BMJ

BMJ 2013;346:f1503 doi: 10.1136/bmj.f1503 (Published 7 March 2013)

VIEWS & REVIEWS

PERSONAL VIEW

After Mid Staffs: the NHS must do more to care for the health of its staff

An occupational health physician who worked at several NHS trusts believes that severe work pressures and poor management have not been taken seriously enough by NHS trust managers and that this has the potential to brutalise staff

Anonymous

I worked for several years in several NHS trusts before the problems at the Mid Staffordshire NHS Trust emerged. I was a consultant occupational physician, tasked with looking after the health and welfare of some 12 000 NHS staff. Other consultant NHS physicians I have met had similar experiences.

I came to the NHS as an outsider, having done my undergraduate training and initial specialisation in occupational medicine abroad. The first post I held in occupational medicine in the UK, while undertaking training for membership of the faculty, was in industry. I found that line managers in engineering regarded the workforce in a similar way to how they view other parts of the production process: if someone was getting worn out or damaged, then the underlying cause should be fixed to prevent it happening again. Although they were not happy to see reports on new cases of work related ill health, they saw them as just as necessary as the plant engineer's report on machine maintenance.

When I started working in the NHS I was taken aback by the resentment and anger that staff expressed toward their employer. However, their feelings became understandable when I tried to present anonymised statistics about work related ill health to management, as I had done in industry. Managers saw my reports as likely to cause them trouble and to provide ammunition for staff who were thinking of making compensation claims. I was told that no other NHS occupational health department produced such reports, and they were "filed" in the bin. NHS management seemed not to understand that it had a duty to protect its staff from the pressures under which they were working. This was a callous disregard for staff wellbeing.

As I persisted in trying to get trusts to tackle this problem over several years, I was investigated for spurious reasons such as "not getting on with others" and had to leave my position with a pay-off and a gagging clause. I have applied for six other consultant posts in the NHS since. On each occasion I have been interviewed but failed to secure the post for unexplained reasons.

After leaving the NHS, I analysed national statistics to see how work related ill health in healthcare staff compared with that in workers in other industries. What I found confirmed my impression that work related ill health was worse in the NHS. I presented a paper on this topic at a conference in the early 2000s. It was recorded in the proceedings, which were brought to the attention of the Health and Safety Executive, with no response to addressing the causes.

I found that healthcare workers were some 70% more likely to have developed work related stress, depression, or anxiety than was the general workforce at that time (146/7056 (2.1%) *v* 818/63179 (1.3%) cases; odds ratio 1.77 (95% confidence interval 1.48 to 2.12)).[1] This odds ratio has worsened since then, and it is now 2.10: the 2012 prevalence of work related mental health problems in health professionals was 110% higher than in the general workforce, as shown in recent government statistics (2560 *v* 1220 per 100 000 employees).[2] Why is this?

Firstly, the NHS is a labour intensive industry that is not easily mechanised. Manual handling while maintaining patient dignity in often cramped conditions and under time pressure is difficult. The environment is highly emotive, with near limitless demands but finite resources.

Secondly, there were more occupational health resources available in industry compared with the NHS, despite a much higher requirement in the NHS—such as for immunisations and dealing with exposure to body fluids. For example, when I worked in industry there was one occupational health physician for every 7000 employees, compared with one for every 11 000 employees in the NHS; and there was one occupational health nurse for every 1000 industry employees but one for every 2700 NHS employees (personal observations).

The 2009 Boorman report into what health interventions would improve the wellbeing of NHS staff was a lost opportunity.[3] The recommendations dealt only with the need to tackle staff sickness absences and with providing counselling and lifestyle changes, none of which have credible evidence bases. Tackling the underlying causes of ill health (understaffing, poor people management, inappropriate targets) was not emphasised.

Thirdly, in most organisations occupational physicians can appeal to senior management's altruism to try to obtain resources to promote employee health and welfare. This does not work when you are directly competing with the urgent needs of ill patients and with ongoing government initiatives to reduce waiting lists.

Fourthly, in the NHS trusts in which I worked, responsibilities for overseeing safe working practices were not delegated to

people who had the necessary authority. The board did not consider any statistics related to work-related ill health; no director was held responsible.

Fifthly, after working in these trusts for several years, I realised that most senior managers moved to new positions in three to four years. Managers seemed prepared to take the chance that they would not be in post when the results of their decisions became apparent.

Sixthly, the ability of an organisation to learn from its mistakes and take corrective action to prevent recurrence is essential for its survival. When provided with evidence that there were escalating cases of work related ill health, senior NHS managers usually put the increase down to greater awareness of cases. No action was taken to prevent recurrence. Eventually, the bearer of bad news was shot.

NHS managers have not grasped the enormity of this waste. Work related ill health leads not only to the loss of staff who provide services but also to then having to treat them as patients. The factors I have identified have led to the brutalisation of some NHS staff so that they no longer respond appropriately to distress in their patients, as recorded in the inquiry in what happened at Mid Staffs. If we wish healthcare staff to behave with compassion they must be treated with such.

Competing interests: I have read and understood the BMJ Group policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned; not externally peer reviewed.

1 Jones JR, Huxtable CS, Hodgson JT. *Self-reported work-related illness in 1998/99: Results from a EUROSTAT ill health module in the 1999 Labour Force Survey summer quarter* . Health and Safety Executive, 2001.
2 Health and Safety Executive. Self-reported work-related illness (SWI) and workplace injuries: results from the Labour Force Survey (LFS). Table STROCC2—2011/12: Estimated prevalence and rates of self-reported stress, depression or anxiety caused or made worse by current or most recent job, by occupation, for people working in the last 12 months, 2011/12. www.hse.gov.uk/statistics/lfs/strocc2.xls.
3 Boorman S. *NHS health and well-being. Final report November 2009* . Department of Health, 2009. www.nhshealthandwellbeing.org/pdfs/NHS%20Staff%20H&WB%20Review%20Final%20Report%20VFinal%2020-11-09.pdf.

Cite this as: *BMJ* 2013;346:f1503