers as appropriate.

We defined 'long-term' sickness absence as four weeks or more. While there are many definitions, this period of time is commonly referred to in the literature. Questions about depression become increasingly appropriate as the period of sick leave increases. We therefore chose the first consultation following at least four weeks of absence as an appropriate point to screen for distress and depression.

National guidelines

There is no national guideline on depression screening in employees on long-term sickness absence. Thus the audit tool (*Appendix 3*) is based on the NICE Guideline on the Management of Depression.¹⁴

¹³ People with chronic pain have been found to be more likely to have depression than those who do not. Magni G, Caldieron C, Rigatti-Luchini S and Merskey H (1990) Chronic musculoskeletal pain and depressive symptoms in the general population; An analysis of the 1st National Health and Nutrition Examination Survey data *Pain* 43(3):299–307.

¹⁴ National Institute for Health and Clinical Excellence (2004) *Depression: management of depression in primary and secondary care* (CG23).

Eligible cases

An NHS staff member's first consultation, between 1 January 2008 and 22 August 2008, with an OH doctor or nurse following four weeks of sickness absence for any health-related reason. Participants were asked to submit a sample of 40 consecutive eligible consultations into the audit.¹⁵

Recruitment of trusts

All NHS trusts in England were eligible. The OHCEU wrote to the chief executives, directors of OH departments and of clinical audit or governance departments inviting them to participate in the audit. Where trusts did not respond we contacted the directors of human resources.

We contacted trusts by email, post and telephone at intervals throughout the data collection period to encourage them to participate and offer support in using the web-based data collection tool.

Data collection and entry

All data entry was through a specially designed audit website that was open from 12 May 2008 until 22 August 2008. Access to each site's data was password protected for confidentiality. For each case note audited, the webtool routed the data collector through the questions, making available only the applicable answers, and responses were validated prior to completion of a case. No patient-identifiable data were requested. Help notes and definitions were provided as were free text 'comment boxes' to enable the data collector to give any clarifications.

The OHCEU Project Manager was available throughout the data collection period to answer any queries from participants. Regular reminders and updates were sent out to maximise the number of cases entered.

We specified that OH doctors and nurses should analyse case notes retrospectively and record the answers to the audit questions. Where feasible, data collection should have been carried out by somebody other than the clinician who wrote the case notes. More than one data collector could enter data for any one site – the site codes and passwords were specific to each site, rather than individuals (no clinician-identifiers were used). Participants were advised that actions not explicitly documented in the case notes should not be recorded as having been performed, even if they were known to be normal practice for a particular OH professional or department.

Inter-rater study

We asked sites to nominate a second OH professional to repeat the data collection for the first five cases entered into the audit. This was to enable us to assess the reliability of the questions, ie the extent to which different auditors agreed when asked to interpret the same set of notes. This is particularly important when using a set of audit questions for the first time, as in this case.

There are two factors that can reduce the reliability of data: disagreement on whether or not a particular question is applicable to the case, and disagreement on the most appropriate answer.

¹⁵ Many sites told us that they had fewer than 40 eligible consultations during the audit period but that they had entered all that met the criteria.

The first of these was less relevant in this audit tool because almost all the questions applied to all the case notes and the auditor was not required to make a judgement of applicability. The second aspect was tested by calculating kappa scores for inter-rater agreement and McNemar-Bowker tests for systematic differences between the two auditors.¹⁶

Pilot

The audit tool and help notes were piloted in early 2008. The audit tool was revised in light of analysis of the data and feedback from participants.

Data analysis

We present descriptive statistics throughout this report without inference (p-values or confidence intervals). This means that differences between groups of cases are described but not tested for statistical significance. Where it was informative, analyses are presented broken down by risk factors and casemix, however these are not adjusted for by more sophisticated statistical models.

The interpretation of results rests as far as possible with the audit participants, who are best placed to understand their meaning in the local context and to formulate quality improvement strategies as a result. The role of central analysis is to produce valid, reliable and high-quality local and national statistics through extensive checking and data cleaning.

Statistical analysis was carried out by the Medical Statistician at the Royal College of Physicians using SPSS Version 15. Results were interpreted by the Audit Development Group and the Project Team. For clarity, figures are usually given without decimal places and graphs may be truncated to omit extreme values.

Presentation of results

The national report shows the pooled, anonymised results from all participating trusts. National results are presented as percentages. Site variation is summarised by the median and inter-quartile range (the range within which the middle half of sites' results lie, one quarter being lower and one quarter higher than the median).

The site-specific reports provide this information at site level under the heading 'your site' for comparison with the national results.

¹⁶ For methods, see Altman DG (1991) *Practical Statistics for Medical Research* Chapman and Hall, pp 258 and 404.

4 Results

Audit results reflect the level of documentation achieved. The importance of documenting a consultation fully and accurately is discussed in the Introduction. There will be a level of under-reporting where actions and discussions took place but were not recorded in the notes and therefore are not reflected in the results.

Inclusion of cases

7,158 completed cases were entered for audit. Eight of these were deleted on the basis of participants' free-text comments in accordance with the audit eligibility criteria, bringing the total to 7,150. Of these, 864 were reliability duplicates as defined below and were set aside, leaving 6,286 completed cases for analysis.

Definition of a site

As detailed in Section 2, the relationships in the NHS between trust and OH provider are complex. The audit was designed and reported to reflect the quality of care provided to NHS staff grouped by the trust at which they are employed. For the purposes of this audit, a 'site' is therefore a sample of employees that presented to a single OH service and are employed by a single trust. Cases were related to sites by the login code used for data entry onto the webtool.

277 sites (covering 267 NHS trusts) submitted cases to the audit. 219 (79%) sites entered ten or more cases. Half of the cases (3,171/6,286) came from 78 (28%) of the sites.

Trust participation

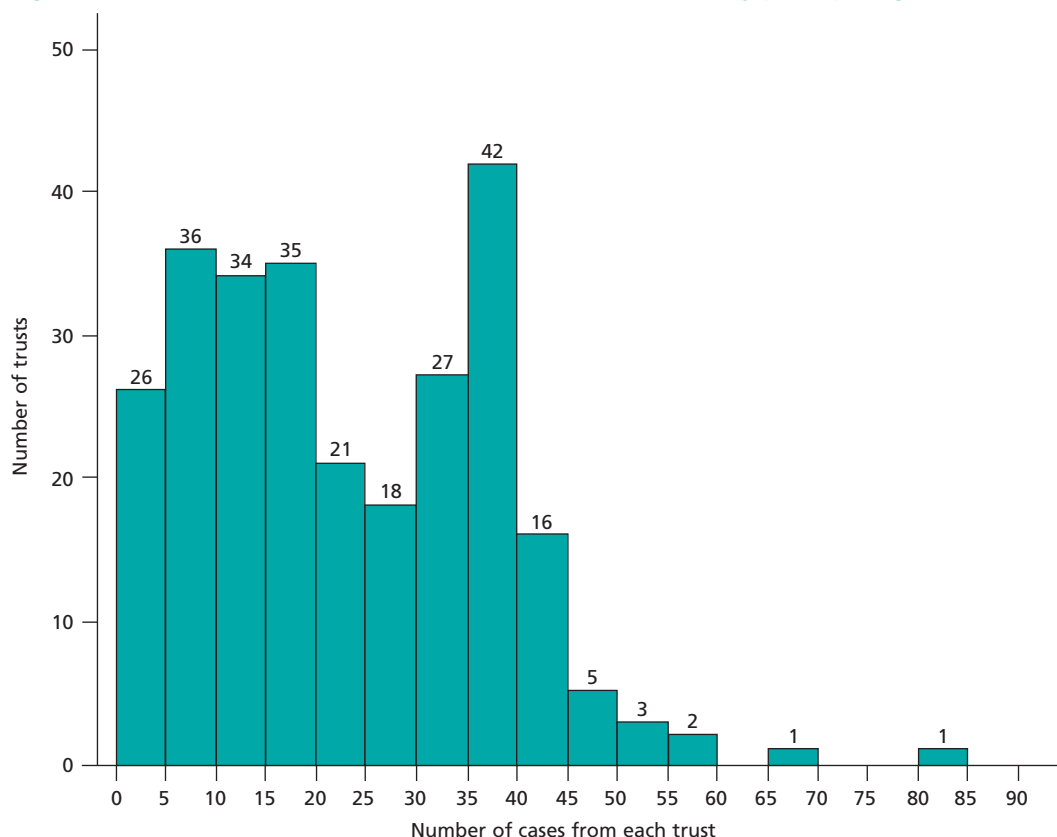
Type of trust	Total (England)	Participating trusts
Acute	170	137 (81%)
Ambulance	11	6 (55%)
Care ¹⁷	3	2 (67%)
Mental health	53	36 (68%)
Primary care	129	75 (58%)
Mixed (providing more than one type of service)	23	11 (48%)
TOTAL	389	267 (69%)

¹⁷ Care trusts are organisations that work in both health and social care. They may carry out a range of services, including social care, mental health services or primary care services. See NHS Choices for further details, www.nhs.uk/aboutnhs/HowtheNHSworks/authoritiesandtrusts/Pages/authoritiesandtrusts.aspx#q04, accessed December 2008.

There was wide variation in the number of cases entered by different sites. In order to assess whether results from sites contributing a small number of cases were likely to be representative of their practice (and thus not bias the audit results as a whole), we compared the demographics of cases from these sites with those from sites with a larger number of cases. No noticeable differences in terms of age, gender and occupation were found.

Fig 2 shows the variation in terms of the numbers of cases entered into the audit.

Fig 2 Variation in the numbers of cases entered into the audit by participating trusts



We ask participants to note that if a small number of cases were entered for their site they should interpret their site-specific results with caution.

Inter-rater reliability duplicates

In total, 864 cases were entered onto the webtool as one part of an inter-rater reliability (IRR) pair (see *Methods*), ie as duplicates of a case already entered into the audit. However, 11 of these were identified as triplicates and hence the case in each set with the highest proforma number (last entered) was excluded entirely from any further analysis.

The 853 IRR duplicates of cases were used in calculating the inter-rater reliability statistics (see *Appendix 1*) but excluded from the main analyses (which used only the first entry of the IRR pairs). The IRR results showed very good agreement between two auditors when answering the audit questions for the same cases, indicating strong reliability of the data. These results are very encouraging in terms of the future utility of the audit tool.

Eligible cases

An NHS staff member's first consultation with an OH doctor or nurse following four weeks of sickness absence for any health-related reason.

Casemix and demographics

Data collectors were asked to enter the age, gender and occupational group of each employee whose case notes were audited. The responses are shown below.

Question 1.1: Age

National (6,286 cases)	
Median	IQR
46	38–53

Question 1.2: Gender

National (6,286 cases)		
	Number	%
Women	5,274	84
Men	1,012	16

Question 1.3: Occupation (6,265 cases, 20 missing data, 1 'not documented')

National (6,265 cases)		
	Number	%
Allied health professionals	748	12
Ancillary staff	1,143	18
Clerical	1,019	16
Doctor	115	2
Nurse	2,832	45
Other	408	7

The median age of cases entered into the audit (46) was very similar to the median age of all staff in the NHS (43).¹⁸ The proportion of women in our audit (84%) was higher than the proportion of women employed in the NHS (77%).¹⁹ A higher proportion of nurses (45%) and

¹⁸ Information provided by The Information Centre, November 2008. Copyright © 2008. Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

¹⁹ Information provided by The Information Centre, November 2008. Copyright © 2008. Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

Depression screening and management of staff on long-term sickness absence

a lower proportion of doctors (2%) were entered into this audit than would be expected from current demographics of the NHS workforce in England (nationally 30% are nurses and 10% are doctors).²⁰ We do not know whether this is because nurses are more, and doctors less, likely to experience long-term sickness absence; or because nurses are more, and doctors less, likely to use their OH department.

It is important that trusts ensure that all staff groups have full access to OH services and are encouraged to seek advice.

Referral diagnosis

In our population of staff absent from work for at least four weeks, the diagnosis described in the referral to OH varied between occupational groups as shown below (this table draws on Question 8.2.1, which is detailed later in this report):

8.2.1 What was the diagnosis as described in the referral to OH?

1.3 Occupation	Cardio-vascular	Malignancy	Musculo-skeletal	Other	Psycho-logical	Respira-tory (non-malignant)	Surgery (non-malignant)	All diagnostic categories
Allied health professionals	16 (2%)	18 (3%)	144 (22%)	95 (15%)	276 (42%)	14 (2%)	89 (14%)	652 (100%)
Ancillary staff	40 (4%)	24 (2%)	259 (27%)	107 (11%)	344 (36%)	36 (4%)	155 (16%)	965 (100%)
Clerical	24 (3%)	39 (5%)	161 (19%)	109 (13%)	362 (43%)	22 (3%)	131 (15%)	848 (100%)
Doctors	3 (4%)	5 (7%)	6 (8%)	9 (12%)	42 (58%)	0 (0%)	8 (11%)	73 (100%)
Nurses	72 (3%)	76 (3%)	598 (25%)	286 (12%)	939 (39%)	59 (2%)	352 (15%)	2,382 (100%)
Other	9 (2%)	11 (3%)	106 (28%)	51 (14%)	125 (33%)	15 (4%)	57 (15%)	374 (100%)
All occupations (17 missing data)	164 (3%)	173 (3%)	1,274 (24%)	657 (12%)	2,088 (39%)	146 (3%)	792 (15%)	5,294 (100%)

The table above shows that for all occupational groups, the most common diagnosis described in the referral was psychological and the second most common was musculoskeletal.

For 9% of sites (26/277), accounting for 3% (186/6,286) of cases, all the cases entered into the audit were referred with a psychological diagnosis (Question 8.2.1). This may have occurred by chance or it could be that some sites only selected cases with psychological problems/depression for entry into the audit, rather than all cases of at least four weeks of sickness absence.

²⁰ The Information Centre (2008) *Staff in the NHS 1997–2007 (England)*.

Period of absence from work at the time of the audited appointment (first appointment following at least four weeks off work)

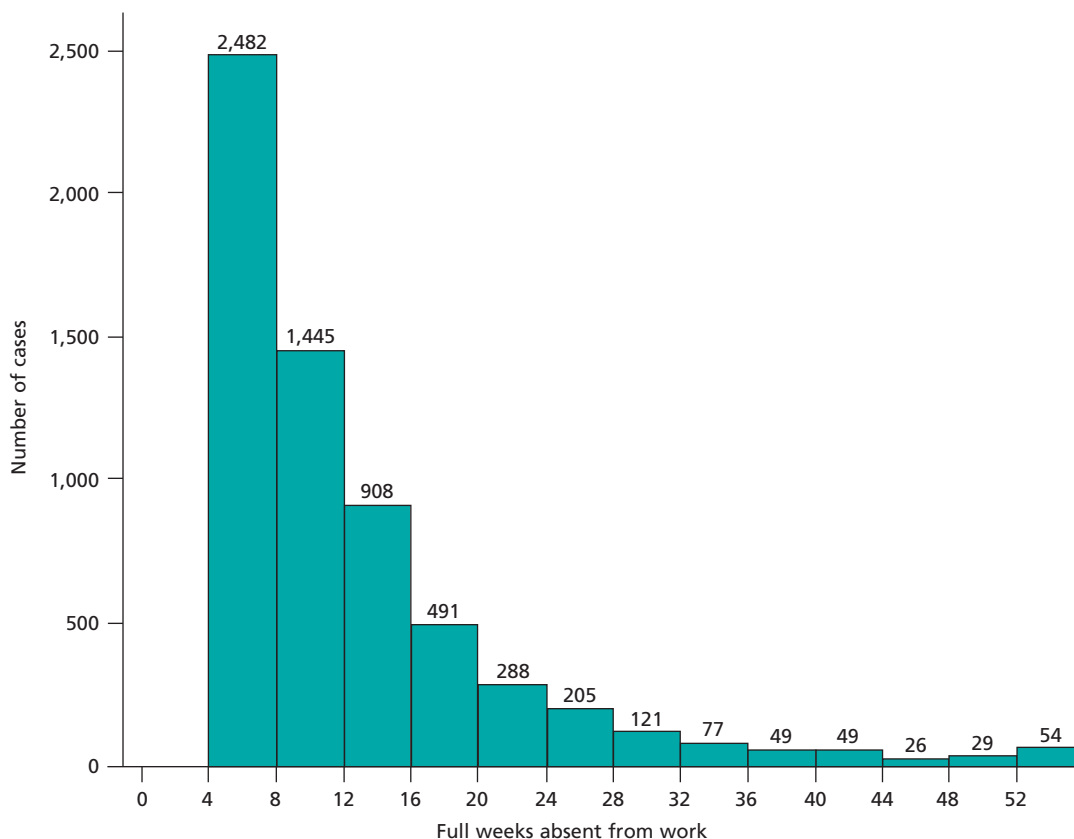
These data were collected as they provide useful background information about the population of cases included in the audit:

1.5: How many full weeks had the patient been absent from work at the time of this appointment? (6,278 cases, 8 missing data)

National (6,278 cases)	
Median	IQR
9	6–14

Fig 3 shows the number of weeks that cases had been absent from work at the time of the audited appointment. The height of the bar shows how many cases are in each category:

Fig 3 Number of weeks absent from work



This graph is truncated at 52 weeks for clarity. 62 cases (1% of the total) had been off work for longer than this at the time of audited appointment and do not appear.

The median period off work at the time of the audited appointment was nine weeks with no clear differences between occupational groups or for different diagnoses. Each case will differ in terms of the period of time off work before which it is appropriate to attend the OH

department. We note that cases may have been seen earlier than four weeks after their episode of sickness absence began, and so the appointments audited here may represent a second or even third appointment for this episode of sickness absence. However, the audited appointment should be the first to occur after four weeks (see *Eligibility criteria* above), and therefore may represent the first time the case has been seen having progressed to long-term sickness absence. The results for this question should therefore be interpreted locally.

Occupational health screening for depression

Rationale and target

Individuals with chronic disease and particularly those on long-term sickness absence are at high risk of depression, whatever the presenting diagnosis.²¹ The NICE Guideline on Management of Depression notes that many patients with established physical diseases become depressed during the course of their illness. Recognition of depression for this population is important and can lead to improved outcomes.²² Depression is an independent predictor of non-return to work,²³ regardless of the primary diagnosis, and the longer a person is off work the less likely they are to return to work.

OH professionals should consider the possibility of psychological problems underlying or complicating the clinical picture for all²⁴ cases that present after four weeks of sickness absence, independent of the reason.

Audit results		
2.1: Is there any evidence that the OH Professional has attempted to assess whether or not the patient might be depressed?	National (6,286 cases)	
	Number	%
Yes	2,650	42
Yes, but no evidence of distress	1,019	16
No	2,617	42

The table shows that 58% of cases were assessed for depression. This figure did not vary noticeably by age, gender or occupational group (once the nature of the referral diagnosis was taken into account, see below). There were notable differences, however, between types of NHS

²¹ Egede LE (2007) Major depression in individuals with chronic medical disorders: prevalence, correlates and association with health resource utilization, lost productivity and functional disability *Gen Hosp Psychiatry* 29(5):409-16.

²² National Institute for Health and Clinical Excellence (2004) *Depression: management of depression in primary and secondary care* (CG23), Paragraph 4.3.

²³ Mykletun A, Overland S, Dahl AA *et al* (2006) A population-based cohort study of the effect of common mental disorders on disability pension awards *Am J Psychiatry* 163(8):1412-8.

²⁴ Where a target of 'all consultations' has been set in this report we acknowledge that there may be rare and exceptional cases where the action would be inappropriate, for example if the patient had not given consent.

trust.²⁵ 33% (53/160) of Ambulance trust staff were assessed, comprising 24% (39) with some evidence of distress²⁶ and 9% (14) with no evidence of distress. By contrast, 61% (553/912) of staff of Mental Health trusts were assessed, comprising 51% (465) with some evidence of distress and 10% (88) with no evidence of distress.

Is screening for depression in people who have had at least four weeks of absence from work dependent on the reported problem at referral (Question 8.2)?

	Referred with psychological diagnosis	Referred with musculo-skeletal diagnosis	All other categories of referral diagnosis
Percentage of patients assessed for depression	83% (1,727/2,091)	12% (147/1,277)	17% (340/1,943)

Screening for depression was recorded in 83% of cases in which a referral for a psychological diagnosis had been made, with little difference between occupational groups. For cases that presented with a different diagnosis on referral, the frequency of screening was 15% (487/3220).

This finding shows that many more consultations need to include screening for depression, particularly where the presenting problem is a physical one.

From this point until Section 8 on Communication below, the questions were only asked for those cases for which the answer to Question 2.1 was 'Yes' (ie only when the OH Professional had attempted to assess if the patient might be depressed *and* there was evidence of distress). 2650 cases were included in this category.

Depression severity

Rationale and target

The OH professional's discussions during consultations with staff who have had at least four weeks of sickness absence and show signs of distress should cover the core features of depressive illness. The symptom list included in the audit question below is based on the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, 10th Revision (2007) (ICD-10) and is not exhaustive. The OH professional should be able to ask sufficient details to diagnose or exclude depression in order to advise the most appropriate care. This is a crucial aspect of the stepped care approach recommended by NICE,²⁷ and without knowledge of the ICD-10 symptoms it would be difficult to assess the appropriate level of treatment indicated.

²⁵ Trust type throughout is considered on the basis of the trust the patients are employed by, rather than where the OH service is based.

²⁶ 'Yes' to Question 2.1 indicates screening for depression took place and evidence of distress was found.

²⁷ National Institute for Health and Clinical Excellence (2004) *Depression: management of depression in primary and secondary care* (CG23).

Audit results		
3.1: Please indicate if the OH Professional has asked the patient any questions about the following aspects of depression:	National (2,650 cases)	
	Number	%
Loss of interest	1,105	42
Loss of appetite or weight	1,089	41
Difficulty concentrating	1,192	45
Depressed mood/sadness	1,971	74
Lack of energy/fatigue	1,149	43
Sleep disturbance	1,685	64

Of the cases that had been off work for at least four weeks, and showed some evidence of distress, 18% (484/2,650) were asked about all the six symptoms of depression above and 11% (288/2,650) were asked about none. 14% (383) were asked about one, 16% (436) two, 17% (455) three, 13% (353) four and 9% (251) five of these six aspects. We found that:

- ‘Depressed mood/sadness’ and ‘sleep disturbance’ were asked about more frequently than other aspects.
- Where only one of the items was not asked, it was most commonly ‘loss of appetite/weight’ (75/251) or ‘difficulty concentrating’ (65/251).

There were no obvious differences between occupational groups in terms of whether the above questions were asked. There were only small differences between types of trust: 15% (69/465) of cases employed in Mental Health trusts were asked about all six aspects, as compared with 21% (108/520) for Primary Care and 18% overall.

These findings suggest that OH professionals need to include more questions about the core symptoms of depression in their consultations, to avoid missing depression in staff on long-term sickness absence.

Suicide or self-harm

Rationale and target

For patients with depression, there is a clear NICE recommendation that healthcare professionals should always ask directly about suicidal ideas and intent.²⁸ If thoughts about suicide or self harm are reported, plans and previous actions should be asked about as they constitute key risk factors for future suicide and self harming.

It might be argued that it would not be appropriate for OH professionals to ask some cases with distress about suicide and self harm. However, if cases present having had at least four

²⁸ National Institute for Health and Clinical Excellence (2004) *Depression: management of depression in primary and secondary care* (CG23), paragraph 2.6.2.5.

weeks off work and showing evidence of distress, the risk of depression described above indicates that OH professionals should ask these questions.²⁹ The responses should always be recorded in the notes.

Thoughts of suicide are relatively common. The presence of a mood disorder is one of the strongest risk factors for both suicidal thoughts and actual self harm.³⁰

		National	
		Number	%
4.1: Is there any evidence that the OH Professional has asked the patient about thoughts of suicide or deliberate self harm?	Yes	823/2,650	31
4.1.1: If yes to 4.1, did the patient report thoughts of suicide or self-harm?	Yes	256/823	31
4.1.1.1: If yes to 4.1.1, is there any evidence that the OH Professional has asked about the patient's plans for suicide or self-harm?	Yes	171/256	67
4.1.1.2: If yes to 4.1.1, is there any evidence that the OH Professional has asked about any previous suicidal acts or actual self-harm?	Yes	124/256	48

Amongst the cases in which evidence of distress was detected, 31% were asked about thoughts of suicide or deliberate self harm. Within this subgroup, a third (31%) of cases reported thoughts of this kind. 67% of cases that reported thoughts of suicide or self harm were asked about actual plans, and 48% were asked about any previous acts.

Thus at least 10% of cases that had been off work for at least four weeks and had documented evidence of distress (256/2,650), had experienced thoughts of suicide or self-harm. This represents 4% (256/6,286) of all cases submitted to the audit (ie 4% of all cases that had been off work for four weeks or more, for any health-related reason).

It is difficult to make direct comparisons with previous surveys, however these results seem to indicate that individuals on long-term sickness absence may be at increased risk of suicidal ideation.³¹ We note that there are some situations in which documentation is more likely, such as when the employee appears at risk of suicide or broaches the subject him/herself.

²⁹ Suicide and self harm were considered together in this audit as assessments carried out by the occupational health professional are similar for both.

³⁰ Nock MK, Borges G, Bromet EJ *et al* (2008) Cross-national prevalence and risk factors for suicidal ideation, plans and attempts *Br J Psychiatry* 192(2):98–105.

³¹ The British Household Survey found that just under 1% of the population had reported suicidal thoughts in the previous week (Jenkins R, Bebbington P, Brugha TS *et al* (1998) British psychiatric morbidity survey *Br J Psychiatry* 173:4–7).

Depression screening and management of staff on long-term sickness absence

Mental Health trusts were compared with other types of trust to investigate whether a general awareness of mental health issues might make it easier to ask these questions, or for members of staff to raise them. In fact, there was little difference, with staff at Mental Health trusts being asked slightly less often about thoughts of suicide or self harm (28%, 129/465) than staff from other types of trust (32%, 680/2,107).³²

For those who were asked, 36% (47/129) of staff at Mental Health trusts reported thoughts of suicide or self harm as compared with 30% (204/680). The supplementary questions were relevant to very few cases so no further comparisons were made. There were no obvious differences between age bands (<40, 40–55, >55), sexes or occupational groups in terms of the above questions having been asked.

We looked at how often cases with a current diagnosis of depression³³ were asked about thoughts of suicide or self harm compared with those who had no diagnosis of depression but presented with some evidence of distress:³⁴

		Patients with diagnosis of depression (1,921 cases)		Patients with no diagnosis of depression but with some evidence of distress (729 cases)	
		Number	%	Number	%
4.1: Is there any evidence that the OH Professional has asked the patient about thoughts of suicide or deliberate self harm?	Yes	719/1,921	37	104/729	14
4.1.1: If yes to 4.1, did the patient report thoughts of suicide or self harm?	Yes	245/719	34	11/104	11
4.1.1.1: If yes to 4.1.1, is there any evidence that the OH Professional has asked about the patient's plans for suicide or self harm?	Yes	166/245	68	5/11	45
4.1.1.2: If yes to 4.1.1, is there any evidence that the OH Professional has asked about any previous suicidal acts or actual self harm?	Yes	121/245	49	3/11	27

37% of cases with a current diagnosis of depression were asked about thoughts of suicide or self harm compared with 14% of those that had some evidence of distress but no recorded diagnosis of depression.

³² Trusts that provide mental health services in addition to their other services were excluded from this calculation.

³³ Made either prior to or during the consultation (Question 7.1 was answered 'yes').

³⁴ These questions were only made applicable for patients who presented with some evidence of distress.

The management of these employees with distress and depression could be improved if appropriate questions about suicide were more frequently asked by OH professionals.

Psychosocial context

Rationale and target

A person's psychosocial context is an important factor in their depression and their return to work. The NICE Guideline states that 'when assessing a person with depression, healthcare professionals should consider the psychological, social, cultural and physical characteristics of the patient and the quality of interpersonal relationships. They should consider the impact of these on the depression and the implications for choice of treatment and its subsequent monitoring.'³⁵

Therefore questions about psychosocial aspects should always be asked of cases who have had at least four weeks of sickness absence and also show signs of distress.

We acknowledge that the answers to some of these questions may not have been documented in the case note entry audited, as the OH professional may have assessed these factors in a previous appointment (earlier than four weeks of sickness absence). However, use of alcohol and street or illicit drugs could be a changing situation and therefore should be asked about regularly, particularly when an employee has been absent from work. Research evidence shows that 16% of those with depression have a current diagnosis of alcohol problems compared with 7% in the general population. Alcohol problems are associated with worse outcomes with respect to course of illness, suicide/death risk, social functioning, healthcare utilisation³⁶ and capacity to work.³⁷

Audit results

5.1: Is there any evidence that the OH Professional has asked any questions about the following aspects of the patient's life?

	National (2,650 cases)	
	Number	%
Patient's spouse or partner, or documented that patient is single	1,685	64
Patient's children or family, or documented that patient has no children	1,578	60
Use of alcohol	874	33
Use of street or illicit drugs	248	9

³⁵ National Institute for Health and Clinical Excellence (2004) *Depression: management of depression in primary and secondary care* (CG23), paragraph 2.6.2.16.

³⁶ Sullivan LE, Fiellin DA and Connor PG (2005) The prevalence and impact of alcohol problems in major depression: a systematic review *American Journal of Medicine* 118(4):330–41.

³⁷ Vahtera J, Poikolainen K, Kivimäki M, Ala-Mursula L and Pentti J (2002) Alcohol intake and sickness absence: a curvilinear relation *Am J Epidemiol* 156(10):969–76.

Depression screening and management of staff on long-term sickness absence

The following tables show variation by age and gender in how often these questions were asked:

5.1: Is there any evidence that the OH Professional has asked any questions about the following aspects of the patient's life?	Age <40 years (848 cases)		Age 40–55 years (1,450 cases)		Age >55 years (352 cases)	
	Number	%	Number	%	Number	%
Patient's spouse or partner, or documented that patient is single	562	66	914	63	209	59
Patient's children or family, or documented that patient has no children	542	64	875	60	161	46
Use of alcohol	258	30	518	36	98	28
Use of street or illicit drugs	109	13	119	8	21	6

5.1: Is there any evidence that the OH Professional has asked any questions about the following aspects of the patient's life?	Men (439 cases)		Women (2,211 cases)	
	Number	%	Number	%
Patient's spouse or partner, or documented that patient is single	291	66	1,394	63
Patient's children or family, or documented that patient has no children	232	53	1,346	61
Use of alcohol	164	37	710	32
Use of street or illicit drugs	56	13	192	9

Over 60% of cases off work for at least four weeks and who showed some sign of distress were asked about family members. 33% were asked about alcohol and 9% were asked about drugs. We also found that:

- 22% (580/2,650) were asked about one of these aspects (most commonly about their spouse/partner or about their children/family),
- 32% (856/2,650) were asked about two,
- 17% (455/2,650) were asked about three,
- 7% (182/2,650) were asked about all four, and
- 22% (577/2,650) were not asked about any of these aspects.

There were no obvious differences between occupational groups in terms of whether the above questions were asked. The tables above show that, with the exception of alcohol, the questions were asked less often as the age of the case increased. Women were asked questions about children/family more often than men. These questions were asked more frequently in consultations that included questions about thoughts of suicide/self-harm than those that did not (regardless of the response).

A better understanding of potential barriers to recovery would be gained by asking about aspects of home and family life more often. Importantly, more consultations should include questions about alcohol and illicit drug use.

Workplace factors

Rationale and target

Identification of workplace factors that are perceived to have contributed to any distress and/or depression is a key role of the OH professional and therefore relevant questions about the workplace should always be asked. If employees think that workplace factors have caused or contributed to any depression, then the OH professional should usually consider discussing this with the employer. The NICE Guideline states that where a patient's depression has resulted in loss of work or disengagement from other social activities over a longer term, a rehabilitation programme addressing these difficulties should be considered.³⁸

		National	
		Number	%
6.1: Is there any evidence that the OH Professional has asked the patient if they think workplace factors have caused or contributed to any depression?	Yes	1,849/2,650	70
6.1.1: If yes to 6.1, did the patient think workplace factors have caused or contributed to any depression?	Yes	1,188/1,849	64
6.1.1.1: If yes to 6.1.1, is there any evidence that the OH Professional has considered discussing this with the employer?	Yes	995/1,188	84

70% of cases off work for at least four weeks, and with evidence of distress, were asked about the contribution of workplace factors to any depression. 64% thought that workplace factors had caused or contributed to their depression. In 84% of this latter subset the OH professional considered discussing this with the employer.

Different types of trust were compared and only small differences were found. The percentage of cases asked about workplace factors showed some evidence of variation between occupational groups, as did the percentage who felt that workplace factors had contributed to any depression (see table below). There were no obvious differences between occupational groups in terms of whether the OH professional had considered discussing workplace factors with the employer (data not shown).

³⁸ National Institute for Health and Clinical Excellence (2004) *Depression: management of depression in primary and secondary care* (CG23), paragraph 2.6.2.15.

	6.1: Is there any evidence that the OH Professional has asked the patient if they think workplace factors have caused or contributed to any depression?		6.1.1: If yes to 6.1, did the patient think workplace factors have caused or contributed to any depression?	
	National		National	
	Number	%	Number	%
Allied health professionals	250/331	76	170/250	68
Ancillary staff	270/425	64	144/270	53
Clerical	345/468	74	250/345	72
Doctor	48/62	77	31/48	65
Nurse	833/1,206	69	524/833	63
Other	97/151	64	66/97	68

Current management

Rationale and target

OH professionals should ask cases with at least four weeks of sickness absence and a current diagnosis of depression about contact with other healthcare professionals concerning their depression and also about any medication they are being prescribed for the depression.

Audit results		National	
		Number	%
7.1: Is it documented that the patient has a current diagnosis of depression from either the OH Professional or another healthcare professional?	Yes	1,921/2,650	72
7.1.1: If yes to 7.1, is there any evidence that the patient has been asked about contact with other healthcare professionals concerning their depression?	Yes	1,770/1,921	92
7.1.1.1: If yes to 7.1.1, which professionals?	GP	1,561/1,770	88
	Psychiatrist/community psychiatric nurse/mental health team	375/1,770	21
	Counsellor/therapist/cognitive behavioural therapy therapist	1,051/1,770	59
7.1.2: If yes to 7.1, is there any evidence that the OH Professional has asked about any medication that is being prescribed for the depression?	Yes, patient being prescribed medication	1,464/1,921	76
	Yes, patient NOT being prescribed medication	297/1,921	15
	No, patient not asked	156/1,921	8

Amongst the 72% of cases that had a current diagnosis of depression, 92% were asked by the OH professional about contact with other healthcare professionals and 92% (1,761/1,921) were asked if medication was being prescribed for the depression. There were very few differences in these results between the different types of trust.

Communication

This section applies to all 6,286 cases in the audit, whether or not the occupational health professional screened for depression.

Rationale and target

Communication is fundamental to the role of the OH professional. Core groups for liaison include the employee, their line manager, their GP and where depression is diagnosed, any mental health professionals involved.

For most cases, the OH professional should communicate with the employee's line manager following an appointment after four weeks of sickness absence (many of these will have been referred by their manager). The GP should be contacted³⁹ in cases where it is appropriate to do so, such as where there is a significant work-related component to the employee's diagnosis or recovery.⁴⁰

As regards communicating with employees themselves, the *Copying Letters to Patients* initiative originated in the Government's NHS Plan and has been rolled out since 2003. It states that letters between clinicians about a patient's care will be 'copied to the patient as of right'.⁴¹ There is divergence amongst OH professionals about whether, and under which circumstances, they should follow this guidance. Some OH professionals, when writing to line managers and/or GP, send a copy to the employee. Others will discuss the content of such correspondence with the employee and may decide not to send copies to patients routinely.

Thus, the targets for communication are as follows:

- most consultations should result in communication with the employee's line manager,
- communication with the employee's GP will depend on the case and the results below should be interpreted locally,
- mental health professionals should be contacted where appropriate, and
- communication with the employee him/herself will depend on the case and the policy of the OH professional and their department and hence the results should be interpreted locally.

³⁹ We note that communication does not always involve informing the GP, it might for example include asking the GP for further information.

⁴⁰ The FOM Guidance on Ethics for Occupational Physicians advises that 'In normal circumstances, and subject to the consent of the individual, the occupational physician should inform the general practitioner, who is responsible for maintaining continuity of the patient's medical care, of work-related facts which may have a bearing on the health of the individual'. Faculty of Occupational Medicine (2006) *Guidance on ethics for occupational physicians, 6th Edition*, paragraph 2.5.

⁴¹ See Department of Health *Copying letters to patients*, www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/Copyingletterstopatients/DH_4000431, access November 2008.

Audit results		
8.1: Is there any evidence that the OH Professional has communicated (telephone or letter or email) with any of the following?	National (all 6,286 cases)	
	Number	%
GP	832	13
Patient's line manager	6,020	96
A mental health professional	246	4
The patient (eg copy of letter to the GP or manager)	3,605	57

Nationally, communication with the employee's line manager was, at 96%, in line with the target. As stated above, the other results should be interpreted locally.

The audit revealed that communication practice appears to vary widely between OH services, as 19% (52/277) of sites communicated with none of their patients and 27% (76/277) communicated with all their patients (this was unrelated to the number of cases entered per site).

For the subgroup of cases who had at least four weeks off work and evidence of distress, communication by the OH professional for those who had a current diagnosis of depression compared with those who did not are shown below:

8.1: Is there any evidence that the OH Professional has communicated (telephone or letter or email) with any of the following?	Patients with diagnosis of depression (1,921 cases) ('yes' to Qs 7.1)		Patients with no diagnosis of depression but with some evidence of distress (729 cases)	
	Number	%	Number	%
GP	384	20	92	13
Patient's line manager	1,842	96	692	95
A mental health professional	183	10	29	4
The patient (eg copy of letter to the GP or manager)	1,148	60	443	61

Finally, the responses were broken down according to whether thoughts of suicide or self-harm had been recorded:

8.1: Is there any evidence that the OH Professional has communicated (telephone or letter or email) with any of the following?	Thoughts of suicide or self harm (256 cases) ('yes' to Q 4.1.1)		No thoughts of suicide or self harm (567 cases)	
	Number	%	Number	%
GP	71	28	135	24
Patient's line manager	238	93	550	97
A mental health professional	42	16	53	9
The patient (eg copy of letter to the GP or manager)	172	67	363	64

The tables above show that OH professionals communicated somewhat more frequently with GPs and mental health professionals where cases had a current diagnosis of depression or had experienced thoughts of suicide or self harm.

Communication with GPs was also more frequent even when cases were asked about thoughts of suicide or self harm than when they were not asked (regardless of the answer).

In light of the divergence of opinion about what constitutes best practice in communicating with the employee, we conclude that OH, as a profession, needs to develop national guidance in this area. The Faculty of Occupational Medicine would be well placed to initiate this work and we recommend that this is taken forward and that occupational health nurses, other healthcare professionals, employee and patient representatives are involved.

Referral diagnosis

Audit results

		National (5,768/6,286, excluding not appropriate or missing)		National (1,785/1,921 patients with a current diagnosis of depression, excluding not appropriate)		National (657/729 patients with no documented current diagnosis of depression but some evidence of distress, excluding not appropriate)		
		Number	%	Number	%	Number	%	
8.2: Is the presenting symptom/problem reported in the referral to OH?		Yes	5,311	92	1,623	91	591	90
8.2.1: If yes to 8.2, please state the diagnosis as described in the referral to OH? (5,311 all cases, 1,623 cases with a current diagnosis of depression)	Psychological	2,091	39	1,418	87	309	52	
	Musculo-skeletal	1,277	24	68	4	79	13	
	Surgery (non-malignant)	798	15	26	2	39	7	
	Cardio-vascular	164	3	8	0.5	18	3	
	Malignancy	173	3	7	0.4	24	4	
	Respiratory (non-malignant)	147	3	9	0.6	19	3	
	Other	661	12	87	5	103	17	

In 92% of cases the presenting symptom/problem was reported in their referral and in 78% of these cases it was psychological, musculoskeletal or as a result of surgery. This positive finding suggests that line managers are communicating helpfully when referring their staff to OH units.

Diagnosis given by occupational health professional

		National (all 6,286 cases)		National (1,921 cases with a current diagnosis of depression)	
		Number	%	Number	%
8.3: Please state the OH Professional's initial diagnosis as described in first clinical encounter? (One option only)	Psychological	2,490	40	1,701	89
	Musculoskeletal	1,440	23	70	4
	Surgery (non- malignant)	932	15	25	1
	Cardiovascular	188	3	7	0.4
	Malignancy	220	3	6	0.3
	Respiratory (non-malignant)	169	3	8	0.4
	Other	707	11	74	4
	Not stated	140	2	30	2

The distribution of diagnoses at referral and after the OH consultation was very similar. The level of agreement in individual cases was, as might be expected, very high, given that data collectors were only able to select the primary (a single) diagnosis. Almost all the disagreement was around classification as 'other' or due to the OH professional's diagnosis being recorded as 'not stated'.

5 | Conclusions

We found wide variation nationally in meeting the criteria we chose to audit.

For all staff on long-term sickness absence, regardless of their presenting problem, OH professionals need to consider the possibility of depression. Where there is a suggestion of depressed mood, individuals should have a more thorough assessment of depression including suicide risk. Additionally, many more cases should be asked about alcohol and drug use.

The audit showed evidence of constructive communication with line managers. OH professionals were good at recording the contribution of workplace factors to any depression and assessing whether to discuss this with the employer. Also positive was the high proportion of cases with depression who were asked about contact with other healthcare professionals.

6 Next steps

Occupational health 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 Guideline, 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;
- developing tools to facilitate improvement, for example algorithms and action plans;
- developing systems to support comprehensive documentation of consultations.

OHCEU

- NHS Plus will host a national conference for OH professionals in Spring 2009. At the conference we will disseminate the findings of the audit and facilitate sharing of good practice. We will begin the process of developing materials and mechanisms for improving OH provision for NHS staff nationally.
- The OHCEU will hold regional workshops and focus groups during 2009. These events will enable participants to share their experiences of using the audit to change practice, barriers to such change, and how these can be overcome.
- 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.

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

List of abbreviations

ANHONS: Association of NHS Occupational Health Nurses

ANHOPS: Association of National Health Occupational Physicians

FOM: Faculty of Occupational Medicine

IQR: Inter-quartile range

NICE: National Institute for Health and Clinical Excellence

OH: Occupational health

OHCEU: Occupational Health Clinical Effectiveness Unit

RCP: Royal College of Physicians

Glossary

Case: A case is a member of staff from a participating trust who was seen by their occupational health department and whose consultation was audited.

Case notes: A case note refers to the entry referring to a consultation in the occupational health record.

Depression screening: Assessment by the OH professional of whether or not their patient might be depressed.

Inter-quartile range: The range within which the middle half of the results lie, one quarter being lower and one quarter higher.

Sites: Trusts either have their own in-house OH service or commission it from another provider. Because some trusts use more than one OH service and some OH services provide to more than one trust, we used the term 'site' for each combination of an OH provider and trust. There was a unique login code for each site for data collection on the webtool.

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National Institute for Health and Clinical Excellence (2004) *Depression: management of depression in primary and secondary care (CG23)*

World Health Organization (2007) *International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)*

Appendix 1 Inter-rater reliability

We compared the data entered on duplicate cases entered by second auditors (see *Methods*). Numerical questions (age, date of appointment and weeks off work) are examined in terms of the simple difference between them. For categorical questions (mostly yes/no/not documented), we applied the kappa statistic. This quantifies the degree to which the assessors agree over and above what could be expected by chance (kappa score). Kappa ranges from 1 (perfect agreement) to 0 (no more than chance agreement) to -1 (complete disagreement).

The kappa is more useful than a percentage agreement, which is a crude rate of exactly the same answer occurring. In a question where the great majority of answers are in one category (eg has the OH professional asked about the use of illicit/street drugs), we would expect a high percentage agreement purely by chance; in these circumstances the kappa will be more stringent and distinguish *how much* more than chance agreement we have.

Additionally, we used the McNemar-Bowker test to see whether one of the assessors was inclined to give more yes or no answers than the other.

There are 37 categorical questions and a kappa score was calculable for each of them except one where webtool problems prevented analysis: communication between the OH professional and ‘other’ (ie not in any of the pre-specified options) professionals. The median kappa score was 0.80. Scores of 0.4–0.6 are usually regarded as moderate, 0.6–0.8 as good and 0.8–1.0 as very good. None of the questions in this audit tool scored below 0.4 and there were only three in the ‘moderate’ range; this is very encouraging in terms of the utility of the audit tool in future and the reliability of the results.

Question	Kappa	Number of valid data	Significant McNemar-Bowker tests?	Question	Kappa	Number of valid data	Significant McNemar-Bowker tests?
1.2	0.966	853	–	5.1 (none)	0.849	364	–
1.3	0.860	428	–	6.1	0.789	364	–
2.1	0.853	853	–	6.1.1	0.848	209	–
3.1a	0.795	364	–	6.1.1.1	0.666	150	–
3.1b	0.881	364	–	7.1	0.798	364	–
3.1c	0.822	364	–	7.1.1	0.483	239	–
3.1d	0.638	364	–	7.1.1.1a	0.747	364	–
3.1e	0.781	364	–	7.1.1.1b	0.838	364	–
3.1f	0.881	364	–	7.1.1.1c	0.755	364	–
3.1 (none)	0.741	364	–	7.1.2	0.827	237	–
4.1	0.925	364	–	8.1a	0.850	853	–
4.1.1	0.884	96	–	8.1b	0.472	853	–
4.1.1.1	0.661	30	–	8.1c	0.789	853	–
4.1.1.2	0.561	30	–	8.1d	0.806	853	First auditor answered ‘No’ more often
5.1a	0.828	364	–	8.1 (none)	0.625	853	–
5.1b	0.788	364	–	8.2	0.681	853	–
5.1c	0.910	364	–	8.2.1	0.910	701	–
5.1d	0.747	364	–	8.3	0.865	853	–

Auditors were classified as 'first' or 'second' chronologically.

The differences between auditors in the numerical questions were as follows:

- In 16% (137/853) of cases there was disagreement on age; 3% (29/853) disagreed by more than one year.
- 9% (79/853) disagreed on appointment date; 6% (47/853) disagreed by more than seven days.
- 22% (88/853) disagreed on weeks off work; 5% (49/853) disagreed by more than four weeks.

Appendix 2 Participating NHS trusts

5 Boroughs Partnership NHS Trust
Aintree University Hospitals NHS Foundation Trust
Airedale NHS Trust
Alder Hey Children's NHS Foundation Trust
Ashford and St Peter's Hospitals NHS Trust
Ashton, Leigh & Wigan Primary Care Trust
Barnet and Chase Farm Hospitals NHS Trust
Barnet Primary Care Trust
Barnet, Enfield and Haringey Mental Health NHS Trust
Barnsley District General Hospital NHS Foundation Trust
Barts and The London NHS Trust
Basildon and Thurrock University Hospitals NHS Foundation Trust
Basingstoke and North Hampshire NHS Foundation Trust
Bassetlaw Primary Care Trust
Bedford Hospital NHS Trust
Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust
Bedfordshire Primary Care Trust
Berkshire Healthcare NHS Foundation Trust
Bexley Care Trust
Birmingham Children's Hospital NHS Foundation Trust
Birmingham East and North Primary Care Trust
Birmingham Women's NHS Foundation Trust
Bolton Hospitals NHS Trust
Bolton Primary Care Trust
Bradford and Airedale Teaching Primary Care Trust
Bradford Teaching Hospitals NHS Foundation Trust
Brent Teaching Primary Care Trust
Brighton and Hove City Primary Care Trust
Brighton and Sussex University Hospitals NHS Trust
Bristol Primary Care Trust
Bromley Hospitals NHS Trust
Bromley Primary Care Trust
Buckinghamshire Hospitals NHS Trust
Buckinghamshire Primary Care Trust
Burton Hospitals NHS Trust
Bury Primary Care Trust
Calderdale and Huddersfield NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Camden and Islington NHS Foundation Trust
Camden Primary Care Trust
Central and North West London NHS Foundation Trust
Central Lancashire Primary Care Trust
Chelsea and Westminster Hospital NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
Christie Hospital NHS Foundation Trust
City and Hackney Teaching Primary Care Trust
City Hospitals Sunderland NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
County Durham Primary Care Trust
Coventry and Warwickshire Partnership NHS Trust
Coventry Teaching Primary Care Trust
Darlington Primary Care Trust
Dartford and Gravesham NHS Trust
Derby City Primary Care Trust
Derby Hospitals NHS Foundation Trust
Derbyshire Mental Health Services NHS Trust
Devon Partnership NHS Trust
Devon Primary Care Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Doncaster Primary Care Trust
Dorset Healthcare NHS Foundation Trust
Dorset Primary Care Trust
Dudley Group of Hospitals NHS Trust
Dudley Primary Care Trust
Ealing Hospital NHS Trust
East and North Hertfordshire NHS Trust
East Kent Hospitals University NHS Trust
East Lancashire Hospitals NHS Trust
East London NHS Foundation Trust
East Midlands Ambulance Service NHS Trust
East Riding of Yorkshire Primary Care Trust
East Sussex Hospitals NHS Trust
Eastern and Coastal Kent PCT
Epsom and St Helier University Hospitals NHS Trust
Frimley Park Hospital NHS Foundation Trust
Gateshead Health NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust
Gloucestershire Partnership NHS Foundation Trust
Gloucestershire Primary Care Trust
Great Ormond Street Hospital for Children NHS Trust
Great Western Ambulance Service NHS Trust
Guy's and St Thomas' NHS Foundation Trust

Halton and St Helens Primary Care Trust	NHS Leicester City
Haringey Teaching Primary Care Trust	NHS Rotherham
Harrogate and District NHS Foundation Trust	NHS Sefton
Harrow Primary Care Trust	Norfolk and Norwich University Hospitals NHS Foundation Trust
Havering Primary Care Trust	Norfolk and Waveney Mental Health NHS Foundation Trust
Heart of Birmingham Teaching Primary Care Trust	North Bristol NHS Trust
Heart of England NHS Foundation Trust	North Cumbria University Hospitals NHS Trust
Heywood, Middleton and Rochdale Primary Care Trust	North East Ambulance Service NHS Trust
Hillingdon Hospital NHS Trust	North East Essex Primary Care Trust
Hillingdon Primary Care Trust	North Essex Partnership NHS Foundation Trust
Hinchingbrooke Health Care NHS Trust	North Middlesex University Hospital NHS Trust
Homerton University Hospital NHS Foundation Trust	North Somerset Primary Care Trust
Hounslow Primary Care Trust	North Tees and Hartlepool NHS Foundation Trust
Hull Teaching Primary Care Trust	North West Ambulance Service NHS Trust
Humber Mental Health Teaching NHS Trust	North West London Hospitals NHS Trust
Imperial College Healthcare NHS Trust	North Yorkshire and York Primary Care Trust
Ipswich Hospital NHS Trust	Northampton General Hospital NHS Trust
Isle of Wight Primary Care Trust	Northamptonshire Healthcare NHS Trust
Islington Primary Care Trust	Northern Devon Healthcare NHS Trust
James Paget University Hospitals NHS Foundation Trust	Northumberland, Tyne and Wear NHS Trust
Kensington and Chelsea Primary Care Trust	Northumbria Healthcare NHS Foundation Trust
Kent and Medway NHS and Social Care Partnership Trust	Nottingham City Primary Care Trust
Kettering General Hospital NHS Trust	Nuffield Orthopaedic Centre NHS Trust
King's College Hospital NHS Foundation Trust	Oldham Primary Care Trust
Kingston Hospital NHS Trust	Oxford Radcliffe Hospitals NHS Trust
Kingston Primary Care Trust	Oxfordshire Learning Disability NHS Trust - Ridgeway Partnership
Lancashire Teaching Hospitals NHS Foundation Trust	Oxleas NHS Foundation Trust
Leeds Partnerships NHS Foundation Trust	Papworth Hospital NHS Foundation Trust
Leeds Primary Care Trust	Pennine Acute Hospitals NHS Trust
Leeds Teaching Hospitals NHS Trust	Peterborough and Stamford Hospitals NHS Foundation Trust
Leicestershire Partnership NHS Trust	Peterborough Primary Care Trust
Lincolnshire Partnership NHS Foundation Trust	Plymouth Hospitals NHS Trust
Lincolnshire Teaching Primary Care Trust	Plymouth Teaching Primary Care Trust
Liverpool Women's NHS Foundation Trust	Portsmouth Hospitals NHS Trust
London Ambulance Service NHS Trust	Princess Alexandra Hospital NHS Hospital Trust
Luton and Dunstable Hospital NHS Foundation Trust	Queen Elizabeth Hospital King's Lynn NHS Trust
Luton Teaching Primary Care Trust	Queen Mary's Sidcup NHS Trust
Maidstone and Tunbridge Wells NHS Trust	Richmond and Twickenham Primary Care Trust
Manchester Mental Health and Social Care Trust	Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust
Medway NHS Foundation Trust	Rotherham NHS Foundation Trust
Medway Primary Care Trust	Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust
Mersey Care NHS Trust	Royal Berkshire NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Mid Essex Hospital Services NHS Trust	Royal Cornwall Hospitals NHS Trust
Mid Essex Primary Care Trust	Royal Devon and Exeter NHS Foundation Trust
Mid Staffordshire NHS Foundation Trust	Royal Free Hampstead NHS Trust
Mid Yorkshire Hospitals NHS Trust	Royal Marsden NHS Foundation Trust
Milton Keynes Hospital NHS Foundation Trust	Royal National Hospital for Rheumatic Diseases NHS Foundation Trust
Newcastle Primary Care Trust	

Depression screening and management of staff on long-term sickness absence

Royal Surrey County Hospital NHS Trust
Royal United Hospital Bath NHS Trust
Royal West Sussex NHS Trust
Salisbury NHS Foundation Trust
Sandwell and West Birmingham Hospitals NHS Trust
Scarborough and North East Yorkshire Healthcare NHS Trust
Sheffield Care Trust
Sheffield Children's NHS Foundation Trust
Sheffield Primary Care Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
Shrewsbury and Telford Hospital NHS Trust
Shropshire County Primary Care Trust
Solihull Care Trust
Somerset Primary Care Trust
South Birmingham Primary Care Trust
South Devon Healthcare NHS Foundation Trust
South East Coast Ambulance Service NHS Trust
South East Essex Primary Care Trust
South Essex Partnership NHS Foundation Trust
South Gloucestershire Primary Care Trust
South London and Maudsley NHS Foundation Trust
South of Tyne and Wear Primary Care Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
South Staffordshire Primary Care Trust
South Tyneside NHS Foundation Trust
South Warwickshire General Hospitals NHS Trust
South West London and St George's Mental Health NHS Trust
South West Yorkshire Mental Health NHS Trust
Southampton University Hospitals NHS Trust
Southend University Hospital NHS Foundation Trust
Southport and Ormskirk Hospital NHS Trust
Southwark Primary Care Trust
St George's Healthcare NHS Trust
St Helens and Knowsley Hospitals NHS Trust
Stockport NHS Foundation Trust
Stockport Primary Care Trust
Suffolk Mental Health Partnership NHS Trust
Suffolk Primary Care Trust
Surrey and Borders Partnership NHS Foundation Trust
Sussex Partnership NHS Trust
Swindon and Marlborough NHS Trust
Swindon Primary Care Trust
Tameside Hospital NHS Foundation Trust
Taunton and Somerset NHS Foundation Trust
Tavistock and Portman NHS Foundation Trust
Telford and Wrekin Primary Care Trust
Torbay Care Trust
Tower Hamlets Primary Care Trust
Trafford Healthcare NHS Trust
Trafford Primary Care Trust
United Lincolnshire Hospitals NHS Trust
University College London Hospitals NHS Foundation Trust
University Hospital Birmingham NHS Foundation Trust
University Hospital of North Staffordshire NHS Trust
University Hospital of South Manchester NHS Trust
University Hospitals Bristol NHS Foundation Trust
University Hospitals Coventry and Warwickshire NHS Trust
University Hospitals of Leicester NHS Trust
University Hospitals of Morecambe Bay NHS Trust
Wakefield District Primary Care Trust
Waltham Forest Primary Care Trust
Walton Centre for Neurology and Neurosurgery NHS Trust
Wandsworth Teaching Primary Care Trust
West Essex Primary Care Trust
West Hertfordshire Hospitals NHS Trust
West Hertfordshire Primary Care Trust
West Kent Primary Care Trust
West London Mental Health NHS Trust
West Middlesex University Hospital NHS Trust
West Suffolk Hospitals NHS Trust
West Sussex Primary Care Trust
Westminster Primary Care Trust
Weston Area Health NHS Trust
Whittington Hospital NHS Trust
Winchester and Eastleigh Healthcare NHS Trust
Wirral Primary Care Trust
Wirral University Teaching Hospital NHS Foundation Trust
Worcestershire Acute Hospitals NHS Trust
Worcestershire Mental Health Partnership NHS Trust
Worcestershire Primary Care Trust
Worthing and Southlands Hospitals NHS Trust
Wrightington, Wigan and Leigh NHS Trust
Yeovil District Hospital NHS Foundation Trust
York Hospitals NHS Foundation Trust

Appendix 3 Audit tool and help notes

National Audit of Depression Screening in the long-term sick presenting to Occupational Health Services 2008 Case Note Review

Please answer all questions and complete one proforma per case.

The case note review refers only to the clinical records of the first consultation after the case meets the inclusion criteria (ie the first consultation that occurred after the employee had been absent for at least four weeks) and any letters or reports that were produced at that time. You should not include any consultations, records or letters before or after this.

Your Site Code

Instructions for completion:

1. Please use a ball-point pen for all sections.
2. Please cross the boxes as appropriate (or .
3. Please refer to the accompanying help booklet.
4. Data should be submitted to OHCEU via our webtool at <http://OHCEUaudit.rcplondon.ac.uk>.
5. The help desk can be contacted on 0207 935 1174 ext 592 or ohceu@rcplondon.ac.uk.

PART ONE: DEMOGRAPHIC INFORMATION

1.0 Case number

1.1 Age (years)

1.2 Gender

Male Female

1.3 Occupation (tick one only):

- Doctor
 Nurse
 Ancillary staff
 Clerical
 Allied health professionals
 Not documented
 Other

1.4 Please enter the date of the case note entry that is being audited:

1.5 How many full weeks had the patient been absent from work at the time of this appointment?

PART TWO: DEPRESSION SCREENING

- 2.1 Is there any evidence that the OH Professional has attempted to assess whether or not the patient might be depressed?
- Yes
- Yes, but no evidence of distress
- No

If 'Yes', please continue to answer parts 3 to 8.

If 'Yes, but...', please go to part 8.

If 'No', please go to part 8.

IMPORTANT! Please note that most of the following questions ask whether a question has been asked, NOT whether the patient has got the symptom.

PART THREE: DEPRESSION SEVERITY

- 3.1 Please indicate if the OH Professional has asked the patient any questions about the following aspects of depression.

Please tick all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Depressed mood/sadness |
| <input type="checkbox"/> Lack of energy/fatigue | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Loss of appetite or weight | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> None of the above | |

PART FOUR: SUICIDE OR SELF HARM

- 4.1 Is there any evidence that the OH Professional has asked the patient about thoughts of suicide or deliberate self harm? Yes No
- 4.1.1 If yes, did the patient report thoughts of suicide or self harm? Yes No
- 4.1.1.1 If yes, is there any evidence that the OH Professional has asked about the patient's plans for suicide or self harm? Yes No
- 4.1.1.2 If yes, is there any evidence that the OH Professional has asked about any previous suicidal acts or actual self harm? Yes No

PART FIVE: PSYCHOSOCIAL CONTEXT

- 5.1 Is there any evidence (within the first assessment after 4 weeks off work) that the OH Professional has asked any questions about the following aspects of the patient's life?

Please tick all that apply:

- | |
|---|
| <input type="checkbox"/> Patient's spouse or partner, or documented that patient is single |
| <input type="checkbox"/> Patient's children or family, or documented that patient has no children |
| <input type="checkbox"/> Patient's use of alcohol |
| <input type="checkbox"/> Patient's use of street or illicit drugs |
| <input type="checkbox"/> None of the above |

PART SIX: WORKPLACE FACTORS

- 6.1 Is there any evidence that the OH Professional has asked the patient if they think workplace factors have caused or contributed to any depression? Yes No
- 6.1.1 If yes, did the patient think that workplace factors have caused or contributed to any depression? Yes No
- 6.1.1.1 If yes, is there any evidence that the OH Professional has considered discussing this with the employer? Yes No

PART SEVEN: CURRENT MANAGEMENT

- 7.1 Is it documented that the patient has a current diagnosis of depression from either the OH Professional or another healthcare professional? Yes No
- 7.1.1 If yes, is there any evidence that the patient has been asked about contact with other health professionals **concerning their depression**? Yes No
- 7.1.1.1 If yes, please tick all that apply: GP
 Counsellor/therapist/CBT therapist
 Psychiatrist/CPN/mental health team
- 7.1.2 If yes, is there any evidence that the OH Professional has asked about any medication that is being prescribed **for the depression**? Yes, patient being prescribed medication
 Yes, patient NOT being prescribed medication
 No, patient not asked

PART EIGHT: COMMUNICATION

- 8.1 Is there any evidence that the OH Professional has communicated (telephone or letter or email) with any of the following?
Please tick all that apply: GP A mental health professional
 Patient's line manager The patient (eg copy of letter to GP or manager)
 None of the above Other
- 8.2 Is the presenting symptom/problem reported in the referral to OH? Yes No
 Not appropriate
- 8.2.1 If yes, please state the diagnosis as described in the referral to OH. Please tick one option only:
 Psychological Musculoskeletal
 Surgery (non-malignant) Cardiovascular
 Malignancy Respiratory (non-malignant)
 Other
- 8.3 Please state the OH Professional's initial diagnosis as described in first clinical encounter. Please tick one option only:
 Psychological Musculoskeletal
 Surgery (non-malignant) Cardiovascular
 Malignancy Respiratory (non-malignant)
 Other Not stated

NATIONAL AUDITS OF THE MANAGEMENT OF LOWER BACK PAIN AND DEPRESSION SCREENING BY OCCUPATIONAL HEALTH SERVICES 2008

HELP NOTES

Acknowledgements

The Occupational Health Clinical Effectiveness Unit (OHCEU) Audit Development Group thanks all those who have been involved in developing and piloting the audit tools, and colleagues for their help and advice.

The OHCEU is a partnership between the Royal College of Physicians and the Faculty of Occupational Medicine, and commissioned by NHS Plus. The audits have been endorsed by Professor Dame Carol Black, National Director for Health and Work.

Introduction

The OHCEU aims to measure and rise standards, and reduce the variability, of Occupational Health (OH) care in the NHS. These are the first national audits of OH care in England, and aim to:

- enable trusts to benchmark the quality of their OH provision against evidence based standards
- evaluate the extent to which OH practice in managing lower back pain and screening for depression is evidence-based
- demonstrate variation in practice
- facilitate change through the delivery of useful data, and provide a basis for identifying change in the quality of care
- provide a forum for sharing experience and good practice.

The audits are not about league tables or individual performance. Information on profession, qualifications or seniority of the OH clinicians managing the cases is not collected. Nor is comparison made between Trusts using NHS occupational health services and Trusts outsourcing to private sector providers. The average data for each Trust will be reported in comparison to the national average data, and Trust-level data will not be put into the public domain by OHCEU or NHS Plus.

These help notes contain all the information needed to participate in the audits. Please read them carefully before commencing data collection and entry onto the webtool. If you have any queries, or find that your OH provision does not fall into the

structures described, the Audit Helpdesk should be contacted for advice, either by email to ohceu@rcplondon.ac.uk or by phone on 0207 935 1174 ext. 592 (Monday – Friday, 10:00am–4:00pm).

Methodology

Both the lower back pain and the depression screening audits are retrospective audits of process. The objective is to compare and contrast the process of care documented in the case notes with national evidence-based guidance (primarily the Faculty of Occupational Medicine's 'Occupational Health guidelines for the management of low back pain' (2000), and elements of NICE guidance CG23 'Depression: management of depression in primary and secondary care' (2004) pertinent to the OH management of long term sickness absence cases). We provide the option of complementing the back pain process data with an audit of patients' and managers' knowledge and attitude following a consultation with OH for lower back pain. We are also asking questions about the resources allocated to OH in relation to head count and the overall Trust budget. An inter-rater study will be conducted for each sample of data to assess consistency between auditors.

Audit tool development has been overseen by a multidisciplinary steering group. The tools were piloted in 7 NHS Trusts, and amended in response to feedback and statistical analysis of the pilot data.

Eligibility

All NHS Trusts in England are eligible and encouraged to participate, irrespective of OH provider. The unit of audit is the Trust.

Audit tools

There are 4 audit tools associated with these audits:

- a casenote review for staff with lower back pain seen in OH, to be completed for a sample of 40 consecutive cases
- an employee questionnaire for staff with lower back pain seen in OH (and covering letter) to be sent to the employees whose case notes make up the sample for the lower back pain case note review

- a manager questionnaire for managers of staff with lower back pain seen in OH (and covering letter) to be sent to the direct line manager of each of the employees whose case notes make up the sample for the lower back pain case note review
- a casenote review for patients seen in OH following at least 1 month absent from work for any health-related reason, to be completed for a sample of 40 consecutive case notes.

Each Trust will undertake the two casenote reviews; the employee and manager questionnaires are optional.

Identification of cases

When approached to register as a participant in the audits, Trusts were advised to start tagging suitable cases from 1st January 2008. This should be continued up to the start of the data collection period even if you reach 40 cases before this time, as the sample to be audited should comprise the 40 most recent cases. If you do not reach 40 cases by the start of data collection, please continue to tag cases throughout the data collection period and include these cases in your audit sample/s. Should you have registered to participate in the audit recently and are not able to identify suitable cases retrospectively, please contact OHCEU for advice on how to proceed.

Inclusion/exclusion criteria

- Depression screening audit:
 - cases must have been seen by an OH doctor or nurse following at least 4 weeks' absence from work for any health-related reason
 - cases may have been seen at an earlier point in the current episode of sickness absence, however only the consultation following the 4 week point may be included in the audit
 - the consultation following at least 4 weeks' sickness absence must have been held no earlier than 1st January 2008.
- Back pain audit:
 - cases must have been seen by an OH doctor or nurse for a 'new' episode of lower back pain ('new' is defined as being separated from any previous episode by at least 4 weeks)
 - the initial consultation for this episode of lower back pain must have been held no earlier than 1st January 2008
 - at least four weeks must have elapsed between the initial consultation for this

episode of back pain and the date of data extraction to allow plans for follow up to be made, where appropriate

- cases of sciatica are to be included in the sample
- cases seen by a physiotherapist must be excluded, unless they have been referred on to an OH nurse or doctor, in which case only the case notes made by the nurse or doctor should be used for data collection (this is to ensure consistency, and comparison of like with like).

Sampling

Each audit tool requires a sample of 40 consecutive cases from which data will be extracted retrospectively (40 is the sample size recommended by our statisticians). We have identified 3 typical scenarios relevant to sampling:

- In house OH provision
40 consecutive cases which meet the inclusion criteria above are to make up the audit sample. You should start by auditing the case most recently identified at the point when data collection commenced, and work strictly backwards through your list of cases until you have audited 40. The earliest consultation date appropriate for inclusion is 1st January 2008, and should you reach this point before you have audited 40 cases you should go on to tag and audit cases seen during the data collection period, in order to achieve as close to 40 as possible. This applies to both audit tools. A single site code and password will be allocated for submission of data. If your OH care is provided at more than one site, please contact OHCEU for advice.
- OH care is commissioned from a single provider
In this case sampling is as above, and a single site code and password will be allocated for submission of this sample. The provider organisation must ensure that employees of the different Trusts to which it provides OH care are allocated to the correct Trust site code and password when data are entered onto the webtool; a separate site code and password will be allocated for submission of data from the provider organisation's own employees where this is appropriate.
- OH care is commissioned from multiple providers
A full sample of 40 cases may be collected at each provider organisation; alternatively the sample of 40 cases may be apportioned across the provider organisations according to the

Depression screening and management of staff on long-term sickness absence

proportion of the commissioning Trust's employee population served by each provider, which will be combined into one sample at the point of data analysis. If the number of cases identified at the start of data collection is below the number required, tagging should be continued throughout the data collection period and any new cases included in the sample. Each provider will be allocated a unique site code and password for use in relation to the commissioning Trust's data, in addition to the site code and password they receive for their own data.

If OH provision at your Trust does not fall into one of the above categories, or if you require further advice on any of the above, please contact OHCEU.

Ethical considerations, confidentiality/anonymity and data protection

No patient- or clinician-identifiable data will be collected, and reports will provide the average data for the occupational health care provided to employees of your Trust in comparison to the national average data. It is the understanding of the OHCEU that you will not need to submit this audit to your local ethics committee. If you are required to submit it and need help with a proposal for ethical review please let us know and we will do our best to support you.

Each OH unit is responsible for ensuring that clients are given generic information that their records may be used for clinical audit purposes (for example by placing notices in staff/waiting areas). Due to the sensitivity of auditing the case notes of employees we advise that a member of the OH unit's clinical team undertakes data extraction.

Data will be submitted via the secure webtool. Each Trust will be provided with an individual site code and password as described under 'Sampling' (which is confidential to the Trust and the OH service it uses, not to the individual). Under no circumstances should users pass on their site code or password to others. If a user believes that their password has been compromised they should inform the OHCEU at the Royal College of Physicians. Users should only be able to see data in records of their own institutions. If a user detects what he or she believes is a breach of security or confidentiality then it is their responsibility not to disseminate the information obtained and to report the event to the OHCEU at the RCP immediately. In the interests of patient confidentiality, no name or number that could be

linked to an individual should be used on the audit documentation or entered onto the webtool.

Employees and managers are contacted by their OH service regarding participation in the audit, and the responses are returned by the employee/manager directly and anonymously to the OHCEU, maintaining the anonymity of the employee/manager and the confidentiality of the data.

The OHCEU processes the contact details held for the purpose of managing the audits in line with the data protection act.

Data quality

Each Trust will have a designated lead clinician who will take overall responsibility for the data submitted to the audit. The data should be extracted by a member of OH unit staff with clinical knowledge. Ideally individuals should not audit their own case notes, however we are aware that in practical terms this will not always be feasible, for example due to small size of an OH unit. An inter-rater study will also be conducted using the first 5 cases to assess the reliability of the audit tools, see 'Data collection' below.

Data collection

The data collection period is 12th May to 8th August 2008. The help desk can be contacted by email to ohceu@rcplondon.ac.uk or phone to 0207 935 1174 ext. 592 throughout this period.

Planning data collection

- Time should be set aside prior to commencing data collection by those responsible for co-ordinating and collecting data, and using the results once they are fed back, in order to plan your Trust's participation.
- A minimum of two auditors should be identified.
- At the start of the data collection period you should check how many cases have been identified which meet the inclusion criteria; if this is below 40 you should continue tagging cases throughout the data collection period and include these in your sample.
- You should keep a secure, local record of the webtool case number that has been assigned to each case in your sample until the end of data analysis, in case we have any queries when analysing your data.

The webtool

- The webtool is accessed at <http://ohceuaudit.rcplondon.ac.uk> and full details

of how to enter data online are available in the support document 'Guide to using the webtool'. This can be downloaded once you have logged into the website. If you have any difficulty getting started please contact the help desk and we will talk you through the process.

- Online help is available at the right hand side of the screen as you enter each case.
- The webtool has been designed for data to be entered at the time of extraction from the case notes. A printable version of the audit tools is available should you prefer to collect data on paper before transferring it onto the webtool.
- Your raw data can be exported into spreadsheet format for additional, local analysis.
- Please note that the OHCEU does not have capacity to accept the case note review data on paper proformas. Casenote review data should be submitted via the webtool.

Reliability cases, inter-rater study

An inter-rater study is conducted for each sample to assess the reliability of the audit tools. A second, independent auditor must audit the first five cases of each sample for a second time, and these cases should be entered onto the webtool as pairs. The first auditor must make a note of the case number assigned by the system when entering the case onto the webtool. The second auditor should then enter the case as a new case, and link the two entries using the case number assigned at the first entry.

Completing the proformas

- the data submitted must reflect what is in the records
- the data must not represent what the auditor knows or assumes about the clinical state of the individual case
- data may be collected by any member of the clinical team, and data may be collected by more than one data collector
- the web tool has the facility to comment about your responses for each question
- 'Yes' means was done, was recorded
- 'No' means was not done, was not recorded; if there is no record "it was not done"
- 'Not applicable' means that there was a clinical judgement/decision that this was not applicable for the patient
- 'Declined' means that there is a record within the patient's notes that they declined a particular assessment or intervention

Employee and manager questionnaires

If you are undertaking the employee and manager

audits you will be provided with a set of questionnaires, cover letters and pre-paid envelopes. At the point of data extraction these should be sent to each employee in the back pain audit sample and their line manager (to whom the employee is not identified). The employee/manager will return the completed questionnaire directly to OHCEU. A secure local record of these should be kept until the end of data collection, as OHCEU will provide reminder letters to send to the individuals.

Publication and dissemination of results

Participation and Trust-level data (these are the average data for each trust) will be available to NHS Plus, who commissioned the audits. Trust-level data will not be put into the public domain by NHS Plus or OHCEU. Trusts will not be ranked and performance indicators will not be used as the data are not deemed mature enough. A generic report will be publicly available describing the national average picture, and each trust will be provided with a confidential report detailing their average results in comparison to the national average results.

National Audit of Depression Screening in the long-term sick presenting to Occupational Health Services:

Help notes for the case note review

The case note review refers **only** to the clinical records of the first consultation after the case meets the inclusion criteria (i.e. the first consultation that occurred after the employee had been absent for at least four weeks) and any letters or reports that were produced at that time. You should not include any consultations, records or letters before or after this.

Part one: Demographic information

Question Number	Question Text	Help Notes
1.0	Case number	A case number will be allocated automatically by the webtool. Please keep a secure local record of the correspondence between webtool case number and case note until data analysis has been completed (so that you can refer to the notes again should further information be required).
1.1	Age (years)	Please record the age, rounded down to full years, of the employee at the time of the first consultation that occurred after the employee had been absent for at least four weeks. This value must be 16–80 (any other value will be rejected by the webtool).
1.2	Gender	
1.3	Occupation	'Ancillary' includes domestics, porters, electricians, catering and allied staff. 'Allied health professionals' includes radiographers, physiotherapists, occupational therapists, speech therapists, dieticians, dentists, chiropodists, podiatrists.
1.4	Please enter the date of the case note entry that is being audited.	Please record the date of the initial appointment after the employee has been absent for at least four weeks. Please remember this is the only appointment you should use when extracting data for this audit. The earliest date that will be accepted by the webtool is 1 st January 2008 (as this is the earliest date at which cases are eligible to be included in the sample).
1.5	How many full weeks had the patient been absent from work at the time of this appointment?	This should be at least 4 weeks.

Part two: Depression screening

Question Number	Question Text	Help Notes
2.1	<p>Is there any evidence that the OH Professional has attempted to assess whether or not the patient might be depressed?</p> <p><i>If 'Yes', please continue to answer part 3 to 8</i></p> <p><i>If 'Yes, but no evidence of distress' go to part 8</i></p> <p><i>If no, please go to part 8.</i></p>	<p>Tick one of the 'Yes' options if there is any evidence that the OH Professional has enquired about psychological distress in any way. The term 'depression' does not need to appear in the notes for this box to be marked 'yes', but there must be some reference to the employee's mood or level of emotional distress. 'Yes, but no evidence of distress' should be ticked when there is clear documentation that there is no distress (eg Patient is reported as being happy, positive, etc). If the OH Professional appears to have considered psychological distress, and a lack of distress is not very clearly documented, 'Yes' should be ticked. If there is any doubt about the level of distress 'Yes' should be recorded. 'No' should be ticked when there is not evidence at all that the OH Professional has considered psychological distress.</p>

Part three: Depression severity

Question Number	Question Text	Help Notes
3.1	<p>Please indicate if the OH Professional has asked the patient any questions about the following aspects of depression. Please tick all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of interest <input type="checkbox"/> Depressed mood/sadness <input type="checkbox"/> Lack of energy/fatigue <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Loss of appetite or weight <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> None of the above 	<p>Tick the appropriate box if there is any evidence that the OH Professional has asked about each one of these symptoms. You can tick as many boxes as are appropriate. It does not matter whether the employee actually had these symptoms, just whether the OHP asked about them.</p>

Part four: Suicide or self harm

Question Number	Question Text	Help Notes
4.1	Is there any evidence that the OH Professional has asked the patient about thoughts of suicide or deliberate self harm?	This question is enquiring about whether the OH Professional has asked about different aspects of self harm. If the OH Professional has not asked any questions about suicidal thoughts or ideas of self harm, then you should tick 'No'. If they have asked about suicidal thoughts and the patient has reported some thoughts of suicide or self harm then you should go on and answer 4.1.1 and 4.1.2.
4.1.1	If yes, did the patient report thoughts of suicide or self harm?	
4.1.1.1	If yes, is there any evidence that the OH Professional has asked about the patient's plans for suicide or self harm?	'Patient's plans for suicide or self harm' refers to aspects such as methods, timing or steps that a patient has taken or considered (eg purchasing tablets, identifying a time, making a will, writing a suicide note, etc).
4.1.1.2	If yes, is there any evidence that the OH Professional has asked about any previous suicidal acts or actual self harm?	Tick 'Yes' if the OH Professional has asked about any previous occasion in which the patient has harmed themselves or attempted to commit suicide. This includes statements such as 'no previous self harm'. 'Yes' should be ticked whenever there is evidence the OH Professional has asked about prior self harm, regardless of the patient's response.

Part five: Psychosocial context

Question Number	Question Text	Help Notes
5.1	<p>Is there any evidence (within the first assessment after 4 weeks off work) that the OH Professional has asked any questions about the following aspects of the patient's life? Please tick all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Patient's spouse or partner, or documented that patient is single <input type="checkbox"/> Patient's children or family, or documented that patient has no children <input type="checkbox"/> Patient's use of alcohol <input type="checkbox"/> Patient's use of street or illicit drugs <input type="checkbox"/> None of the above 	This question is seeking to identify if the OH Professional has gained information about the employee's general situation. The actual details of the employee's situation are not important, just whether the OH Professional has recorded the information. Once again you can tick between one and four of the options provided.

Part six: Workplace factors

Question Number	Question Text	Help Notes
6.1	Is there any evidence that the OH Professional has asked the patient if they think workplace factors have caused or contributed to any depression?	'Workplace factors' may include the type of work undertaken, an employee's perception of 'stress' in their job, interpersonal disputes with work colleagues, the hours they are asked to work, or any other factors specific to their work.
6.1.1	If yes, did the patient think that workplace factors have caused or contributed to any depression?	
6.1.1.1	If yes, is there any evidence that the OH Professional has considered discussing this with the employer?	Communication of this information to the employer may be via a phone call, an e-mail, a personal discussion or a letter. There must be some evidence that the OHP considered or actually carried out this communication. Tick yes if it is clearly documented that such a communication was suggested by the OHP, but the patient declined.

Part seven: Current management

Question Number	Question Text	Help Notes
7.1	Is it documented that the patient has a current diagnosis of depression from either the OH Professional or another healthcare professional?	Tick 'yes' if a current diagnosis was made and recorded either prior to the initial consultation (by another healthcare professional) or made at the end of the initial consultation (by the OH Professional). The diagnosis may be recorded by the OH Professional in either their consultation notes or the communication which resulted from this consultation.
7.1.1	If yes, is there any evidence that the patient has been asked about contact with other health professionals concerning their depression?	In order to tick 'yes' there must be evidence that the OH Professional has specifically asked the employee if they have been in contact with any other health professionals. If there is evidence of correspondence with other health professionals which includes a discussion or the employee's depression, then it is reasonable to tick that box.
7.1.1.1	If yes, please tick all that apply: <input type="checkbox"/> GP <input type="checkbox"/> Counsellor/ therapist/ CBT therapist <input type="checkbox"/> Psychiatrist/ CPN/ mental health team	
7.1.2	If yes, is there any evidence that the OH Professional has asked about any medication that is being prescribed for the depression? <input type="checkbox"/> Yes, patient being prescribed medication <input type="checkbox"/> Yes, patient NOT being prescribed <input type="checkbox"/> No, patient not asked	Tick 'yes, patient NOT being prescribed medication' if there is evidence that the OH Professional enquired about antidepressant medication, but the employee stated they had not been prescribed any. 'Yes, patient being prescribed medication' may be ticked if the OH Professional recorded the fact they were on some antidepressant medication. This may be recorded as part of a list of medication. If so the following are the most common antidepressants prescribed: Citalopram (Cipramil), Fluoxetine (Prozac), Fluvoxamine (Faverin), Paroxetine (Seroxat), Sertraline (Lustral), Mirtazepine (Zispin), Venlafaxine (Efexor), Duloxetine (Cymbalta), Escitalopram (Cipralext), Nefazodone (Dutonin), Reboxetine (Edronax), Moclobemide (Manerix), Phenelzine (Nardil), Lofepamine (Gamanil), Amitriptyline (Triptafen), Clomipramine (Anafranil), Dulsulpin (Prothiaden), Doxepin (Sinequan), Imipramine (Tofranil), Nortriptyline (motival), Trazadone (Molipaxin).

Part eight: Communication

Question Number	Question Text	Help Notes
8.1	<p>Is there any evidence that the OH Professional has communicated (telephone or letter or email) with any of the following? Please tick all that apply:</p> <p><input type="checkbox"/> GP</p> <p><input type="checkbox"/> Patient's line manager</p> <p><input type="checkbox"/> A mental health professional</p> <p><input type="checkbox"/> The patient (eg copy of letter to GP or manager)</p> <p><input type="checkbox"/> None of the above</p> <p><input type="checkbox"/> Other</p>	<p>Evidence of communication may be a copy of a letter or e-mail in the case notes, or record of a conversation having occurred (for example being documented in the case notes).</p>
8.2	<p>Is the presenting symptom/ problem reported in the referral to OH?</p>	<p>Tick 'Yes' if the nature of the presenting problem was outlined in the referral document. If there was no referral (the patient self presented), then tick 'Not appropriate'. If more than one problem/ diagnosis is listed then record the diagnosis that is listed as the primary or main diagnosis.</p>
8.2.1	<p>If yes, please state the diagnosis as described in the referral to OH. Please tick one option only.</p> <p><input type="checkbox"/> Psychological</p> <p><input type="checkbox"/> Musculoskeletal</p> <p><input type="checkbox"/> Surgery (non-malignant)</p> <p><input type="checkbox"/> Cardiovascular</p> <p><input type="checkbox"/> Malignancy</p> <p><input type="checkbox"/> Respiratory (non-malignant)</p> <p><input type="checkbox"/> Other</p>	<p>Tick 'Yes' if the nature of the presenting problem was outlined in the referral document. If there was no referral (the patient self presented), then tick 'Not appropriate'. If more than one problem/ diagnosis is listed then record the diagnosis that is listed as the primary or main diagnosis.</p>
8.3	<p>Please state the OH Professional's initial diagnosis as described in first clinical encounter. Please tick one option only:</p> <p><input type="checkbox"/> Psychological</p> <p><input type="checkbox"/> Musculoskeletal</p> <p><input type="checkbox"/> Surgery (non-malignant)</p> <p><input type="checkbox"/> Cardiovascular</p> <p><input type="checkbox"/> Malignancy</p> <p><input type="checkbox"/> Respiratory (non-malignant)</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Not stated</p>	<p>The OH Professional's diagnosis should be recorded at the end of the clinical notes related to this initial assessment or in the correspondence written following this assessment. If more than one problem/diagnosis is listed then record the diagnosis that is listed as the primary or main diagnosis. This only needs to be the diagnosis recorded at the time of this initial assessment, even if this is different to the diagnosis that was agreed at a later time.</p>

NICE guidance CG23 Depression: management of depression in primary and secondary care (NICE, 2004)

Further copies of this report are available from NHS Plus:
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