DEVELOPING A MODEL FOR OCCUPATIONAL HEALTH PROVISION IN PRIMARY CARE

JOHN HARRISON1 and CATHERINE E. HARRISON2

1 University of Newcastle upon Tyne
United Kingdom
2 Clinical Nurse Leader in Occupational Health
Newcastle Occupational Health
Weston Court
Newcastle General Hospital
Newcastle upon Tyne, United Kingdom

Abstract. This is a report of a survey commissioned by Newcastle and North Tyne Health Authority. The aim of the project was to assess the occupational health needs of both GPs and their staff working in the General Practice in Newcastle and North Tyneside. The aim of the survey has been to obtain information about occupational health needs from general practitioners and their practice managers. The survey design has been a cross-sectional study using questionnaires and practice visits. The information obtained from the practice managers was validated by visits to selected practices. The visits also facilitated a qualitative assessment of occupational health arrangements, training needs and issues that might be important in determining an appropriate model for a primary care-based occupational health service. The results of the needs analysis have shown both general support for an occupational health service and priority areas for such a service. The challenge will be to develop a service that delivers targeted occupational health in a way that is acceptable to all members of staff working in general practice. The service should be seen as a developing service, initially focused to provide a dual role. There will be a core occupational health service for all staff, including GPs, and a specialist service designed to meet the specific identified needs. There will be an opportunity to include the service in an overarching occupational health service within the Tyne and Wear area.

Key words: Occupational health, General practice, Primary care, Health and safety, Qualitative research

INTRODUCTION

The National Health Service (NHS) national plan [1] envisages a comprehensive occupational health service provided to all staff within the NHS. Improving working lives [2] is an initiative for the NHS that has set the objective that aims to ensure that every member of staff is entitled to work in an organisation which can prove that it is investing in more flexible, supportive and family friendly working arrangements. An implication of this is the extension of such provision to staff working in general practice and in primary care, a service that has not been available previously in the majority of cases. It is anticipated that the occupational health (OH) needs of staff working in a primary care setting may be different from those staff working in hospitals [3]. General practices, for example, are the NHS equivalent of small to medium sized enterprises, the occupational health needs of which remain unknown. This is a report of a survey of the occupational health needs of general practitioners and their staff in an...
area of the North East of England. The survey has concentrated on general practice, although it should be possible to extend it to include other primary care staff, at a later date.

METHOD

The study design was a cross-sectional survey utilizing questionnaires and visits to general practices. General practitioners and their practice managers represented the study population. Two questionnaires were used:

a) A simple short questionnaire to be completed by general practitioners. This questionnaire was designed *de novo* with the aim of encouraging compliance. Information was collected concerning the views of general practitioners about occupational health and their experience of occupational health services.

b) A questionnaire for practice managers based on a similar one used during a regional audit of NHS Trusts, in Northern and Yorkshire, assessing the management of occupational health [4].

A list of General Practices, GPs and Practice Managers in Newcastle and North Tyneside was supplied by the Newcastle and North Tyne Health Authority. Questionnaires were sent to all the GPs and to individual Practice Managers, asking them to complete the questionnaires and to return them in confidence to the research team, in a stamped addressed envelope provided. The information obtained from the practice managers was validated by visits to selected practices. Practices visited were selected at random. Each Practice was given an identifying number. Sixteen practices, 8 from Newcastle and 8 from North Tyneside were selected, contacted and asked to participate in the study. During the visits a qualitative assessment of occupational health arrangements, training needs and issues that might be important in determining an appropriate model for a primary care-based occupational health service was performed. This took the form of a structured in-depth interview with an experienced and senior occupational health nurse.

The in-depth interview was structured using an “audit tool”, which was developed from use in hospital settings. Answers to questions were classified using the following system:

- A = 1 point nothing in place.
- B = 2 points awareness of hazard or problem, no action taken.
- C = 3 points awareness of hazard or problem, work in progress.
- D = 4 points understanding of occupational health need, policy/protocol being developed.

RESULTS

Questionnaire survey of General Practitioners

Of the 288 questionnaires, 134 were returned. The response rate was 47% (Newcastle 50%; North Tyneside 42%). There were 41 practices listed for Newcastle. One or more GPs from 36 practices returned a questionnaire. There was no response from 5 practices (12%). Four of the practices that did not respond were single-handed practices: A GP from one of these practices had retired recently. There were 34 practices listed for North Tyneside. One or more GPs from 23 practices returned a questionnaire. There was no response from 11 practices (32%). Four of the practices that did not respond were single-handed practices. Two of the practices that did not respond had a practice vacancy and were temporarily being run by the Health Authority. None-respondents were given one reminder by telephone.

In all, 96% of the respondents were aware of occupational health and 85% indicated an understanding of occupational health. There was strong support for the provision of an occupational health service for general practitioners and 90% of those who expressed a preference (89 in total) favored a service from within the NHS.

All the GPs had an opportunity to provide free text comments on the questionnaire. Comments on Occupational Health provision for General Practice have been grouped under subject headings. In order to give an indication of the concerns and opinions expressed, a synopsis of the comments and reasons for answers are given.
Synopsis of comments supporting Occupational Health provision

Important points to consider when establishing a service for GPs should include an outline of the service to be provided, practice visits and general promotion of the values of the service. The provision of an occupational health service is seen as a means of ensuring that expert advice would be available on health and fitness to practice. It was also seen as a means of managing disputes within the practice between GPs and staff, particularly in relation to managing sickness and absence.

Concern was raised about jobs and prospects and protecting patients. There were also worries about the conflict that might arise when the OH specialist was advised, in confidence, about a health issue or a dependency that might impact on safety to practice. Emphasis was made on the need to choose OH staff with care and the requirement for a confidential service, provided by specialists. The occupational health service should be independent from the Health Authority, easily accessible and available at times convenient for GP practices.

Occupational Health provided from the NHS is seen as being able to understand the work of the GP Practice, to have a role in raising staff morale and in helping to facilitate staff to work to their full potential. It is also seen as a means of improving communication and providing independent support and advice for all staff.

The need for confidential and independent support for GPs was raised as an issue by 26 respondents. Concern about the inability to raise sensitive issues with their own GP who may be a friend or known to the respondent was raised as an issue by 13 respondents. Stress, burnout and mental health concerns were raised by 13 respondents. There was a perception that GPs are under increasing pressure and that they need quick and easy access to expert help that must be confidential and independent of the Health Authority. Doctors rarely take sick time. They need support and advice to help them to look after themselves and consequently after their patients. They also need the Health Authority and the general public to understand the pressures that they work under.

Work related issues

Although a range of workplace issues were mentioned in the survey, the following issues were most frequent:

- Health and Safety: 21 respondents
- Health of the Worker: 22 respondents
- Sickness Management: 11 respondents
- Immunizations: 3 respondents

Questionnaire survey of practice managers

Of the 77 questionnaires, 33 (43%), were returned; 24 responses (73%) indicated that practices had a health and safety policy. In addition, there were policies to assess hazardous substances (64%), violence to staff (49%) and manual handling (43%). Most practices had a fire safety policy (76%). There was reported evidence of training programs for staff covering issues such as violence to staff and display screen equipment (46%), hazardous substances (39%), manual handling and stress (36%). Referral to occupational health after an accident was indicated by 6 respondents (18%), although 27 respondents (81%) indicated a reporting system for work-related injuries and diseases.

Assessment of fitness for work, at pre-employment or in relation to absence from work, was an infrequent occurrence. Table 1 shows that 5 responses indicated the performance of an assessment of all staff pre-employment, with fewer taking a vaccination history and almost no enquiry about pregnancy. Table 2 refers to responses concerned with sickness absence referrals. There was a lack of protocols for referral; the responses suggested a lack of information provided in the referral and occupational advice was not requested.

<table>
<thead>
<tr>
<th>Table 1. Assessment of fitness for work – Pre-employment</th>
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<tbody>
<tr>
<td>Pre-employment assessment of all staff</td>
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<tr>
<td>Physical health</td>
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<td>Psychological health</td>
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<td>Medication</td>
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<td>Vaccination history</td>
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<td>Sickness and absence history</td>
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<td>Pregnancy</td>
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In-depth interviews of Practice Managers

Thirteen practices were visited. They represent a small sample of General Practices in Newcastle and North Tyneside (17%). Very few practices could provide evidence of policies, protocols, risk assessment or training records. Classification of the answers was agreed between the Practice Manager and the interviewer, based on discussion and where possible review of systems in place.

Although it appears that GP practices provide similar services with similar resources and systems they are very different. Each Practice is a small enterprise managing on limited resources. Practice Managers were asked for their list size and the number of Practice employees. There appears to be no correlation between list size and staffing establishment (Table 3).

Occupational health standards varied considerably and this seemed to have little to do with list size, staff resource or location. There does not appear to be a core training requirement for Practice Managers or for any of their staff. Training is difficult for some practices to access because of staff and financial resource problems. There appear to be some change resistant workforces who have worked together for many years. However, this is contrasted with some very efficient and effective practices. There are some effective practice administrators and some effective managers.

Understanding of Health and Safety responsibility was very varied. Many practices who thought that they had carried out risk assessments or had Health and Safety policies in place could not produce evidence of this. Most of the policies produced for review were in fact guidelines. It appears that very few practices have policies in place to manage sickness absence. However, the majority stated that arrangements for sickness and absence management were included in the individual employment contracts. It was evident that some practices promoted teamwork. The members of these teams seemed more relaxed and helpful to the patients who attended the surgery. In some practices it was evident that staff were so busy and under so much pressure that they were unable to give anything but the minimum time or attention to patients.

The record management systems were reviewed in each practice, in order to provide some baseline information on the common task of tracing clinical records. Most practices had systems in place that demonstrated an understanding of the clinical risk implication of record keeping and storage. However, some practices were operating systems that relied on memory for record tracing. There were also some practices that relied heavily on the familiarity and memory of the practice staff for system management. There was a misperception about the status of occupational health records and personnel records and the need for them to be separated from other clinical records.

The classification of the information obtained from the in-depth interviews has been presented graphically and can be found in Figs. 1–8. Most of the histograms show a bimodal distribution with category A (no awareness) and category D (understanding of occupational health issue and developing policy to address it) being most frequent.

For health and safety management health surveillance was a prominent category A finding. Accident recording and reporting, followed by first aid arrangements were the

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**Table 2. Assessment of fitness for work – Sickness absence**

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<tr>
<td>SA protocol for referral to OH</td>
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<tr>
<td>Demographic data included</td>
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</tr>
<tr>
<td>Sickness absence data included</td>
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<tr>
<td>SA Policy include rehabilitation</td>
<td>2</td>
</tr>
<tr>
<td>Employee aware of reason for referral</td>
<td>7</td>
</tr>
<tr>
<td>Clear procedure for ill-health retirement</td>
<td>3</td>
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<tr>
<td>OH advice sought</td>
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**Table 3. List size/staffing establishment (13 practices randomly selected)**

<table>
<thead>
<tr>
<th>Patients</th>
<th>Staff</th>
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<tbody>
<tr>
<td>3000</td>
<td>6</td>
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most frequent category D scores. With respect to hazard identification, category A findings predominated. Failure to recognize manual handling and hazardous substances were found most frequently and there was also a lack of training of staff in manual handling techniques and general lack of compliance with statutory measures to protect staff against hazardous substances. However, containment of hazardous substances was the most frequent category D score.

When addressing infection control issues, a large number of the practices had no policy to deal with infection or carriage of Methicillin Resistant *Staphylococcus aureus* (MRSA) or for recording infection with blood-borne viruses, such as HIV or hepatitis C. Awareness of hepatitis B was better and there were policies for protecting
well consistently, but it of is note that this aspect of health and safety management is carried out centrally via arrangements implemented by the Health Authority. Mandatory training of staff, that is training required either by legislation of national policy, was addressed moderately well with respect to cardio-pulmonary resuscitation, fire safety and first aid. Training in health and safety was the most frequent category A response. Most of the practices did not perform risk assessments for pregnant workers, although approximately half of them provided some form of rest facility. Compliance with statutory requirements to minimize the risks to health associated with display screen equipment was poor with respect to provision of vision screening, analysis of workstations and provision of health and safety information. However, approximately half of the practices did identify users of display screen equipment.

DISCUSSION

The results indicate a high level of awareness of occupational health amongst general practitioners and a high percentage supported the provision of an occupational health service from an NHS base. Management of health and safety was lacking in many practices, although the results suggest that some practices were successful in implementing some aspects. Despite the awareness of occupational health, the questionnaire survey of practice managers revealed that occupational health assessments of staff at recruitment and in relation to sickness absence were not well established. Caution must be exercised in extrapolating these findings to general practice in Newcastle and North Tyneside, or elsewhere. The response rate to the questionnaires was not as high as was hoped, but anecdotal evidence suggests it is probably typical of response rates from general practitioners. Similar results have been found by other researchers [5]. Visits to the selected practices highlighted a lack of understanding of occupational health issues amongst some practice managers and, thus, further caution is necessary when interpreting the results of the questionnaire survey. The qualitative in-depth interviews conducted by an experienced occupational health nurse produced a better insight into the problems faced by staff working in general practice and of the range of different working arrangements in place.

The aim of occupational health services will be to deliver occupational health that is appropriate to general practitioners and their staff and, ultimately, to all members of the primary care team. The structure of the service and the processes of delivery must be based on established occupational health practice, whilst tailored for the needs of general practice. Thus, the quality of care provided must be at least as good as that provided to other NHS staff, but the look and feel of the service must reflect the views expressed by respondents in the survey. It is clear, from views expressed locally and in other pilots within the UK, that a bolt-on service linked to an existing secondary care model will not be acceptable.

There are currently three models for an occupational health service for general practice for which information is known. The model endorsed by the Royal College of General Practitioners (RCGP) was published in 1997 [6]. Data linked to the development of the model was published separately [5]. The method used was similar to the one used in this survey, although fewer practices were visited by the Chambers team and details as to how the practices were evaluated were not stated. Of the key points in the proposal, it is of note that local areas are encouraged to build on the individuals and organizations who have the potential to provide, or are already providing, any aspect of occupational health in the locality. It is stated that “The independence of the service should be absolute.”

The occupational health resource anticipated by the RCGP includes:

- Access to an experienced occupational health physician
- Practical support and guidance from an occupational health nurse available to undertake practice visits
- An educationalist providing management skills, health and safety guidance sessions and other educational sessions
- Independent psychologists or counselors
- Some provision or prior agreement about extra-contractual referrals
Policies and procedures to clarify the services that are available.

A second model is the Sandwell Occupational Health and Safety Services for General and Dental practices. This is an evolving service to 69 general practices and 42 dental practices. There is a total staff population of 2000, including 151 GPs and 121 dentists. Activity to date has been marketing of the service and a needs assessment carried out in 5 general practices. An occupational health nurse advisor has been recruited to perform these tasks.

The third model is the Woodroof/Longdon arrangement for occupational health. This has been created in the South West of England. There is an emphasis on stakeholder management and independence from existing organizational structures. The service includes: pre-employment health screens, immunization policies, sickness absence advice, rehabilitation/ill-health retirements, needlestick injury advice, counseling/mentoring, training/education, health and safety support, and research/audit/clinical governance. Services are provided using a telephone advice system which is supplemented by practice visits as required. Internet pages are being developed giving details of how to manage needlestick injuries, immunization requirements and how to access mentors, counsellors, clinicians out of area, OH physicians, health and safety training and support and stress courses. There is a lack of data regarding the efficacy of any of the above models. However, all appear to be reasonable approaches and, individually, they have the support of stakeholders. We propose a model for Newcastle and North Tyneside that will draw on existing knowledge and experience, but will be influenced by the results of the needs analysis. In addition to the need to address generic occupational health issues, a number of specific issues must be accommodated. These can be broken down according to staff groupings.

General Practitioners

There is a level of mistrust of “the Health Authority”. There is a general perception of being “stressed” whilst, at the same time, being unable to access help either from their own GPs with whom they are registered, or from experts.

There was a strong message that a service independent of the Health Authority, from a specialist provider who has an understanding of the NHS and of the pressures that GPs are under, would be the only acceptable model for the majority of GP respondents from Newcastle and North Tyneside. This is consistent with the requirement for a doctor sensitive service recommended in the Chambers model. The need for an independent service should be reflected in the choice of OH staff, the location of the service and the storage of records.

It is important, however, to differentiate between occupational health needs, fitness to practice and general medical needs. An occupational health service cannot and should not duplicate the work of GPs, particularly in relation to treatment, even though responses from GPs indicate that there is difficulty around seeking advice from their own GPs who may be a friend or a colleague.

This survey has identified a requirement for a model that will address both the core occupational health needs of GPs and their staff and a focused service for “sick” GPs. A focused service to meet the specific needs of GPs would include confidential advice from a specialist occupational health practice on sensitive issues such as stress, mental illness, dependency and, the need for support and advice on when to stay away from work. Ideally, the specialist should be an experienced NHS consultant with a good understanding of the needs of the GPs. The facility for out of area referrals for treatment should be included.

GPs, from an employers’ perspective, also identified core service requirements for their staff. They include, pre-employment assessments, health surveillance, health and safety advice, immunizations support and, sickness and absence management.

Practice Managers

The results of the in-depth interviews demonstrated a need for occupational health, health and safety advice, health and safety training, accident and incident investigation, risk management, sickness and absence management and the development of policies to manage drug and
alcohol and sickness absence. The practice visits revealed that many practice managers feel, and/or are underprepared for their job. There are issues around the recruitment and training of managers and the provision of a support network to assist them. The lack of occupational health and health and safety awareness in most of the practices visited was of concern. There is a clear role for an experienced and suitably trained occupational health nurse to assist in the risk management process and to provide training.

Other staff in the practices
These employees have not been considered to be NHS staff. Issues that need to be addressed include recruitment methods, health surveillance and appropriate occupational health provision.

Some staff are registered with their GP employer. This can create difficulties when managing occupational health problems. Most of the staff are in the front-line of health care provision. A particular issue identified in the needs analysis is the pressure felt by staff to meet rising patient expectations and to cope with aggressive and violent patients and their families. An important message is that it is not only doctors that feel “stressed” as a result of their jobs and that all staff should have access to independent psychological support.

Occupational health to other small and medium-sized enterprises (SMEs)
Another issue for consideration is the provision of occupational health to patients of the practices. Some GPs indicated that one advantage of having an occupational health service would be to raise the general level of awareness of how to deal with the occupational health issues affecting their patients. There is the potential to consider how the development of primary care occupational health services might influence the delivery of national health strategies and improve access to small and medium-sized enterprises.

CONCLUSION
The proposed model for an occupational health service for the staff of general practice in Newcastle and North Tyneside addresses the identified needs and provides a response to the NHS imperative to provide a comprehensive occupational health service to the entire workforce. It is envisaged that the service will be developed and extended to include all primary care staff. There will be an opportunity to include the service in an overarching occupational health service within the Tyne and Wear area.

REFERENCES

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