POLICE FORCE BLUES Reflections on protracted sickness absence

Reflecting on his time as consultant occupational psychiatrist to the Metropolitan Police Service, **Derek Summerfield** finds that sickness absence on mental health grounds has roots both in organisational culture and in broader cultural trends across society

I was consultant occupational psychiatrist to the Metropolitan Police Service from 2001 to 2004 and assessed around 600 officers and 300 civilian staff. Around half of the 600 officer assessments concerned retirement on grounds of ill health, and many of these cases were protracted and contentious. Here I use these 300 cases to highlight the dynamics of fitness for work, entitlement to ill health pensions, general practitioner certification, and the role of mental health services for police officers and other occupational groups.

Role of wider culture

As with all patients, what a police officer brings to the doctor is shaped by wider culture. A big feature of 20th century Western culture has been the rise in the authority assigned to medicotherapeutic ways of understanding the trials of life. Arguably, the contemporary concept of a person emphasises not resilience, as it once did, but vulnerability.[1] A widening range of everyday experiences, including work, have come to be viewed as capable of inducing illness. "Stress," until recently a folk category, has now gained the medical imprimatur of a real ailment: "work stress" is the number one cause of sickness absence in the United Kingdom.[2]

The number of people of employable age receiving incapacity benefit for longer than six months quadrupled to two million between 1981 and 2002. The Department for Work and Pensions states that 70% of patients receiving long term disability benefits have medically unexplained symptoms.[3] Certification on mental health grounds is the leading cause of sickness absence in most high income countries, accounting for around 40% of lost time, with average time off sick for people with mental health problems at least twice that of workers certificated on physical grounds.[4] Antidepressant prescribing, currently around 35 million prescriptions a year, has quadrupled since the early 1990s, but without a reduction in the reported population prevalence of depression.[5 6]

Role of police culture

The police officer also brings to occupational health aspects of organisational culture in which retirement and pension entitlement occupy a particular place. Officers are awarded a pension only on completion of 30 years' service or if they retire on grounds of ill health. I was told that in the past the Metropolitan Police Service had seldom sacked officers for inefficiency or other problems but had often used ill health retirement instead. This had left a culture of entitlement regarding ill health retirement, yet officers were liable to see the role of occupational health as directed to reduce the pensions bill—and they often reminded me of the 2001 pledge of then home secretary, David Blunkett, to cut the bill. The hostility engendered when occupational health doctors contested claims for retirement on health grounds is shown by the regular reporting of doctors to the General Medical Council (in my case, three times).

At the time I was there 4.8% of the workforce was not doing full operational duties, with the loss of the equivalent of 180 police officers monthly because of stress related absence. There was a strong association between extended absence and work disputes, and a Metropolitan Police study has found an association between extended absence and the perception of the organisation as uncaring.[7] Retirement on mental health grounds as a proportion of all ill health retirement had been rising—up to 46% in 2002-3. The service operated a recuperative duties scheme, whereby officers could return to work on limited duties on full pay for one year or longer.

Role of general practitioners

General practitioners officiate over the boundaries between sickness and health through their power to grant sickness certificates. Mental health problems are the commonest reason for writing a sickness certificate.[8] The General Medical Council's *Good Medical Practice* states that doctors must "respond to" patient preferences, not merely respect them.[9] Doctors are reluctant to invalidate the illness claims of their patients. Although objective findings are present in only a few instances of sickness certification, and GPs believe that up to 40% of the certificates they issue may be dubious, many see their primary duty to the patient rather than to the Department for Work and Pensions or the employer. In one study half of participating GPs wanted to give up their certificating role.[10]

ALASTAIR GRANT/AP/PA

My experience was that only a few officers absent with post-traumatic stress disorder ever fully resumed their careers: the definitive role of traumatic stress clinics was not to produce a fit officer but to support his wish for ill health retirement and pension

These findings are in line with the discussions I had with certificating GPs while working as an occupational psychiatrist, and show why certificates could continue to be issued regardless of occupational health assessments. Many GPs did not know about the police recuperative duties scheme.

Role of psychiatrists

The dominant biomedical culture of psychiatry conceives illness as a naturalistic process rather than being socially influenced. But psychiatric categories are not real diseases—validated facts of nature and biology (as is, say, tuberculosis or a fractured tibia)—but conceptual devices based on constellations of symptoms decided by committee. Diagnostic criteria for categories like depression or post-traumatic stress disorder distinguish poorly between situational distress and free standing disorder.[1112] Psychiatric formulations do not encompass the role of social engagement in buttressing personal adjustment and wellbeing. Their positivistic thrust is in tension with interpretative approaches that highlight the patient not as a mere recipient of illness but as an actor engaging with his situation. No diagnosis captures this active conceptualising and meaning making, and what flows from it. There is no objective test of whether a worker cannot resume work or will not.

PRACTICE POINTS

- Certification on mental health grounds is the leading cause of sickness absence, yet is largely patient led
- The medicalisation of non-specific symptoms may promote secondary handicap and prolong disability
- Long term sickness absence is strongly associated with workplace disputes
- NHS mental health services do not promote rehabilitation and are disconnected from occupational aspects of patients' lives
- The main predictive factor regarding return to work was not psychiatric, but simply whether the officer wanted to
- Early intervention with goal setting is essential to prevent protracted sickness absence

Clinical findings in occupational health

The clinical interview and discussions about rehabilitation were much more straightforward when the officer had a "big" diagnosis such as schizophrenia, scarcely 1% of the 300 cases. These officers were clear that they wished to resume their police careers.

Interviews with the majority whose sickness certification was of "common mental disorders" often felt differently. Many officers had re-evaluated past police service in the now negative light occasioned by present feelings of grievance or weariness. The not uncommon presence of a trade union representative in the room suggested that assessment by the occupational psychiatrist was regarded with mistrust rather than as an opportunity to discuss getting better with a specialist. Many felt estranged from the police service or the everyday role of a police officer. Once an officer saw ill health retirement as his preferred option, there was an imperative to maintain the illness presentation until the matter was decided.

Categories like post-traumatic stress disorder and "work stress" presume a single cause, yet psychiatric problems generally arise multifactorially. In at least three quarters of my assessments, officers were experiencing a range of stressors: conflict with other staff, being subject to management investigation, unresolved grievance procedures, marital discord, financial worries, children with drug problems. Some officers expressed a sense of loss of good name and momentum in their career, which disinclined them to resume, and lack of contact with the workplace over time itself generated a sense of distance.

Analysis of case material made clear a systemic complication of the functioning of NHS mental health services, undue prolongation of sickness absence, and fostering of secondary handicap. The psychiatrists and psychologists following up officers seemed to see diagnosis and treatment as having a life of its own (that is, separated from what else was going on in the patient's overall situation, especially occupational). The officer sat passively at home between outpatient appointments, generally on antidepressants, waiting for the supposed cure of his anxiety or depression. There was little recognition, as sickness absence lengthened, of the potentially

negative effects of a chronic sick role—an erosion of a sense of agency and competence, or the development of illness behaviours like apathy, increased preoccupation with symptoms, and avoidance of occupational health appointments. Some officers claimed disability benefits, which is a predictor of poor treatment outcomes.[13] Clinic letters consistently failed to articulate treatment objectives in which the resumption of functioning represented by a negotiated return to work, if necessary through the recuperative duties scheme, would have a central place. The Healthcare Commission has criticised mental health services for their low expectation of what people can achieve in employment.[14]

Regarding treatment of post-traumatic stress disorder, professionally directed attention to the past, sometimes years previously, and to "emotion," seemed antitherapeutic rather than curative in these officers. My experience was that only a few officers absent with post-traumatic stress disorder ever fully resumed their careers: the definitive role of traumatic stress clinics was not to produce a fit officer but to support his wish for ill health retirement and pension. This is in contrast to a study by Neal and colleagues of 70 UK armed services personnel referred for assessment of possible post-traumatic stress. Symptoms of depression predicted disability, including work, but symptoms of post-traumatic stress disorder did not.[15]

Officers submitted supporting psychiatric reports, mostly from the NHS but also from private psychiatrists seen once. A consultant psychiatrist might write in to recommend ill health retirement only a few weeks after an officer had first been referred to his service, despite no previous psychiatric history and positive evidence of many years of robust functioning, including police commendations. Rehabilitation was not mentioned. One consultant gave the wear and tear of an officer's entire police career as the criterial stressor event for his post-traumatic stress disorder, for which ill health retirement was recommended. Overall, these reports seemed largely to be recycling in medical language what the officer said he wanted.

To qualify for retirement on psychiatric grounds an officer must be deemed "permanently disabled" from resuming the full duties of a police officer, a test that in my clinical judgment only a few could pass. The number one predictive factor regarding a return to work and career was whether the officer wanted to, which no psychiatric formulation captures.[16]

Conclusions

Although I do not want to play down the experiences of these officers, the medicalisation of non-specific symptoms, allied to social rewards that create perverse incentives, reliably prolongs disability. The longer sickness absence lasts, the more the secondary handicap of a chronic sick role is the main therapeutic challenge, and the harder it is for an officer to contemplate resuming his career. Psychiatry has a subjective emotional focus, yet as time passes the clinically urgent question is not "How are you feeling?" but "What do you have to do to get back to normal?" The evidence is that in most situations the benefits of work for an individual's mental health outweigh any risks.[17] Psychiatric and psychology services have failed to put graded normalisation back to customary social roles, notably work, at the heart of therapeutic objectives from the start. For their part GPs sign sickness certificates without setting goals and often without knowledge of recuperative work schemes. They are understandably uneasy about taking responsibility for a scheme that is largely patient led.

Certification is diagnosis based, but static biomedical categories cannot capture problems rooted in a situation, with its own dynamic, rather than in a "mental state." In much sickness absence based on workplace stress, the problem is really an operational or staffing one: dislocation to a psychiatric arena can paralyse the practical problem solving required to normalise the situation.

The medicalisation of non-specific symptoms, allied to social rewards that create perverse incentives, reliably prolongs disability

The basic concept in rehabilitation must be early intervention. Management systems need to resolve disputes and grievances promptly, before they fester. More recently the Metropolitan Police have taken some of the heat out of the occupational health assessment process by shifting the final decision on ill health retirement to external assessors. There needs to be much closer working between occupational health departments and NHS services, starting early in the sickness absence period. The switch in sickness certification that focuses on what a person can do rather than what he cannot, following the Black report, is positive.[18] But above all we need a culture change in mental health service practice.

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1 Summerfield D. Cross cultural perspectives on the medicalisation of human suffering. In: Rosen G, ed. *Post-traumatic stress disorder. Issues and controversies.* John Wiley, 2004:233-45.
2 Wainwright D, Calnan M. *Work stress: the making of a modern epidemic.* Open University Press, 2002.
3 Waddell G, Burton A, Bartys S. *Concepts of rehabilitation for the management of common health problems.* Stationery Office, 2004.
4 Harvey S, Henderson M, Lelliott P, Hotopf M. Mental health and employment: much work still to be done. *Br J Psychiatry* 2009;194:201-3.
5 Brugha T, Bebbington P, Singleton N, Melzer D, Jenkins R, Lewis G, et al. Trends in service use and treatment for mental disorders in adults throughout Great Britain. *Br J Psychiatry* 2004;185:378-84.
6 Summerfield D. Depression: epidemic or pseudo-epidemic? *J R Soc Med* 2006;99:161-2.
7 Cahill Canning E. To what extent is sickness absence in the MPS influenced by organisation culture and the quality of employer-employee relations? [MBA thesis]. University of Hull, 2003.
8 Dobson R. GPs want more help and training in sick note certification. *BMJ* 2010;340:c5688.
9 Horton R, Gilmore I. The evolving doctor. *Lancet* 2006;368:1750-1.
10 Hussey S, Hoddinott P, Wilson P, Dowell J, Barbour R. Sickness certification system in the United Kingdom: qualitative study of views of general practitioners in Scotland. *BMJ* 2004;328:88-91.
11 Cole J, McGuffin P, Farmer A. The classification of depression: are we still confused? *Br J Psychiatry* 2008;192:83-5.
12 Rosen G, Spitzer R, McHugh P. Problems with the post-traumatic stress disorder diagnosis and its future in DSM-V. *Br J Psychiatry* 2008;192:3-4.
13 Prins J, van der Meer J, Bleijenberg G. Chronic fatigue syndrome. *Lancet* 2006;367:346-55.
14 Healthcare Commission, Commission for Social Care Inspection. No voice, no choice. A joint review of adult community mental health services in England. Commission for Healthcare Audit and Inspection, 2007.
15 Neal L, Green G, Turner M. Post-traumatic stress and disability. *Br J Psychiatry* 2004;184:247-50.
16 Bigos S, Battie M, Spengler D, Fisher L, Fordyce W, Hansson T, et al. A prospective study of work perceptions and psychosocial factors affecting the report of back injury. *Spine* 1991;1:1-6.
17 Waddell G, Burton A. *Is work good for your health and well-being?* Stationery Office, 2006.
18 Black C. *Working for a healthier tomorrow.* Department of Health, 2008.

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COMMENTARY

A police officer's lot is not a happy one

Derek Summerfield's time spent working as a psychiatrist in the occupational health department of London's Metropolitan Police Service was frustrating for him, and for the police officers that he saw.[1] Summerfield found little evidence of formal mental disorders in the officers; they perceived him as a barrier between themselves and the ill health retirement to which they felt entitled. Labels such as post-traumatic stress disorder or work stress were common, ill defined, and rarely led to satisfactory treatment. Instead, Summerfield felt that professional, occupational, and domestic issues were more relevant, but ones that both doctor and officer were powerless to address. Summerfield echoes the comments of two sociologists who link the medicalisation of the workplace and the epidemic of work stress: "Why do problems and antagonisms which previously led to the picket line and the political demonstration now so often lead to the general practitioner or the counsellor?"[2]

Summerfield is describing the stasis that can develop once an employee starts the search for ill health retirement, especially if this is for mental health or quasi-mental health problems. A similar systems inertia has been postulated in the vast US Veterans Administration, which cares for former service personnel with a service related disability. Once veterans file for disability, treatment of their problems becomes increasingly fraught and fruitless.[3] The dilemmas of the employee, trapped in a system that creates perverse barriers to recovery and leaves both patient and doctor increasingly irritated and powerless, have been recognised. Carol Black's 2008 report for the Department for Work and Pensions noted the problem, but whether the proposed reforms will tackle it remains to be seen.

As with the armed forces, sources of stress within the police force are somewhat different from the popular perception. Of course, both police officers and military personnel are occupationally exposed to traumatic events. However, these are not the main sources of stress in the police, any more than in the military.[4] What outsiders call trauma, is for many the reason why they have joined the uniformed services. Instead, too many studies to cite report that organisational culture and workload are the chief causes of unhappiness and stress within police forces.[5] It is the violation of professional codes of conduct and behaviour that are more likely to lead to occupational psychiatric injury in all the uniformed services.

For police officers who have not made it to senior command, there comes a point when chasing criminals or grappling with rioting students is no longer for you

Summerfield's dispatch from the occupational front line can be contrasted with the situation in the UK armed forces. Most people who join the services intending to make it their career will expect to leave in their 30s and 40s, with only a few progressing to the highest ranks. They will receive a good pension and a generous resettlement package to prepare them for a second career. There is a separate process surrounding the award of war pensions, which are to recompense those who have been injured in service, and for which medical evidence is necessary.

One reason such a system has evolved is because war is a young person's game. The physical strain of deployment, and the impact on families, becomes increasingly onerous as you enter middle age, and most will choose to develop a second career.[6] Likewise, for police officers who have not made it to senior command, there comes a point when chasing criminals or grappling with rioting students is no longer for you. But Summerfield is suggesting that the process of leaving, at least in the Met, has become increasingly medicalised, with the result that officers leave embittered and encumbered by inappropriate medical labels that will make it far more difficult for them ever to work again.

Working lives have changed beyond recognition over the last century, but for Summerfield's police officers some things have not changed as much as we might believe.

"If any single factor dominated the lives of nineteenth-century workers it was insecurity . . . They did not know when accident or sickness would hit them, and though they knew that some time in middle age they would become incapable of doing a full measure of adult physical labour, they did not know what would happen to them between then and death."[7]

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1 Summerfield D. Metropolitan Police blues: protracted sickness absence, ill health retirement, and the occupational psychiatrist. *BMJ* 2011;342:d2127.
2 Wainwright D, Calnan M. *Work stress: the making of a modern epidemic*. Open University Press, 2002.
3 Frueh B, Grubaugh A, Elhai J, Buckley J. US Department of Veterans Affairs disability policies for PTSD: administrative trends and implications for treatment, rehabilitation, and research. *Am J Public Health* 2007;97:2143-5.
4 Fear N, Jones M, Murphy D, Hull L, Iversen A, Coker B, et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK Armed Forces? A cohort study. *Lancet* 2010;375:1783-97.
5 Collins P, Gibbs A. Stress in police officers: a study of the origins, prevalence and severity of stress-related symptoms within a county police force. *Occup Med* 2003;53:256-64.
6 Iversen A, Nicolaou V, Unwin C, Greenberg N, Dandeker C, Ross J, et al. What happens to UK veterans when they leave the Armed Forces? *Eur J Public Health* 2005;15:175-84.
7 Hobsbawm E. *The age of capital, 1848-1875*. Weidenfeld and Nicholson, 1975.

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JUNIOR DOCTOR OF THE YEAR:

Influencing healthcare at home and abroad

Helen Jaques introduces the shortlist

Junior doctors could be excused for not having the time to make noteworthy contributions to healthcare in this country, what with carrying service provision in the NHS and the demands of training and exams. Some exceptional young doctors, however, manage to juggle their everyday commitments with projects that considerably enrich the world around them.

The Junior Doctor of the Year category of the BMJ Group Awards, introduced last year, rewards the doctor in training who has done most to improve the world we live in or to inspire others. The three candidates shortlisted for the 2011 award have all made an important difference to health within the different spheres of charity, research, and leadership. They have all shouldered huge additional commitments on top of their NHS training and excelled in their chosen field despite the demands of their jobs.

Dan Magnus

Dan Magnus was nominated for his long term commitment to charity work in the developing world. Dr Magnus, a paediatrics specialty trainee in Severn Deanery, co-founded the Kenyan Orphan Project (www.kopafrica.org) in 2001 while a medical student at Nottingham University and continues to act as a trustee.

The charity has two key aims: improving the lives of orphans and vulnerable children in western Kenya and providing global child health education and experience for students and medical volunteers in the United Kingdom. The Kenyan Orphan Project has set up and supports a large range of grassroots projects—such as orphan feeding centres in the rural villages of Kochogo and Ombeyi and a centre for street children in Kisumu—that are then taken forward by local communities.

The charity also sends groups of university students to Kenya to assist with its programmes and leads trips for doctors and nurses to organise free rural outreach medical camps. More than 800 medical and other students at 12 UK universities have supported and taken part in Kenyan Orphan Project programmes.

As well as leading practical global health projects, Dr Magnus is in charge of developing global health teaching for medical undergraduates at the University of Bristol, acting as a lecturer in maternal and child health on the international health BSc and a dissertation supervisor for the course. He also sits on the committee of the international child health group at the Royal College of Paediatrics and Child Health.

Rameen Shakur

Research—of the international, high impact variety—is one of the things that makes Rameen Shakur, a specialty registrar in cardiology at the London Deanery and an honorary cardiology research fellow at the National Heart and Lung Institute, stand out.

He has published more than 15 peer reviewed papers on his work with cardiovascular magnetic resonance imaging in journals such as *Circulation*, *European Heart Journal*, *JAMA*, and *BMJ*. He has presented his research at international conferences, and his study of the predictive value of scarring of cardiac tissue for cardiac events is one of the largest clinical trials in the world on this topic.

However, Dr Shakur has had a more direct effect on those around him through his contributions to medical education. He is a clinical teacher at Green Templeton College, Oxford, and is the author of two books for junior doctors: *A Career in Medicine: Do You Have What it Takes?* and *The Essential Handbook for the Foundation Programme*, a comprehensive guide for junior doctors and medical students on how to achieve the necessary competences. As a member of the General Medical Council's postgraduate education training board, he has helped shape the curriculum for postgraduate training.

He has also helped get medical students, in particular those from disadvantaged backgrounds, involved in hospital audits and clinical research as founding chair of London-wide society Medic-SHARE (Medical Doctors and Students Hospital Audit and Research Exchange).

Yasmin Ahmed Little

Yasmin Ahmed Little's outstanding achievement is her work on clinical leadership in the North West region, which she fits in around her job as a public health specialty trainee at Stockport Primary Care Trust. The initiatives she has helped set up include the Emerging Clinical Leaders Network, the Leadership Schools pilot, and a buddy scheme that pairs up junior doctors and clinical leaders.

Dr Little established and led the first multiprofessional Darzi fellow programme in 2009 and co-founded "The Network," an online community for medical students and junior doctors with an interest in clinical leadership and medical management, which was set up to fill the vacuum left by the closure of the British Association of Medical Managers. Her commitment to developing leadership opportunities was recognised in her appointment as a fellow of the Department of Health's National Leadership Council.

Dr Little has also led various quality improvement initiatives, such as the North West Strategic Health Authority European Working Time Directive team, which fully implemented the directive a year early and won her and her team a *Health Service Journal* award for workforce development in 2008.

Also of note is her Dragons' Den venture, where junior doctors pitch projects relating to service improvement; education and training; and improving junior doctors' working lives to a panel of senior health service "dragons." On top of all this she holds two non-executive director roles.

Judging

The award will be judged by Clare Gerada, chair of the Royal College of General Practitioners; Shree Datta, co-chair of the BMA's Junior Doctors Committee; and Doug Noble, public health registrar at London Deanery, who was one of last year's finalists.

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SUSTAINABLE HEALTHCARE

Getting more from less

Kirsten Patrick introduces the shortlist

Although health is affected by climate change, the healthcare sector contributes massively to greenhouse gas emissions. In 2009 a report in *JAMA* estimated that nearly one tenth of carbon dioxide emissions in the United States were generated by the healthcare sector (doi:10.1001/jama.2009.1610). Although this figure may be higher than the global average, it shows the magnitude of the carbon footprint of an industry that is both necessary and likely to increase in scale globally as population sizes increase and services improve. Healthcare needs to become more sustainable.

This year the BMJ Group's Sustainable Healthcare award will recognise an organisation that has gone beyond its core business of providing healthcare and has committed to and achieved greater sustainability. Three entries have been shortlisted for the award, which is sponsored by the Climate and Health Council.

Sandwell Primary Care Trust, UK

Over the past two years Sandwell Primary Care Trust in the West Midlands has implemented several policies that are in line with the NHS Sustainable Development Unit's good corporate citizenship agenda. As many companies do, the trust began by auditing its carbon footprint. A team comprised of staff from all levels and departments within the organisation agreed on a five year carbon reduction plan and an environmental management policy. The trust is taking actions under each of the six domains of the good corporate citizenship model: transport, community engagement, employment and skills, procurement, facilities management, and new buildings. Numerous outreach schemes have engaged the trust's staff. Sandwell was the first primary care trust in the country to introduce national standard BikeAbility cycle training for staff and people from the local community. The trust has introduced salary sacrifice schemes for bus tickets and buying bicycles, "dump the car" days, car share, and a lease policy for hybrid fuel vehicles. It has improved existing recycling schemes and developed a sustainable procurement policy through outsourcing technical support, introducing hot desking to reduce the number of buildings and amount of equipment used, and replacing physical with virtual servers. It has even modelled its patients' carbon footprint and looked at ways to reduce it.

Having reduced its carbon dioxide emissions by 21% from 2008 to 2010, the trust hopes to achieve a 25% reduction by 2014. It estimates that implementation of its carbon management plan will lead to potential financial savings of around £300 000 a year by 2014. As a result, Sandwell is one of only five NHS trusts to have achieved a high level of financial sustainability according to independent audit.

Nottingham and Nottinghamshire primary care trusts, UK

Another of the five NHS trusts to have been recognised for achieving high financial sustainability is Nottingham. NHS Nottingham and Nottinghamshire primary care trusts have been working with Nottingham Energy Partnership since January 2008 to train their staff and to find ways to cut their carbon emissions, reduce waste, and improve efficiency and sustainability. People across many departments have been involved in planning how they can cut energy use, waste and sewage, water consumption, and conventional transport by influencing staff behaviour and changing procurement practices. The trusts have also sought to use their substantial influence when commissioning and procuring important goods and services, insisting that their suppliers make sustainability a priority too. Over two years the trusts have achieved over 85% recycling rates for their domestic waste, which is a remarkable achievement. Because of their collaboration with Nottingham Energy Partnership they have been able to be part of a wider public health initiative in the local community that aims at combating fuel poverty and excess winter deaths and in so doing also reduce carbon dioxide emissions in the local community. Vulnerable householders have received funded energy saving home improvements, particularly through referrals from trained health workers and advice given at general practice flu vaccination clinics.

Peninsula Health, Australia

Providing top level healthcare takes a lot of water. Peninsula Health began refurbishing Frankston Hospital in Victoria, Australia, in 2008. Part of the brief was to reduce the entire site's water consumption by 20% from pre-2008 figures. This was an ambitious target that exceeded Australian best practice and official governmental guidelines but necessary given the severe drought conditions in the area over the past decade. The designers of the new facility used innovative mechanical designs to conserve water, such as water efficient fixtures and fittings that restricted water flow where high flow was not needed, and mechanisms to harvest rain water and reclaim water of sufficient quality for re-use in toilet flushing. They redesigned the hospital's cooling system to use less water, and through use of careful landscaping of the hospital's surroundings, patients still benefit from beautiful hospital grounds without the need for much water to maintain them.

Even though the refurbished and extended hospital has a greater demand for water than the previous facility, the project has reduced the hospital's water usage by an astounding 21%. The new site uses about 13.25 million litres of potable water less each year than the previous facility.

The uneviable job of judging which of these three outstanding projects should win the award belongs to David Nicholson, chief executive of the NHS, David Pencheon, director of the NHS Sustainable Development Unit, and Ron Saporta, director of engineering and plant services at St Michael's Hospital, Toronto, Canada, and last year's winner.

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Sustainability: the teams from (from left) Sandwell, Nottingham, and Peninsula Health