

# NHS Health and Well-being Review

Interim Report



## Foreword

I very much welcome the opportunity afforded to lead this review. It has been a privilege to work with the NHS and the Department of Health in undertaking this work.

Health and well-being is now increasingly being recognised as more than a matter for individual attention – successful organisations have recognised that good health is a key enabler to good business. The health, safety and well-being of staff directly contributes to organisational success and poor workforce health has a high cost.

The NHS needs to support and improve the health and well-being of its workforce if it is to meet the challenge of delivering high-quality care without excessive cost – the health and well-being of its staff should no longer be a secondary consideration, but needs to be at the heart of the NHS mission and operational approach.

Our research shows clearly the significant financial and performance benefits such an approach may accrue, but, importantly, better care for the carers is a vital benefit to staff. The NHS workforce is large, and improving the health of NHS staff and their families has enormous potential to prevent future ill-health throughout the country.

This review highlights that the NHS loses over 10 million working days each year due to sickness absence alone. It also highlights that many NHS workers are working when they feel unwell. It shows for the first time clear links between workforce well-being and key measures such as patient satisfaction and Trust performance, and it also documents the impact that simple lifestyle issues such as smoking or lack of exercise have on the organisation.

While some may challenge whether it is feasible to suggest that the NHS can improve its performance on staff health and well-being to the same extent that leading private companies have achieved, I have seen clear examples from the NHS during this review which suggest that this can be done. The variations in performance highlighted within this report provide scope for improvement.

We have made a number of recommendations to improve staff health and well-being, and have highlighted the next steps that need to be taken to achieve this. We recognise that these will require some investment in improving services. We believe that adopting innovative approaches to supporting staff health and well-being, as we recommend in the report, will free up resources that can be reinvested in better and more appropriate services. More importantly, we are confident that any costs will be outweighed by the benefits which will flow to NHS organisations. As well as financial benefits – from reduced costs of sickness absence, increased productivity and lower spending on staff turnover, agency spending and ill-health retirement – there will be benefits to patient care and patient satisfaction from being treated by happy, healthy staff working in teams with familiar colleagues, rather than by tired, unwell and unhappy staff.

There were over 200 responses to the call for evidence and over 11,000 responses to our staff perception research. During the review process, meetings and events were held across the country and I have been immensely impressed by the willingness of individuals and organisations to contribute freely and with passion. I am grateful for the quantity and quality of material provided.

I hope this report will serve as a catalyst to prompt change – a change that makes the health of its workers of key importance to the NHS, and which recognises that this will support the high-quality care patients and the public expect.

We deliberately conducted this work to demanding timescales, enabling its recommendations to be produced quickly, supporting the pledges in the recently adopted NHS Constitution. This is a complex topic with diverse stakeholders and substantial breadth – in the time available we have had to adopt a pragmatic approach, seeking to identify the main issues. Further work may be necessary in some areas, particularly to strengthen the evidence base for specific interventions and to evaluate their cost-effectiveness: our aim, however, has been to make the case for change.

Our intention in publishing this Interim Report is to use its contents as a basis for discussion at workshops throughout the country, seeking further feedback from NHS workers and other stakeholders during summer and early autumn. Feedback may also be given via the website ([www.nhshealthandwellbeing.org](http://www.nhshealthandwellbeing.org)), and we will produce a final summary of this work in late autumn.

I am grateful to the small review team that co-ordinated and managed the collation of the material informing this document, and to the experts from The Work Foundation, RAND Europe, Aston Business School and the NHS Information Centre who have worked together to deliver the pieces of the jigsaw we seek to show here. Throughout the period I have worked with them, they have all delivered consistently to changing demands and with cheerful enthusiasm!

I am also grateful to 3 groups of diverse specialists listed in Appendix 3, whose counsel and input have been crucial in identifying the approach and priorities of this work. They have all given freely of their time and support, and their guidance has been invaluable.

The Department of Health and NHS have taken an important step in asking for this review, as part of their response to Dame Carol Black's report *Working for a healthier tomorrow*, reinforcing their commitment to patients, the public and staff set out in the NHS Constitution. The review team believes that the information presented here makes a compelling argument to systematically support NHS workforce health and well-being for the benefit of all concerned.



**Dr Steven Boorman**  
Lead Reviewer

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## Executive summary

This Interim Report sets out the results of our work and thinking on how to improve the health and well-being of NHS staff. It draws heavily on work commissioned from a range of external bodies which has helped to identify issues of concern with current staff health and well-being services in the NHS; to bring together best practice in the NHS and other organisations; and to highlight the benefits, to staff, patients and NHS bodies, of investing in improving staff health and well-being.

The key messages from the report are summarised below, and a full list of recommendations is at Appendix 1. But one overarching point needs to be made here. Staff health and well-being needs to be seen as central to the NHS and recognised as a crucial issue at board level as much as at ward level. Staff health and well-being is not just the responsibility of occupational health departments or well-being advisers – **it is the responsibility of every single member of staff**. Making this happen requires nothing less than a sea change in the way in which staff health and well-being is perceived. This report and the recommendations it makes are intended to help achieve that change.

**Chapter 1** sets out the background to this review and the context within which it has been undertaken. It positions it in relation to the staff health and well-being pledge in the NHS Constitution, Lord Darzi's report *High Quality Care For All* and the Department of Health report *A High Quality Workforce*, as well as the proposals in Dame Carol Black's review *Working for a healthier tomorrow*. It also sets out how investment in staff health and well-being can help the NHS to make progress on

the 4 key issues of quality, innovation, productivity and prevention. It summarises the key benefits that such investment can deliver to NHS organisations and the prerequisites for delivering an effective service, which can be summarised as:

- ▶ **board commitment, top management leadership and staff engagement**
- ▶ **embedding staff health and well-being in the core business of the organisation as part of what it means to be a good employer**
- ▶ **proper resourcing for staff health and well-being services, with a clear understanding that this represents investment that will deliver both long-term savings and improved patient care**
- ▶ **agreed and consistent measures of the effectiveness of staff health and well-being programmes, which can be used for board and national reporting.**

**Chapter 2** identifies key priorities and recommendations for action by NHS employers in relation to improving staff health and well-being. These centre on:

- ▶ **contributing to getting 2 million people more physically active by 2012**
- ▶ **achieving further reductions in smoking**
- ▶ **achieving significant reductions in the number of adults who drink too much**
- ▶ **reversing the rise in adult obesity**
- ▶ **improving the mental health and well-being of NHS staff.**

This requires concerted action in the workplace by employers, and the NHS has an opportunity to lead by example.

**Chapter 3** sets out the current state of NHS staff health and well-being, drawing on a major staff survey which we commissioned



and analysis of other data sources. Key findings are as follows:

- ▶ NHS staff have relatively high levels of sickness absence. On average, staff are absent for some 10.7 days a year, more than the public sector as a whole (9.7 days) and the private sector (6.4 days).
- ▶ These levels of sickness absence are reducing, but not as significantly as in other organisations. In the public sector as a whole, sickness absence fell from 9.8 to 9.7 days, while across the private sector it reduced from 7.2 to 6.4 days.
- ▶ Respondents report high levels of presenteeism, with many staff reporting that they come to work when they feel sufficiently unwell to justify staying at home.
- ▶ Many staff report significant levels of stress.
- ▶ Many staff do not believe that senior managers or their employer as an organisation take a positive interest in their health and well-being.
- ▶ Most staff believe that their state of health affects patient care.

Chapter 3 identifies shortcomings in the evidence base for monitoring the health

and well-being of the NHS workforce and makes recommendations for improving this.

Chapter 4 sets out the case for change and the benefits that will accrue to staff and NHS organisations from effective investment in staff health and well-being. Improving staff health and well-being is not only the right thing for NHS Trusts to do as exemplary employers: investment in such services can bring financial and performance benefits. Reducing current levels of sickness absence across the NHS by a third, a challenging but realistic target, would result in a gain of 3.4 million days a year, equivalent to 14,900 extra whole-time equivalent (WTE) staff and an annual direct cost saving of £555 million. There are also potentially significant savings in indirect costs such as spending on agency staff. It could also improve performance on a range of outcome measures, including patient satisfaction rates.

Chapter 5 summarises perceptions of NHS occupational health services and wider staff health and well-being services and suggests that they are falling short of providing consistent, high-quality health and well-being support for staff. While many people commented positively on aspects of current





services, and good practice examples were identified, a number of general concerns were raised, in particular:

- ▶ **staff shortages and a lack of investment in skilled staff**
- ▶ **inadequate resourcing, and resources not linked to need**
- ▶ **inconsistent, and in some cases inadequate, occupational health services**
- ▶ **lack of visible board and top management commitment to tackling staff health and well-being issues**
- ▶ **a failure to analyse and use information both on the extent, and costs, of poor health and well-being in individual organisations and on the benefits of investing to improve services**
- ▶ **uncertainty over the role and function of occupational health services and the balance between supporting staff and managers**
- ▶ **cultural barriers to investing money in services for staff and to enabling staff to access services effectively**
- ▶ **lack of consistent line management support to enable staff to benefit from health and well-being programmes.**

In many places the role of staff health and well-being services in maximising the contribution that staff make and in helping Trusts to deliver consistent high-quality and economical services was overlooked. This chapter also makes recommendations for strengthening the NHS occupational health workforce.

**Chapter 6** touches on the key issue of prevention, which will be a focus for further development as we prepare our final report. We would particularly welcome proposals and contributions on this issue.

**Chapter 7** sets out our views on approaches to providing high-quality health and well-being support to NHS staff. The key principles that underpin our vision are of a staff health and well-being service which is:

- ▶ **focused on prevention and health improvement as well as providing excellent support for staff who present with ill-health and sickness**
- ▶ **proactive in tackling the causes of ill-health, both work-related and lifestyle-related, as well as responding effectively to cases presenting for treatment. This should include the provision of early intervention services where these are of clear benefit to individuals, patients and the Trust**
- ▶ **centred on, and responsive to, staff and their concerns, as well as providing responsive advice to management, with services available to staff through both self-referral and managerial referral**
- ▶ **holistic, bringing together the variety of initiatives in occupational and public health into a single approach**
- ▶ **embedded as a core element of Trust business, with appropriate resourcing and routine monitoring and reporting to the board**



- ▶ supported by a service specification setting out clear expectations of the service
- ▶ fully connected with wider NHS provision, especially general practice and public health.

We make a number of detailed recommendations intended to help deliver this vision. These include a nationally agreed minimum service specification for NHS staff health and well-being services; consistent metrics for such services, which can be aggregated to national level; proper, needs-based, resourcing of staff health and well-being services in Trusts; the appointment of a board executive champion for staff health and well-being, with clearly defined senior management leadership; and arrangements for supporting and enabling line managers to support staff and tackle their health and well-being issues.

**Chapter 8** examines the case for early intervention services to be provided in the NHS and concludes that such services should be routinely available for illnesses and injuries that are common in the NHS, suitable for effective early treatment and liable to result in long-term or recurrent absence if not treated quickly. These should include musculoskeletal disorders and mental health conditions. They should also be available on a case-by-case basis for other illnesses or injuries where the benefit to the NHS Trust clearly outweighs the cost to the organisation. Services should be

available to all staff on the basis of self-referral as well as managerial referral and should be easily accessible to staff, with a mix of telephone, internet and face-to-face advice. They should be supported by high-quality advice on prevention of illness and injury and on health improvement.

**Chapter 9** considers action needed to strengthen the workforce. It recommends action to improve education and training, to improve the evidence base on effective interventions, and to improve the dissemination of such evidence in the NHS.

**Chapter 10** sets out the next steps that we consider the range of organisations (national and local, and including professional bodies and trade unions) needs to take to turn the proposals in our report into a reality.

The report is underpinned by a number of research reports, listed in Appendix 4 with details of the website from which they can be accessed.





# Background and context





1.1 The NHS and its patients depend on its staff to deliver the high-quality services that people have a right to expect. In turn, those staff should expect to be properly treated and supported both when they are at work and when they are unable to work due to ill-health. This is reflected in the NHS Constitution,<sup>1</sup> which committed the NHS to:

“provide support and opportunities for staff to maintain their health, well-being and safety”.

In their turn, employees have a duty to “take reasonable care of health and safety at work for you, your team and others”. This report is centrally concerned with ensuring that the NHS has the information, tools and incentives to help it deliver high-quality health and well-being services to its staff. It looks at:

- ▶ the support that NHS bodies currently provide for staff
- ▶ what exemplar approaches to NHS staff health and well-being would look like
- ▶ what action needs to be taken to deliver such exemplar approaches.

1.2 The report was commissioned following Dame Carol Black’s report on the health and well-being of the working-age population *Working for a healthier tomorrow*,<sup>2</sup> Lord Darzi’s report *High Quality Care for All*,<sup>3</sup> and the Department of Health report *A High Quality Workforce*.<sup>4</sup> It starts from the premise that **all NHS Trusts should provide exemplary support for their employees’ health and well-being**<sup>5</sup> because it

supports the goal of delivering high-quality care for all, because the NHS should be seen as a leader in this area and importantly because it makes sense in financial and performance terms. The evidence we have received shows wide variability in the performance of NHS organisations in this area, and there is substantial scope for improving performance to attain the standards already achieved by the best organisations in the public and private sectors.

1.3 As well as being exemplary employers, it is also important that, in line with the pledge on staff health, well-being and safety in the NHS Constitution, NHS commissioning organisations put staff health and well-being at the centre of their commissioning decisions by ensuring that services are only commissioned from NHS bodies that are demonstrably committed to improving staff health and well-being. They may also wish to ensure that the above responsibilities are reflected in contracts with non-NHS providers.

1.4 Finally, improving the current provision of staff health and well-being services will be critical both to supporting delivery of the proposals in *Working for a healthier tomorrow* and to meeting the major public health challenges of increasing levels of exercise, reducing smoking, tackling excessive drinking, reducing obesity and improving mental health. Workplace interventions have a crucial role to play here.

<sup>1</sup> *The NHS Constitution: The NHS belongs to us all*. London: Department of Health, 2009.

<sup>2</sup> *Working for a healthier tomorrow: Dame Carol Black’s review of the health of Britain’s working age population*. London: The Stationery Office, 2008.

<sup>3</sup> *High Quality Care for All: NHS Next Stage Review Final Report*. London: The Stationery Office, 2008.

<sup>4</sup> *A High Quality Workforce: NHS Next Stage Review*. London: Department of Health, 2008.

<sup>5</sup> For the purposes of this report we have used the World Health Organization definition that health and well-being is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

## The current context

- 1.5 The improvements in staff health and well-being services which the review recommends can support not only delivery of the NHS Constitution pledge but also the 4 key facets of **quality** (quality care delivered by healthy staff in quality workplaces, with key links to safety, efficiency and patient experience); **innovation** (innovative leadership and management practices, and models of staff healthcare); **productivity** (increasing capacity and productivity by addressing staff ill-health and absenteeism); and **prevention** (innovative staff care models and pathways aimed at prevention).
- 1.6 First, *High Quality Care for All* lays out the central challenge of delivering comprehensive and consistent high-quality

care for patients. Over 80% of staff who responded to our survey believed that the health and well-being of staff had an impact on patient care. And, as set out more fully in Chapter 4, our work showed links between staff health and well-being and important issues such as patient satisfaction, meticillin-resistant *Staphylococcus aureus* (MRSA) rates and Annual Health Check ratings. As Figure 1.1 indicates, there are clear relationships between a range of outcome measures and staff health and well-being. Those Trusts which had lower rates of sickness absence, turnover and agency spend nearly always scored better on measures of patient satisfaction, quality of care and use of resources.

**Table 1.1: Outcome measures for 4 acute Trusts with high and low staff health and well-being measures**

	Trust A	Trust B	Trust C	Trust D
Absence	4.21%	4.04%	4.58%	4.70%
Turnover	10.50%	9.79%	11.65%	17.02%
Agency spend	1.70%	2.96%	1.71%	4.57%
Patient satisfaction	78.9	76.4	77.4	67.5
MRSA cases per 10,000 bed days	0.65	0.88	1.56	0.95
Standardised patient mortality rate	87.5	100.2	110.0	100.2
Annual Health Check: Quality of services	Excellent	Excellent	Weak	Fair
Annual Health Check: Use of resources	Excellent	Excellent	Weak	Weak

Note: Green figures represent Trusts which are performing well on health and well-being indicators; blue figures represent Trusts which are performing poorly on health and well-being indicators; health and well-being measures in the above table relate to responses in the Annual Staff Survey.

Source: *The Work Foundation, RAND Europe and Aston Business School*

1.7 Second, there is the challenge for the NHS to continue to improve the services it delivers at a time of resource constraint. Unnecessary staff absence through preventable ill-health, delayed intervention to tackle illness or injury, and the use of agency services to replace absent staff, all lead to avoidable costs for NHS Trusts, wasting resources which can be better used to increase and improve services.

- ▶ **Current levels of sickness absence mean that 10.3 million working days are lost in the NHS in England each year.**
- ▶ **This is the equivalent of 45,000 whole-time equivalent (WTE) staff or some 4.5% of the current workforce.**
- ▶ **The annual direct cost of absence is some £1.7 billion a year.**

Reducing these by a third – not an unrealistic target given what other organisations have achieved – would bring major benefits, including:

- ▶ **a gain of 3.4 million working days a year**
- ▶ **equivalent to 14,900 extra WTEs**
- ▶ **with an estimated annual direct cost saving of £555 million.**

1.8 Third, there is the challenge to improve health, to prevent illness and to reduce demands on the NHS from avoidable illness. Health improvement and promotion has for too long been the poor relation in the NHS but Lord Darzi's report stresses that "we all have a part to play in making ourselves and our communities healthier". It is important that NHS employers recognise and accept their responsibility for improving the health and well-being of their own staff as well as those in the wider community. Similarly, staff themselves need to take responsibility for their health and take advantage of opportunities for health improvement.

1.9 Fourth, there is the challenge of delivering staff health and well-being services in an innovative fashion. For example, the NHS has not taken full advantage of the opportunities to provide web-based and telephone support for staff, or to use a wider range of staff to provide care and support. Tackling these issues, and delivering a modern service comparable with the best performers in industry, has the potential to enable the NHS to develop and maintain a position at the leading edge of health and well-being provision for its staff.

1.10 Fifth, there is the challenge for NHS organisations of attracting and retaining staff, of being recognised as the employer of choice. Having a reputation as an employer that cares about the health and well-being of its staff can help an NHS Trust achieve this both in its own right and as part of an overall reward package for staff. Investing in staff health and well-being services can bring benefits both for patient care, by having strong and consistent teams of staff, and financially because healthier and happier staff are likely to be more productive and more motivated to remain with their employer, so reducing recruitment and associated costs. For commissioning organisations, governed by the World Class Commissioning framework, investing in staff health and well-being will help them make sustainable improvements against competency one 'Recognised as a local leader of the NHS' and the sub-competency relating to 'employer of choice'.

1.11 Finally, there is the challenge for the NHS to use its reputation to influence other organisations with which it comes into contact. The NHS deals with many organisations through purchasing goods and services and in other ways, and it has the potential, by setting an example through providing high-quality staff health and well-being services and showing leadership in this area, to demonstrate the importance of this issue and persuade others of its importance.

1.12 In short, **being an exemplar employer in terms of staff health and well-being will:**

- ▶ benefit individual staff
- ▶ support the drive to deliver high-quality healthcare services for all
- ▶ reinforce the NHS brand image as a caring and committed employer
- ▶ produce real benefits to the NHS bottom line
- ▶ reinforce and support public health promotion and prevention initiatives.

Top-class staff health and well-being services are not simply a 'nice-to-have' but an essential to deliver a health service fit for the 21st century.

## Where does the NHS stand now?

1.13 The research which we commissioned showed that, despite reported reasonable levels of health, NHS staff have relatively high levels of sickness absence. On average, staff are absent for some 10.7 days

a year. While this has reduced slightly in recent years, it is higher than the average for the public sector of 9.7 days and much higher than levels in the private sector, which have fallen to 6.4 days according to the latest absence management survey by the Chartered Institute of Personnel and Development (CIPD).<sup>6</sup> Other organisations, which have invested strategically in health and well-being services, have achieved major reductions in absence rates. For example, in BT they reduced by 30% from 3.5% to 2.43% in 5 years, and in Royal Mail by 40% from 7% to 4.2% over a similar period. Similar reductions would deliver significant benefits to NHS Trusts.

1.14 As well as high levels of sickness absence, respondents to our survey reported high levels of presenteeism (individuals attending work with symptoms of illness which have the potential to reduce performance) with many staff reporting that they come to work when they feel sufficiently unwell to justify staying at home, often because they feel they should. They also reported significant levels of stress and did not believe that senior managers or their employer as an organisation took a positive interest in their health and well-being.

1.15 Providing high-quality support to enable staff to return to work as soon as they are fit to do so is clearly critical for both the health of the NHS and that of the individual. There is ample evidence that 'good work' is beneficial and helps to improve physical and mental health.<sup>7</sup>

<sup>6</sup> See [www.cipd.co.uk](http://www.cipd.co.uk)

<sup>7</sup> See, for example, Waddell, Gordon and Burton, A. Kim, *Is work good for your health and well-being?* London: The Stationery Office, 2008.



By contrast, those unable to work – especially if they are unable to work for a long period of time – suffer poorer health themselves and their absence from work can also adversely affect their families. For the individual, the NHS and the wider economy, it is important for employers to help people return to work quickly through appropriate early interventions.

1.16 But it is equally if not more important for the NHS to prevent staff sickness and ill-health and improve their health and well-being, both physical and mental. As the NHS values set out in Lord Darzi's report make clear, the NHS must "strive to improve health and well-being and people's experience of the NHS", and recognise that "we all have a part to play in making ourselves and our communities healthier". This applies as much to staff in the NHS as those who turn to it for care. Supporting staff to improve their health and well-being needs more than the services traditionally provided by occupational health units. It needs to embrace services such as health trainers, screening services, counselling support, funding for gym membership, health checks, smoking cessation clinics and anti-obesity advice. These services need to be commissioned and provided in an integrated fashion and to be available to staff when and where they need them, in ways that meet their needs and preferences, and at their request. And staff themselves need to take advantage of the support available to them, and be supported by their managers to do so. Well-being is influenced by personal

individual perception and requires an organisational culture of care, supported by good management practices and positive behaviours. A comprehensive approach to staff health and well-being requires good leadership and management as much as good support services.

1.17 While many people who responded to our call for evidence commented positively on aspects of current NHS staff health and well-being services and identified areas of good practice, there was a range of concerns about them. They were seen as being short of staff and under-resourced, with resources often historically based rather than related to current need, and lacking in board and top management support. There was a perception that occupational health services prioritise support for managers over support for staff, and that line managers do not consistently provide support for those who want to take advantage of staff health and well-being programmes. NHS Trusts did not all make good use of the information available on staff health and well-being and, as a result, there was a lack of awareness both of the cost of staff ill-health and of the benefits from investing in better support and targeting key issues. Finally, there were cultural barriers to investing money in services for staff and to enabling staff to access services effectively. In many places, the role of staff health and well-being services in maximising the contribution that staff make, and in helping Trusts to deliver consistent high-quality services, was overlooked.

1.18 While Primary Care Trusts (PCTs) are giving priority to health and well-being in commissioning for their communities, the evidence we received suggests that a similar priority is not being given to NHS staff, even though the benefits – both financial and in terms of staff satisfaction and patient outcomes – far outweigh the costs of providing high-quality support. Unless the NHS tackles these issues vigorously, it can easily be accused of not practising what it preaches.

## What should staff health and well-being services look like?

1.19 We have set out our vision of an exemplar approach to providing high-quality health and well-being support for NHS staff. Such an approach is centred on prevention and health improvement; is proactive and responsive to staff as well as to managers; is integrated and fully connected with wider NHS provision; and above all is fully embedded in Trust business and appropriately resourced to do the job. Achieving this will require a number of things to be put into place. These include:

- ▶ commissioning services on a strategic basis, linked to wider organisational goals and values and recognising the benefits both to individuals and to the quality of services to patients which investment in staff health and well-being can bring
- ▶ ensuring that service delivery meets levels agreed in a Service Level Agreement (SLA) setting out clear expectations of the service
- ▶ commissioning integrated services through a single process rather than on an ad hoc basis. There should be a common minimum service specification for all Trusts but with flexibility to address local needs and priorities which will vary between organisations
- ▶ engaging with staff on the range of services they want to see and how they should be provided, particularly through self-referral facilities
- ▶ ensuring that services meet accredited standards such as those currently being developed by the Faculty of Occupational Medicine and the competency framework for occupational health nurses developed by the Royal College of Nursing
- ▶ delivering staff health and well-being services to a consistently high standard throughout NHS organisations
- ▶ ensuring that services are available to staff when and where required, including on different Trust sites and at times that are convenient for all workers, including those working on night shifts
- ▶ ensuring that management training and internal communications give clear and consistent messages on the importance of support for staff health and well-being
- ▶ funding services on the basis of regular assessments of the needs of staff, with monitoring of return on investment being the central measure of service effectiveness
- ▶ recognising high-quality staff health and well-being services as a key part of the NHS brand to attract, motivate and retain staff

- ▶ ensuring that managers throughout the Trust recognise their responsibility to support employees who need or wish to access staff health and well-being services
- ▶ establishing clear lines of responsibility and accountability for staff health and well-being services.

## What needs to be done to get there?

1.20 We have made a number of recommendations in the report on the action that needs to be taken to transform current health and well-being services in the NHS, and these are summarised above. Our recommendations focus on what works, drawing on best practice in the NHS and in other organisations, rather than being idealistic proposals. They are intended to address the concerns of staff and managers, as we heard them, and to deliver real improvements to both patient care and financial performance. They represent a major agenda of change intended to put staff health and well-being at the heart of the NHS and to resource it appropriately. We do not believe that one size fits all, and NHS organisations will need to tailor action to their particular circumstances. But we are sure that **all NHS organisations will need to take action to improve their staff health and well-being services and to ensure that they deliver at least an agreed minimum standard.** Our recommendations contain ideas that every NHS body can learn from and draw on.

1.21 However, if they are to be implemented effectively, there are a number of crucial prerequisites:

- ▶ The drive to deliver an effective staff health and well-being service requires board commitment, clearly identified top management leadership and staff engagement. Without this, initiatives, however well intentioned, are likely to be less than fully effective.
- ▶ Optimising staff health and well-being requires an organisational culture that establishes behaviours which actively promote care and support.
- ▶ Staff health and well-being approaches need to be embedded in the core business of every NHS organisation and seen as part of what it means to be a good employer. Such approaches need to be recognised as critical to achieving the wider aims of improving staff and patient satisfaction and patient outcomes. It is important that they are not seen as a series of one-off initiatives, but as a joined-up programme of work which is integral to the organisation's business plan.
- ▶ Staff health and well-being services need to be properly resourced and spending on them recognised as an investment which will deliver both long-term savings and improved patient care.
- ▶ There need to be agreed and consistent measures of the effectiveness of staff health and well-being programmes which can be used for board reporting and other purposes, including national measurement and reporting. It is an old adage that what

gets measured gets done, but it is vital that those running these programmes can demonstrate the benefits they are achieving, including importantly their financial benefits.

1.22 At the end of our report, we set out our views on the next steps which need to be taken to deliver the changes we want to see. Some of our recommendations will require action at national level and we look to NHS leaders, particularly the NHS Management Board, to take a clear leadership role here by ensuring that the health and well-being of NHS staff is a key priority in the Operating Framework in future years. Similarly, we look to the National Quality Board to ensure that staff health and well-being is reflected in the developing quality programme. We also look to other national bodies, including Royal Colleges, professional organisations and trade unions, to play their part in driving forward the changes needed to transform NHS health and well-being services.

## Our evidence base

1.23 In coming to our conclusions and recommendations, we have drawn on a range of evidence and information, in particular:

- ▶ a survey of NHS staff intended to find out about their experience of health and well-being support and about those things that affect their working lives and their health and sense of well-being. There were over 11,000 responses to this and it was supplemented by work with staff focus groups

- ▶ evidence and views gathered from a call for evidence which received over 200 responses
- ▶ information on best practice drawn from a comprehensive literature review
- ▶ engagement with staff and managers at workshops and other events around the country.

1.24 In taking the review forward, we have been mindful of the NHS's key principles of change, which are:

- ▶ co-production – the review has been carried out in partnership, we have consulted openly and sought to develop the material in this review through wide debate and discussion with stakeholders
- ▶ subsidiarity – we have looked outwards to stakeholders for guidance and advice, which has been clear and helpful to the review process
- ▶ clinical leadership – we have engaged with clinicians as staff and with staff health and well-being professionals as practitioners
- ▶ system alignment – we have involved all parts of the NHS system so that our recommendations can be implemented effectively.

It will be important that these principles remain at the core of work in implementing the recommendations outlined in the report.

1.25 To ensure that our research work has been fully inclusive of all sectors of NHS staff and the wider stakeholder community, we have conducted an equality impact assessment.

## Conclusion

- 1.26 It will be clear from what we have said and from the more detailed analysis in later sections of this report that we believe a sea change is needed if NHS organisations are to reap the benefits from investment in health and well-being support for their staff. The recommendations we make will, if fully and effectively implemented, enable the NHS to make that change to the benefit of staff, patients and NHS organisations themselves.



# Our key health priorities



2.1 This chapter sets out our key priorities for health and well-being services for NHS staff. It starts from the comments made by Lord Darzi in *High Quality Care for All: Our journey so far*:<sup>8</sup>

“Rather than relying solely on occupational health services, we need to move towards a broader commitment to improving health and well-being across the workplace.”

At the heart of our approach is the need for the NHS to embrace the concept of health and well-being for its staff in its widest form. As well as tackling sickness absence issues, NHS organisations need to look at what they are doing to prevent ill-health and promote good health among their staff. The importance of prevention is stressed in the national strategies for improving public health and is also increasingly reflected in wider strategy, as exemplified by the Government’s document *Building Britain’s Future*, which highlighted the opportunities afforded by linking transport development to improving the health and well-being of the population.<sup>9</sup>

2.2 NHS staff face the same health and lifestyle issues as the population at large, and they need to be tackled vigorously. The results of our staff perception survey, set out in more detail in Chapter 3 of this report, show a number of relationships between physical and mental health and well-being and the likelihood of staff being either absent from work or present when they should not be. It is important, therefore, that NHS bodies address these issues both for the benefit of the staff themselves and to improve the quality of services to

patients. It is also critical that the NHS is seen to align its priorities for improving staff health and well-being with those on the wider public health agenda.

2.3 We have identified 5 key target areas to tackle. The first of these is contributing to the target of getting 2 million people more active by 2012. *Building Britain’s Future* commits the Government to producing an active transport strategy intended both to encourage low carbon transport options and to improve personal health and well-being. Although our survey suggested that staff already engage in regular physical exercise, some 40% did so on 2 days or fewer each week. There is clearly scope for significant improvement here, with real benefits to staff themselves and to the NHS. Exercise is linked to satisfaction with life and reduces the risk of physical ill-health, and our analysis suggests that those who consider themselves to be healthy are less likely to be off sick or to be at work when they are unfit. NHS sites are often large public buildings and provide many opportunities for simple exercise-promoting initiatives, such as using stairs rather than lifts and encouraging walking. We are aware of some successful NHS programmes to promote increased exercise, such as the QActive approach in Nottingham, where NHS staff have joined activity schemes supported by commercial partners. In the private sector, initiatives such as Tesco’s support for ‘Race for Life’ have successfully gained the support of staff and customers and fulfil the twin goals of promoting



<sup>8</sup> *High Quality Care for All: Our journey so far*. London: Department of Health, 2009.

<sup>9</sup> *Building Britain’s Future*. London: The Stationery Office, 2009.

physical exercise and raising money for a good cause. There is considerable scope for the NHS to consider its own 'activity challenge', either as an annual event or as a cumulative, measured, activity goal. Such an approach has the potential to develop staff engagement in planning and delivery; to promote improved physical activity and health; and to generate considerable positive publicity for public health and prevention messages. **We recommend that this should be explored further.**

2.4 Second is achieving further reductions in the level of smoking. Although, as we will show in Chapter 3, NHS staff report smoking levels equivalent to those for the population as a whole, those who do smoke are more likely to be absent due to ill-health, and for longer, than those who do not smoke. It is well known that smoking is a major risk factor for many common and serious diseases, and NHS staff have the opportunity to be role models. Many Trusts already support staff who wish to reduce or stop smoking. North Tees and Hartlepool NHS Foundation Trust, for example, has provided smoking cessation support since 2000, using nicotine replacement therapy and psychological support. However, in the course of the review we visited too many hospitals where uniformed NHS staff were publicly sharing very visible smoking areas with patients and visitors. The message this sends contradicts the important public health message on the risks and consequences of smoking on health. We do not believe that this is acceptable and we believe that NHS staff should take a clear lead by taking advantage of existing programmes to reduce levels of smoking and give up where possible. **We recommend that NHS organisations should ensure that staff avoid obviously visible public areas when they smoke and**

**should challenge their staff to reduce smoking next year, measuring progress against current national targets.**

2.5 Third is achieving significant reductions in the number of adults who currently drink too much – over one third of the adult population. This is a vital area for public health improvement and one where the NHS needs to give clear leadership. Although our survey results suggested that NHS staff predominantly drink in moderation, nearly 20% reported drinking more than 10 standard units a week, and this may underestimate the scale of the problem. Those reporting drinking more than 10 units are 10% to 15% more likely to report being stressed. The recently launched Coalition for Better Health is working with business and sector leaders to address key health issues relating to alcohol use, as well as physical activity and obesity. **We recommend that the NHS plays an active role in the Coalition for Better Health, to identify successful strategies to reduce harmful drinking by NHS staff and their families.**

2.6 Fourth is reversing the rise in adult obesity; two-thirds of the UK population are in the 'at-risk obese' group. Again, this is an area for NHS leadership, and we are aware of Trusts that have tackled this issue through lifestyle advice and promoting exercise at work. Trafford Healthcare NHS Trust, which has taken positive steps in this area, calculated that staff who had participated in their weight management programme lost over a tonne of fat in 6 months. We are aware of major employers who have worked successfully with their staff and catering suppliers to lower the amount of salt and fat in food served in their restaurants, with clearly labelled healthy choice options, supported by 'special offers' to raise awareness of nutritional content.

In the NHS, Trusts such as Salisbury NHS Foundation Trust have introduced a salad bar in each staff restaurant in addition to the normal sandwiches and other meals. We welcome the introduction of the Healthier Food Mark as a way of encouraging public sector organisations, and their catering suppliers, to provide healthy and nutritious food and would want to see the NHS participating fully in this initiative. **We recommend that all NHS organisations should work to improve the healthiness of food served in their restaurants and staff awareness of healthy food choices, and should set a widely communicated target for reducing obesity among their own staff.**

2.7 Fifth is tackling mental health problems. As later sections of the report make clear, mental health conditions are a major contributor to NHS staff sickness absence and they are issues that are not always identified and tackled quickly and effectively. Mental health conditions also contribute to staff feeling stressed, a major issue in the NHS. We are concerned at the evidence that management practices contribute to stress and mental ill-health. Tackling this issue will require addressing some of the deep-rooted cultural issues that are endemic in the NHS, such as a culture of long hours and high levels of bullying and harassment. It will also need to address ways of improving the skills of managers to recognise and support staff with mental health problems – as well as overcoming the reluctance of staff to admit to problems. But action on this front is important, not least to promote awareness of mental health problems, to reduce the stigma often, and unfairly, attached to those who suffer from them, and to encourage early access to care services for staff with mental health problems. **We recommend that the**

**Social Partnership Forum should give high priority to addressing the underlying issues which may serve as risk factors.**

2.8 Finally, it is critical that we use the workplace, both in the NHS and elsewhere, as a primary site for health promotion and prevention. People spend a lot of time at work, and there is real scope for using that time to promote good health, provide support and help to those who want to improve their health, and make time available for health-promoting activities. Doing this requires a genuine commitment from employers to improving the health of their staff, and through them their families, and from staff to take advantage of the opportunities provided. We believe that this is an area where the NHS is well placed to take a leading role. In this context we welcome the inclusion of categories for promoting a healthy workplace and promoting work–life balance in the 2010 Healthcare 100 Awards process, aimed at identifying the top healthcare providers to work for in the NHS. We believe that competitions such as these, and similar competitions at a local level, provide very real incentives for Trusts and their staff to up their game when it comes to providing and taking advantage of staff health and well-being services.

2.9 While focusing on these key priorities, however, it is important that the NHS, and other employers, also tackle work-related illness and injury quickly and effectively. There needs to be a coherent and co-ordinated approach to providing staff with advice on health promotion, to preventing illness and injury, and to tackling conditions leading to sickness absence. Later sections of this report look at these issues in more detail.



# The current health and well-being of NHS staff







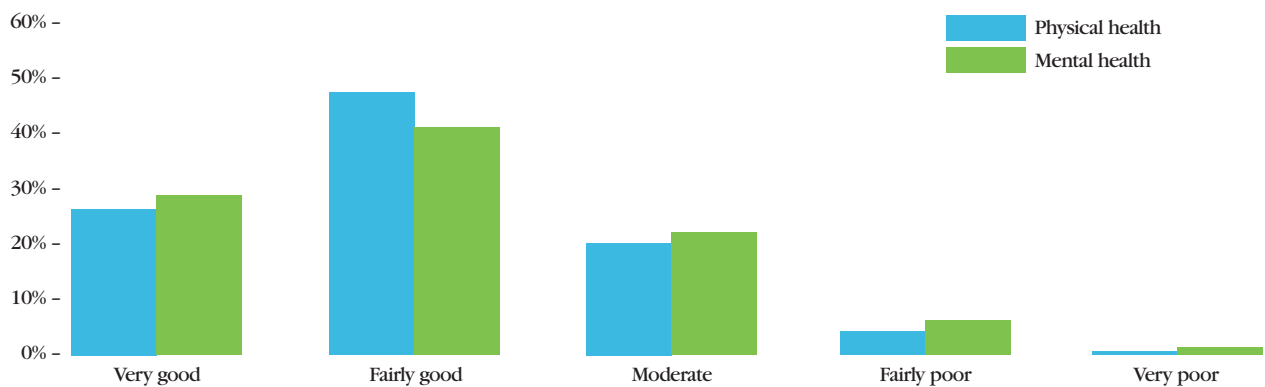
3.1 This chapter will look at what we know about the health of the NHS workforce and what contributes to the patterns of health and ill-health. It also identifies gaps in our knowledge base and proposes action to fill them. It draws heavily on the staff perception survey carried out for us by The Work Foundation, RAND Europe and Aston Business School. This survey had 11,337 completed responses, and responses to the demographic questions in the survey indicate that it covered a reasonably representative subset of the entire population, particularly in relation to the age, gender, ethnicity and occupation group of the respondents.

## Staff health

3.2 Based on the responses to our survey, NHS staff believe they are quite healthy. While there may be a degree of under-reporting, respondents to our survey say that they drink in moderation and nearly 80% of them do not smoke (there is a degree of casual smoking, or people trying to quit, with around 20% smoking up to 10 cigarettes or cigars per day, and a small minority of heavy smokers smoking over 21 per day). They report that they undertake regular exercise and many have good social networks at work and enjoy their work, although they find it pressured. Figures 3.2, 3.3 and 3.4 give more information on this.

Figure 3.1: Reported health of NHS staff

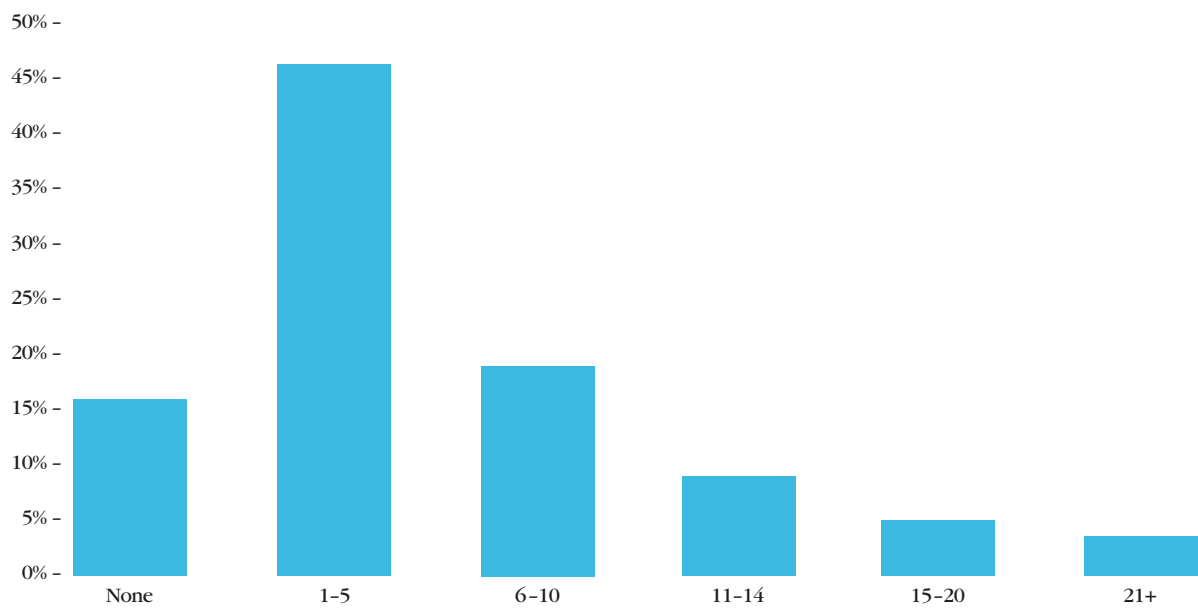
### Current physical and mental condition



Source: *The Work Foundation, RAND Europe and Aston Business School*

Figure 3.2: Reported levels of drinking of NHS staff

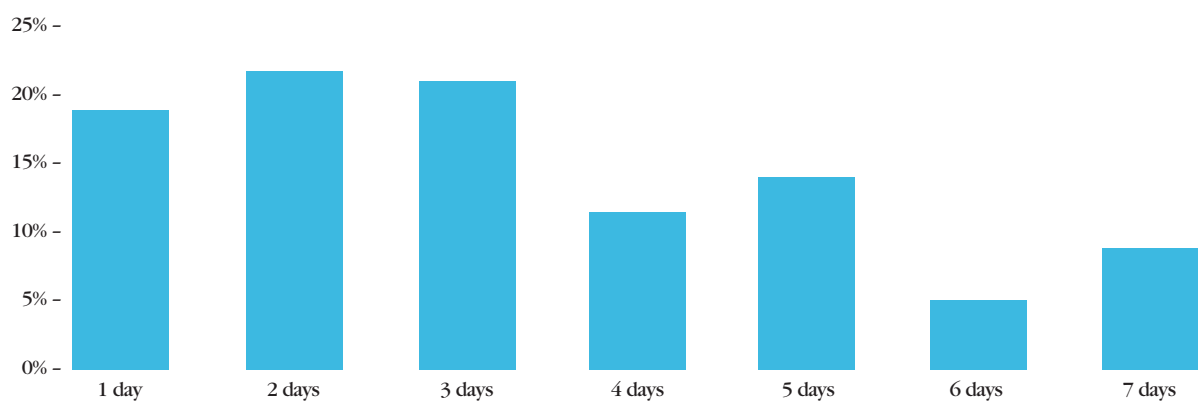
How many standard drinks do you consume each week?



Source: The Work Foundation, RAND Europe and Aston Business School

Figure 3.3: Reported levels of exercise of NHS staff

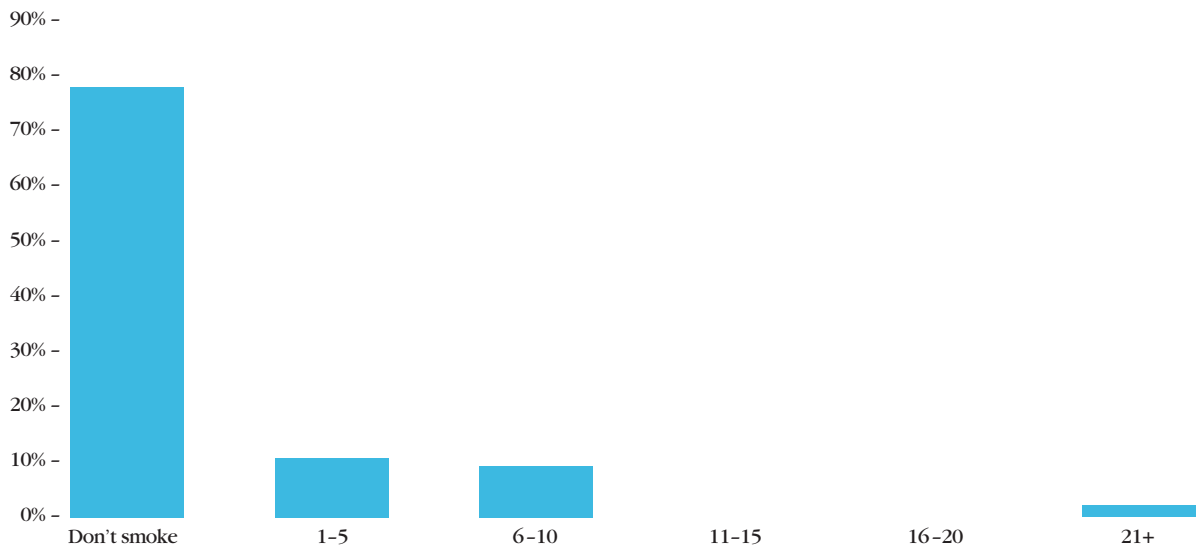
How many days a week do you undertake exercise?



Source: The Work Foundation, RAND Europe and Aston Business School

Figure 3.4: Reported levels of smoking of NHS staff

How many cigarettes or cigars do you smoke a day?



Source: The Work Foundation, RAND Europe and Aston Business School



## Staff absence through illness

3.3 Despite reporting generally good health, NHS employees have high levels of sickness absence.<sup>10</sup> At an average of 10.7 days, their sickness absence compares unfavourably with staff in government departments and is well above the average for the public sector as a whole (9.7 days), let alone the private sector (6.4 days), as reported in the most recent absence management survey conducted by the Chartered Institute of Personnel and Development (CIPD). And like the public sector as a whole, NHS sickness rates are not coming down at the same rate as in the private sector – the CIPD survey reported that, while private sector sickness rates had fallen from 7.2 days to 6.4 days in

the last year, public sector rates had fallen only from 9.8 days to 9.7 days. While the introduction of the Electronic Staff Record (ESR) has resulted in improvements in recorded attendance, we believe more improvement is achievable.

3.4 There is a greater propensity for NHS staff to incur a work-related illness or accident than other comparative groups of workers. For instance, as Table 3.2 shows, the probability of an NHS worker having an illness is 1.491 times greater than a non-health worker and the probability of having an accident is 1.731 times greater. These are significantly greater than the probabilities for others working in human health.

Table 3.1: Average working days lost per staff member in government departments, 2006/07

Department	Average working days lost per WTE
Department for Transport	12.4
HM Land Registry	12.2
Department for Work and Pensions	11.1
National Health Service	10.7
Home Office	10.5
Scottish Executive	9.9
Department for Education and Skills	8.4
Ministry of Defence	7.3
Department of Health	6.4
Cabinet Office	3.3

... although few other public bodies operate services 24 hours a day, 7 days a week...

Source: RED Scientific Ltd, 2007

<sup>10</sup> Figures exclude maternity leave and non-sickness absence, including dental appointments and appointments to see a GP.

Table 3.2: Probabilities of incurring a work-related illness or accident, by industry

Category of worker	Illness	Accident
Public administration, education and health worker (compared with manufacturing worker)	1.375	1.178
Human health worker	1.173	1.147
NHS worker	1.491	1.731

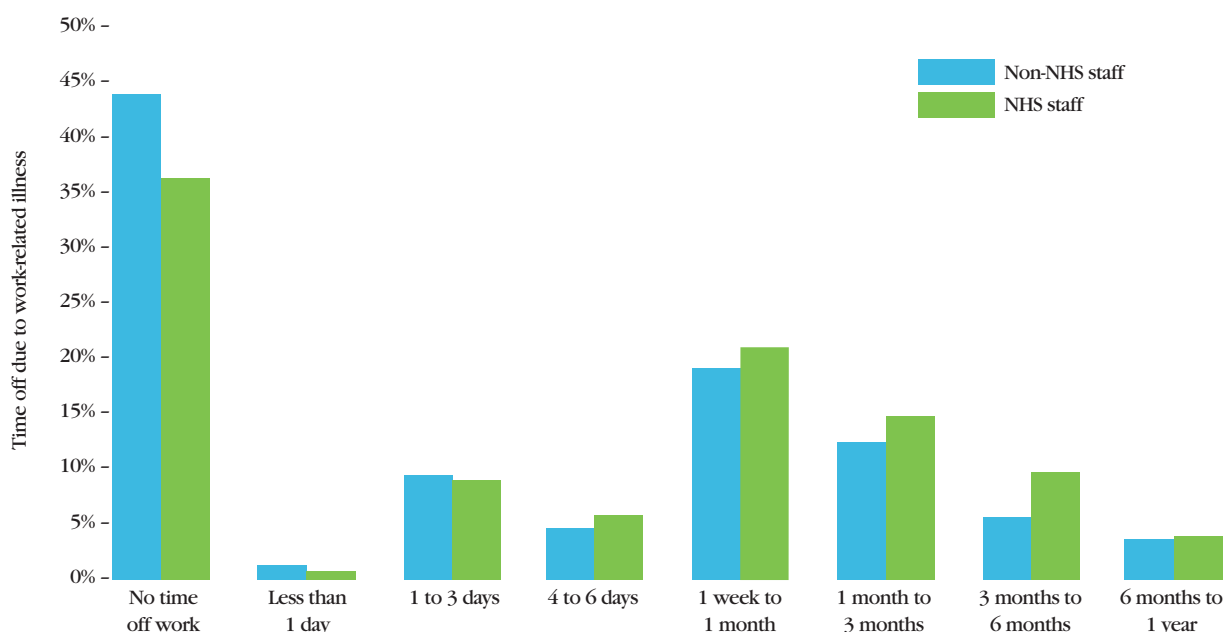
'Human health worker' refers to people working in the 'human health activities' industry sector (SIC 85.1).

Source: *The Work Foundation, RAND Europe and Aston Business School*

3.5 Clearly, there are a number of factors that may help to account for these figures. For instance, NHS work is often physically and psychologically demanding, which increases the risk of illness or injury; the NHS workforce is extremely diverse in terms of occupations and skills compared with many other public sector employers; and staff are involved in a wide range of activities, some of which (eg moving

and handling patients) carry higher risks of injury than in other walks of life. Nonetheless, the fact is that **NHS staff are more likely to be absent through illness than other workers, and, as Figure 3.5 shows, more likely than others to be absent for more than a week.** While the risk factors alluded to above may play a part, these risks should be controlled and reduced.

Figure 3.5: Distribution of length of time off work, NHS staff and non-NHS staff



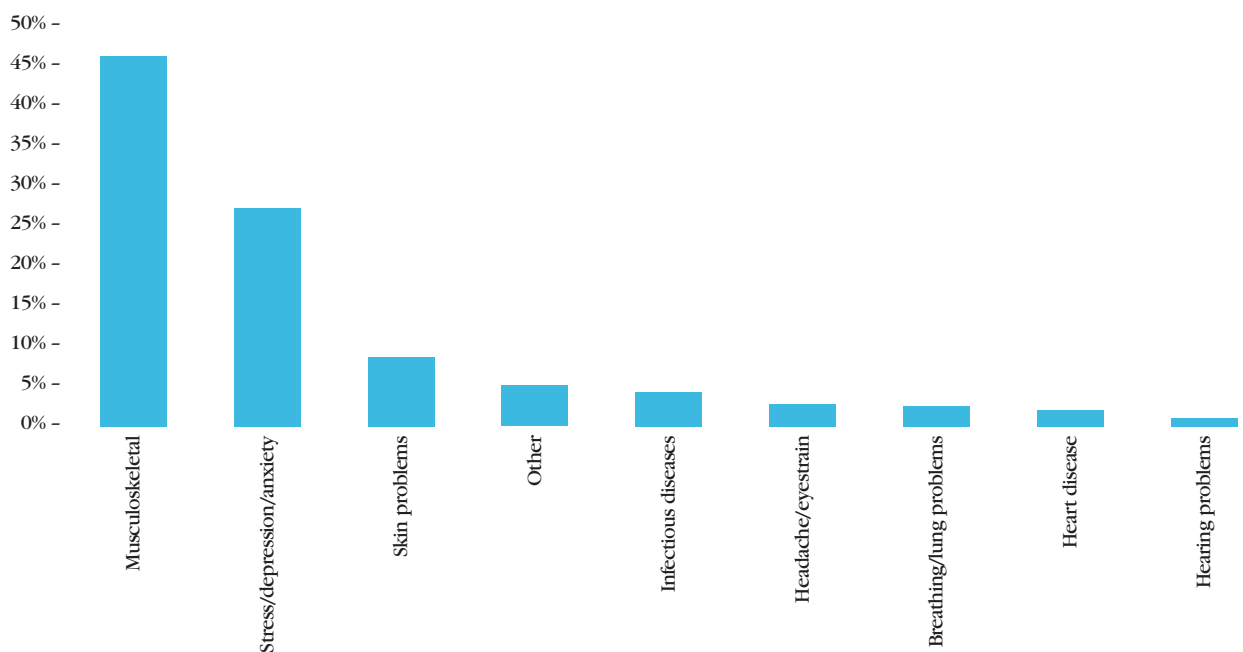
Source: *Labour Force Survey*



3.6 Figure 3.6 below shows the main causes of sickness in NHS workers. Nearly half of all NHS staff absence is accounted for by musculoskeletal disorders, and more than a quarter by stress, depression and anxiety, which emphasises the importance of

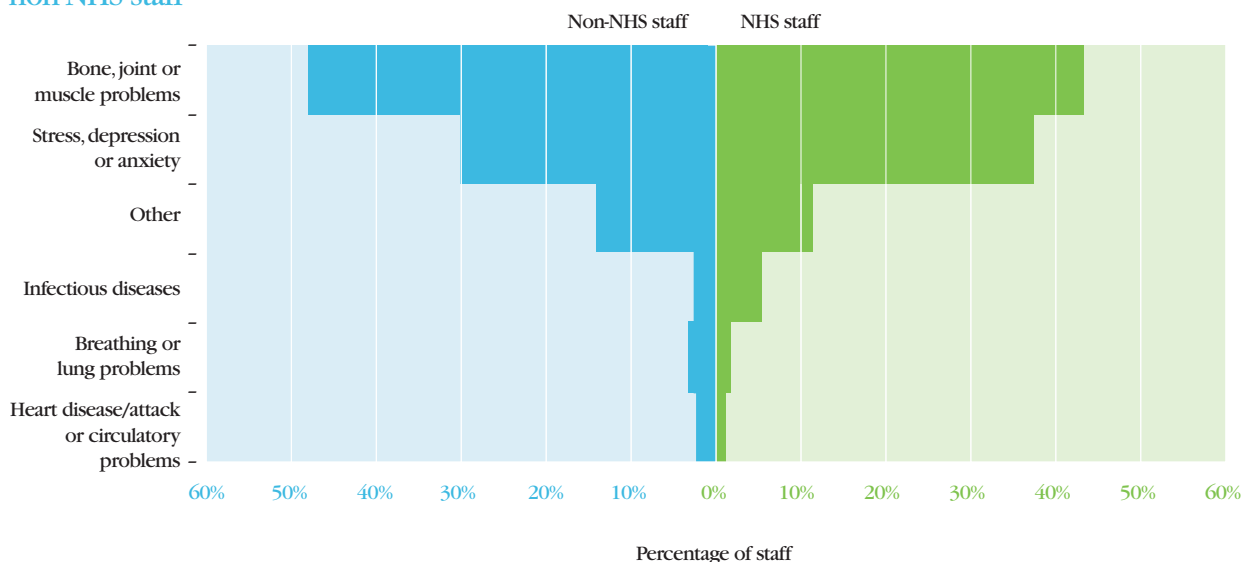
preventing such conditions, and tackling them quickly and effectively when they occur. And as Figure 3.7 shows, NHS staff reported more work-related illnesses due to infectious diseases and stress, depression and anxiety than did workers in other sectors.

Figure 3.6: Type of illness, NHS staff



Source: Labour Force Survey

Figure 3.7: Distribution of self-reported illnesses caused or made worse by work, NHS staff and non-NHS staff



Source: Labour Force Survey

3.7 We are particularly concerned at the high levels of psychological and mental health problems that NHS staff suffer from, not least because, as later sections of this report suggest, management attitudes and practices may contribute to this. We are aware that the National Institute for Health and Clinical Excellence will soon be producing guidance on promoting mental well-being at work; this will offer evidence-based suggestions on organisational approaches that can promote and protect the mental well-being of staff. This includes the role of line managers, the organisation of work, managing risks to employees' mental well-being and identifying and implementing opportunities for improving staff mental well-being. **We recommend that all NHS bodies should give priority to implementing this guidance as a sign of their commitment to staff health and well-being. We also recommend that all NHS bodies ensure that their management practices are in line with the Health and Safety Executive's management standards for the control of work-related stress.**<sup>11</sup>

## Factors associated with sickness absence

3.8 Our survey suggested that there are associations between lifestyle and sickness absence. For example, those who smoke 6 cigarettes or more a day have a 34% higher incidence of being absent than do non-smokers, and a 10% higher incidence of being absent for longer; staff with poor physical health report more absence and for longer periods of time than those in good health. But working patterns are also associated with absence rates. For example, those who work more than 8 hours a day for any number of days in a month have much higher absence rates than those who

never work for more than 8 hours a day. And those who perceive greater pressure to return to work when unwell have more absence.

3.9 Other factors can also affect sickness absence. For example, our survey showed that carers are more likely to be absent for longer than non-carers (and we welcome the recent announcement of additional funding to support carers' health and well-being), while staff with postgraduate education are less likely to be absent. But very importantly, **those who believe their concerns are listened to at work have less absence than those who do not believe their concerns are listened to, and there is some evidence that those who feel comfortable about accessing occupational health services have lower absence rates than those who do not feel comfortable in accessing occupational health services.**

3.10 However, the survey also identified some important trends in relation to patterns of sickness absence. In particular, absence was higher among women and among those with longer NHS service. Some 80% of NHS staff are women and 43% of NHS staff have worked in the NHS for more than 15 years. Further work is needed to understand these trends and to determine effective interventions. However, as an organisation with a high proportion of women in its workforce, and with many staff with long service, the NHS is likely to have higher sickness rates than other organisations with a different demographic in their workforce. The NHS therefore needs to pay careful attention to supporting these staff in order to help them to improve their health and well-being and reduce the risk to the NHS of having staff off sick.

<sup>11</sup> Available at [www.hse.gov.uk/stress/standards/](http://www.hse.gov.uk/stress/standards/)

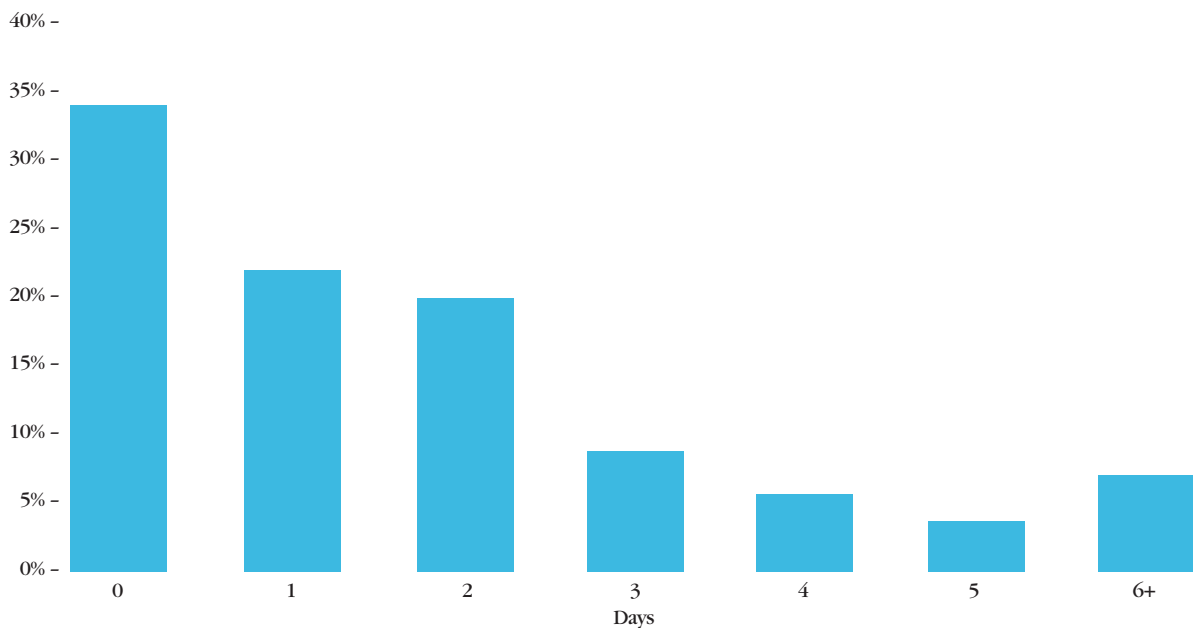
## Staff presence when ill

3.11 Illness-related absence is, of course, only one measure of staff health and well-being. The extent to which staff work when they are not really well enough to do so – what is known as ‘presenteeism’ – is also of major importance, as staff who work when they are not well enough to do so can have adverse effects on themselves, on their colleagues, on patients (who may be put at risk), and on the reputation of the organisation as a whole. As Figure 3.8 shows, over a 4-week period over 65% of NHS staff reported that they had not taken time off work despite feeling ill enough to do so. We do not have evidence on the conditions that staff suffer from while

remaining at work, nor their severity, and further information would be helpful in establishing whether there are patterns of illness or injury which might be amenable to early intervention to prevent them getting worse. Although we know that, for instance, 71% of qualified nurses and midwives in the 21–30 age group report presenteeism compared with 45% of staff in the same age group in corporate services, more work is needed to understand variations between occupational groups. We recommend that further research should be undertaken into presenteeism to identify in more detail its causes, variations between occupational groups and impact on patient care and safety.

Figure 3.8: Presence at work despite feeling ill enough to justify being at home

In the last 4 weeks, how many days have you gone to work despite feeling that you were ill enough to justify staying at home?



Source: *The Work Foundation, RAND Europe and Aston Business School*

## Factors associated with presenteeism

3.12 Pressure to return to work is related to presenteeism – those who do not feel pressure to return have over 30% lower rates of presenteeism. As Figure 3.9 shows, staff consider that it is predominantly self-induced pressure that leads them to return to work before they are feeling fully fit.

Staff at our focus groups said that such self-induced pressure reflects both concerns about letting colleagues down:

“If I don’t come in, then she [colleague] has to do it”

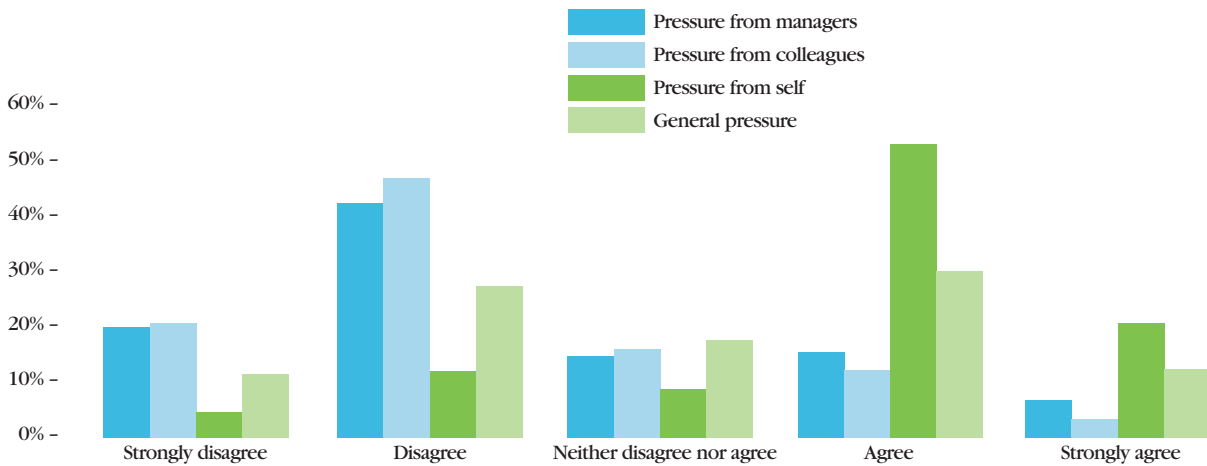
and worry about the effect of absence on individual workloads:

“If I don’t come in, then it just piles up waiting for my return.”

There are also concerns about the quality of agency and temporary staff cover:

“We come in when we’re unwell because temp staff mess things up - they’re not the solution they’re claimed to be: they just cost more, without delivering more.”

Figure 3.9: Sources of pressure to return to work



Source: The Work Foundation, RAND Europe and Aston Business School

3.13 Again, the evidence from our staff survey suggests a relationship between lifestyle factors and the propensity of staff to be present at work when they should not be. Those who smoke, who drink heavily or who have financial problems go in to work when feeling unwell more than other staff. So also do those with a longstanding illness, perhaps because of fears that action may be taken against them if they are absent from work. And, as with sickness absence, presenteeism is more pronounced among women than among men. **But, importantly, presenteeism is greater in those who work long hours and experience managerial pressure to return to work.**

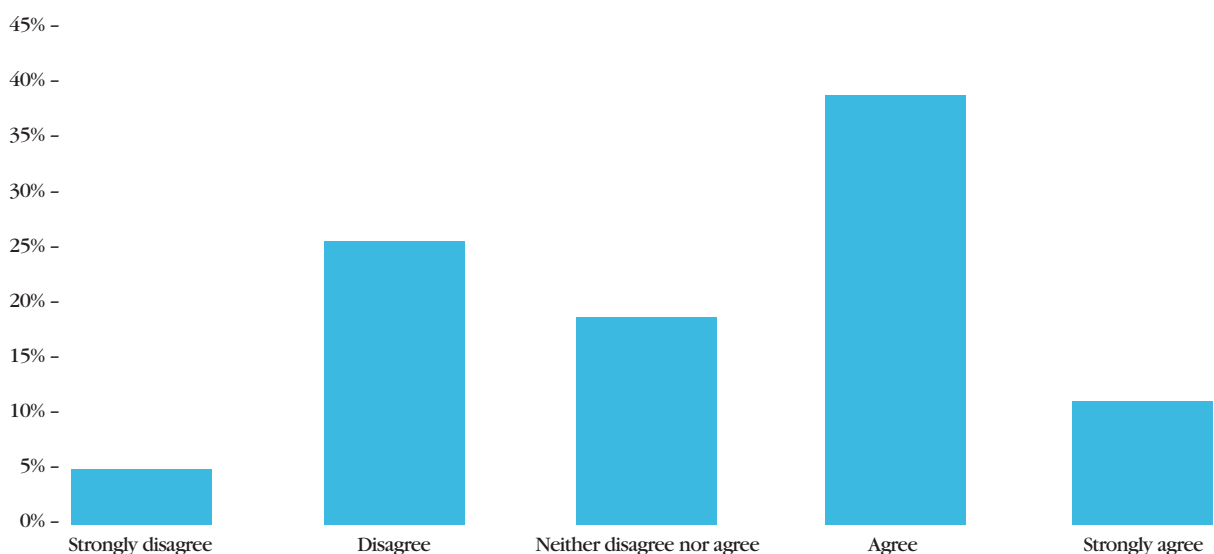
## Stress and harassment

3.14 Stress is widespread in the NHS – as Figure 3.10 shows, half the respondents to our survey reported being more stressed than usual at the time of completing the survey.

3.15 Analysis of the staff perception survey identified a range of factors that are related to reported stress levels. Some are general lifestyle issues – for example, staff reporting sleep deprivation, financial concerns and caring responsibilities all report higher levels of stress than those without these considerations. So too do those with lower levels of mental well-being. But there are also work-related factors that are related to levels of stress. Apart from the general levels of stress that come from busy and often demanding NHS jobs, staff who have been working for the NHS for a long time report higher levels of stress than those who have joined more recently, as do those in managerial roles. Unsurprisingly, those who cannot cope with their jobs report being more stressed than those who can – twice as much among our respondents.

Figure 3.10: Levels of reported stress

### I feel more stressed than usual at present



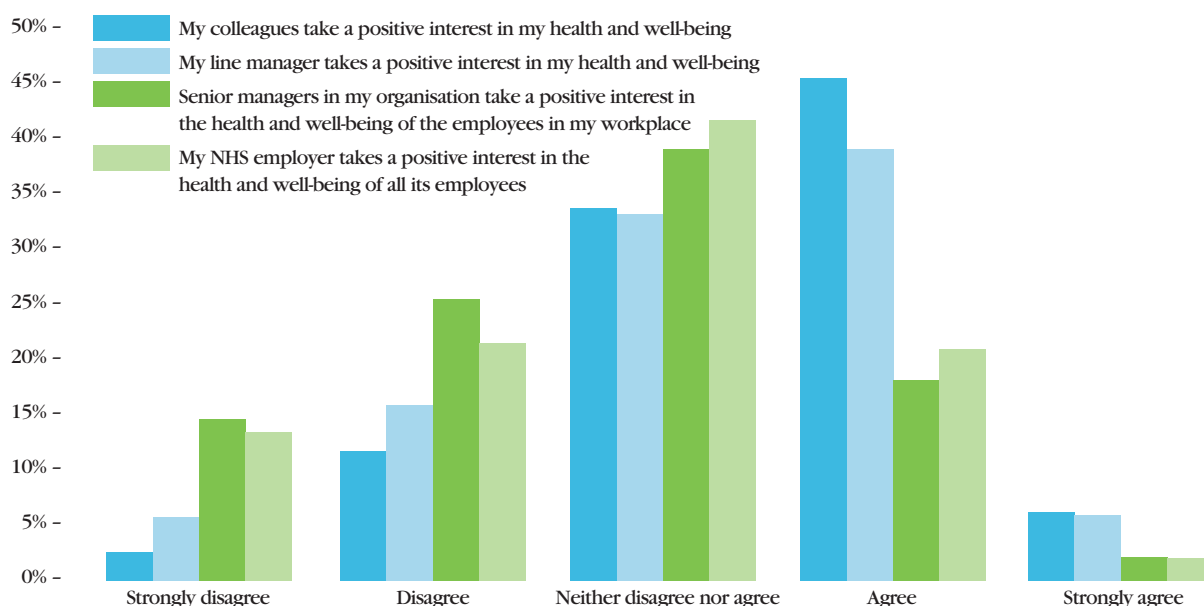
Source: *The Work Foundation, RAND Europe and Aston Business School*



3.16 Conversely, those staff who feel able to talk to their managers about their health, those who feel valued and those who are satisfied with their responsibilities report lower levels of stress than those who feel unable to talk to their managers, do not feel valued or are dissatisfied with their responsibilities. However, respondents to

our survey generally do not believe that managers beyond their immediate line manager are interested in their health and well-being, as shown in Figure 3.11. This is an important finding in considering what needs to be done to promote a positive staff health and well-being culture in the NHS.

Figure 3.11: Employer and manager interest in staff health and well-being



Source: *The Work Foundation, RAND Europe and Aston Business School*

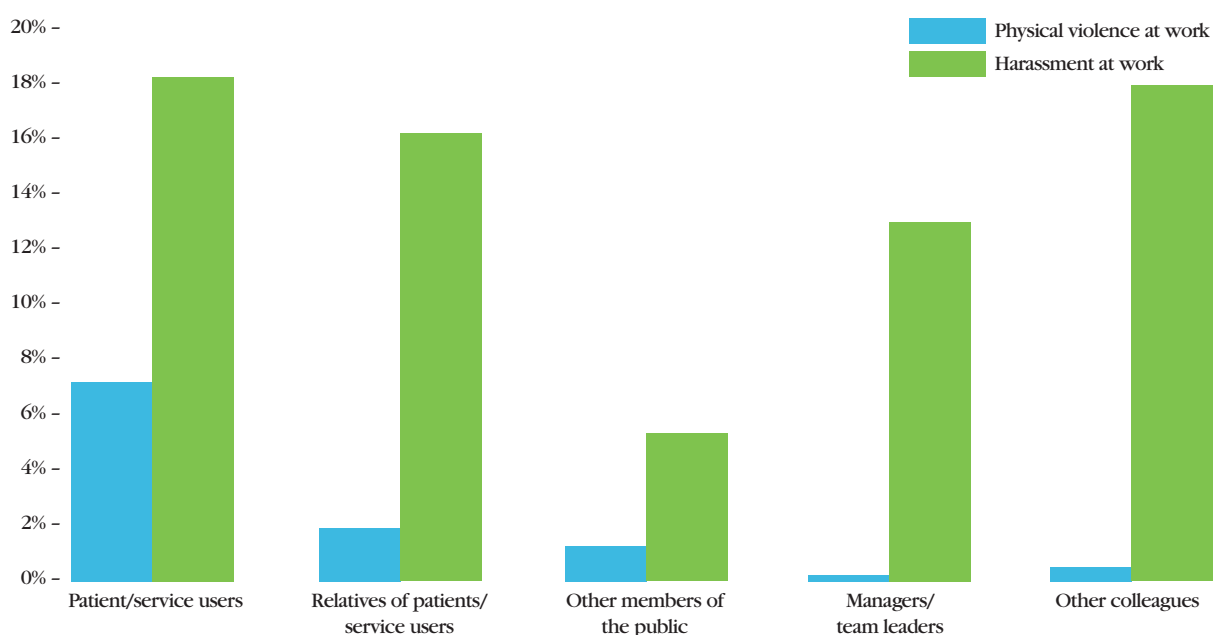
## Bullying and harassment

3.17 In its report on the national NHS Annual Staff Survey 2007,<sup>12</sup> the Healthcare Commission (now the Care Quality Commission) said that research had shown that bullying and harassment were major causes of stress at work. The report was concerned at the high levels of bullying and harassment identified in the survey, which showed, among other things, a rise in staff reporting personal experience of bullying by managers and colleagues from 18% in 2005 to 21% in 2007 (though this fell back to 18% in 2008). The report also suggested that many incidents went unreported and that not all staff were confident that their employer would take action to tackle such incidents – less than 50% agreed or strongly agreed that their Trust took effective action where staff were bullied, harassed or abused by other members of staff. Respondents to our survey also

reported high levels of harassment at work, as shown in Figure 3.12.

3.18 We are concerned about the picture emerging from our survey and from the Healthcare Commission report in relation to bullying, harassment and stress. We welcome the priority given to this issue by the Social Partnership Forum and would wish to see this continue in future years. We also welcome the work undertaken by the NHS Security Management Service to improve the level of reporting of incidents. But this is also an issue that Trusts need to tackle vigorously, including through training for managers, support for staff who are the victims of bullying and harassment, and other means such as mediation services (we are aware of such services in some Trusts, such as North Tees and Hartlepool NHS Foundation Trust, and believe there is scope for them to be introduced elsewhere).

Figure 3.12: Experience of workplace violence and harassment by NHS staff



Source: *The Work Foundation, RAND Europe and Aston Business School*

<sup>12</sup> *National NHS staff survey 2007*. London: Commission for Healthcare Audit and Inspection, 2008.

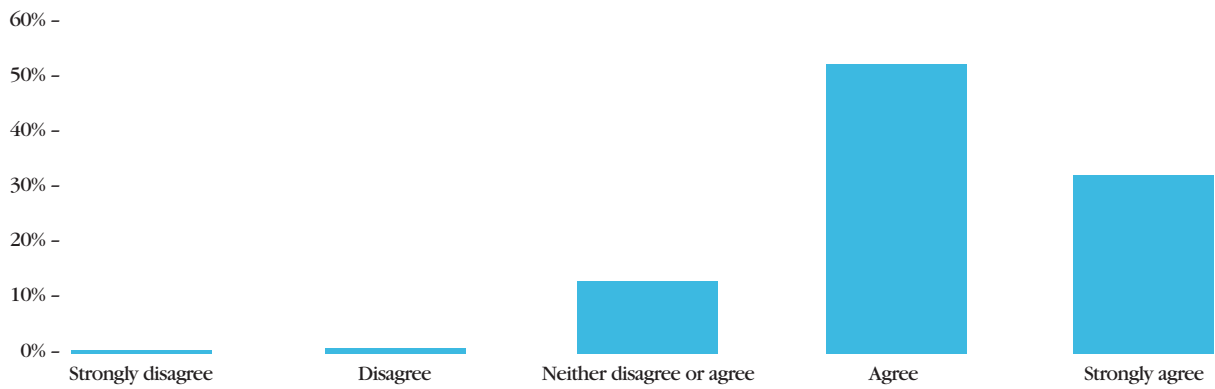
## Links between staff health and well-being and patient care

3.19 Importantly for this report, and for the aspirations of the NHS, over 80% of staff considered that their state of health affected

patient care, and virtually none disagreed with this. Furthermore, as the next chapter will demonstrate, a failure to tackle staff health and well-being affects other aspects of a Trust’s performance as well its delivery of patient care.

Figure 3.13: Impact of staff health and well-being on patient care

The health and well-being of staff impacts on the level of patient care



Source: *The Work Foundation, RAND Europe and Aston Business School*

## The overall picture

3.20 It is clear from what is said above that all is not completely well with the health and well-being of the NHS workforce. Despite a workforce that reports reasonably good general health:

- ▶ NHS staff sickness absence, at 10.7 days, is higher than that for the public sector as a whole (9.7 days) and well above that for the private sector (6.4 days). Furthermore, like the public sector as a whole, NHS staff sickness absence has not reduced significantly at a time when the private sector is seeing major reductions. For example, organisations such as BT and Royal Mail, which have invested strategically in health and well-being services, have achieved reductions of 30% to 40% in absence rates over a 5-year period. Similar reductions would deliver significant benefits to NHS Trusts
- ▶ staff perception survey respondents report high levels of presenteeism, with many staff reporting that they come to work when they feel sufficiently unwell to justify staying at home, often because they feel they should
- ▶ many staff report significant levels of stress
- ▶ many staff do not believe that senior managers, or their employer as an organisation, take a positive interest in their health and well-being
- ▶ most staff believe that their state of health affects patient care.

3.21 Despite the overall picture, there are of course examples of NHS bodies that have identified problems and have taken effective action to deal with them.

## NHS case studies

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust identified a doubling of work-related stress in 2006/07, which was contributing to a high sickness absence rate of 5.34%. The Trust recognised that a management-led, not a medically-led, approach was needed. It appointed a project manager and set targets for the organisation, including for reducing reported cases of stress as measured by occupational health by 30% and reducing the overall Trust sickness absence rate to 4.3%. By taking a comprehensive approach that engaged the board, senior management and line managers, phase 1 of the project has made significant progress, with sickness absence down to 4.69% and a 40% reduction in cases of work-related stress reporting to occupational health. Other benefits have included better responses to staff surveys, increased completion of staff appraisals and active management of long working hours. And reduced sickness absence has benefited patient care through increasing permanent staff presence and improving staffing ratios.

Similarly, Trafford Healthcare NHS Trust has established a comprehensive health and well-being programme that has targeted health promotion and prevention work and has improved staff satisfaction and morale. This has led to further commitments to improve staff health as the management is able to demonstrate the effectiveness of investment.

It is important that initiatives such as these, and others we are aware of, are built on and become common across the NHS.

## Improving information about the health and well-being of NHS staff

- 3.22 As indicated in paragraph 3.1, the analysis above draws heavily on the staff perception survey that was conducted on our behalf by The Work Foundation, RAND Europe and Aston Business School. One-off surveys, however representative, have their limitations, but it was necessary to take this approach in the absence of any routine and long-term data on the health of the NHS workforce. We will be addressing information requirements for local NHS organisations later in the report, but we believe it is essential that there is a more co-ordinated approach to monitoring the health of the NHS workforce nationally. **We recommend that the Department of Health should put in place arrangements to collect and publish annual data on sickness absence in the NHS, drawn from the ESR, to enable long-term monitoring of trends. To ensure comparability, all Trusts should collect and report ESR data in a consistent and comparable form.**
- 3.23 As will be clear from what we have said, sickness absence alone is an inadequate measure of NHS staff health and well-being. In order to capture changes in the overall state of NHS staff health, **we recommend that specific questions on staff health and well-being be included in the NHS Annual Staff Survey to enable trends to be monitored over time.**
- 3.24 As highlighted in paragraph 3.23, there is an absence of systematic information detailing the health and well-being of NHS staff and trends over time. As well as collecting information through the Annual Staff Survey, a cohort study of a similar nature to those in the Civil Service and the military would enable longer-term trends to be understood, differences in the experience of specific staff groups to be identified for targeted intervention, and the long-term impact of interventions to be evaluated. We believe this is a serious gap in the evidence base and **recommend that a longitudinal survey of the health and well-being of a representative cohort of NHS staff should be established.**
- 3.25 Finally, it will be important that the effectiveness of the interventions we recommend is properly evaluated both through long-term research projects and through short-term audit work of the sort that the Occupational Health Clinical Effectiveness Unit is well placed to carry out. **We recommend that the Department of Health should put in place arrangements for independent evaluation of the effectiveness of the interventions recommended in our review.**



# Why staff health and well-being matters





4.1 The previous chapter set out a number of issues about the health and well-being of the NHS workforce. This chapter sets out the case for NHS employers tackling these concerns for 3 main reasons:

- ▶ to demonstrate their role as exemplar employers
- ▶ to deliver financial benefits
- ▶ to achieve performance benefits.

## NHS bodies as exemplar employers

4.2 Promoting health and well-being is at the heart of the NHS's business. Lord Darzi's report *High Quality Care for All* establishes it as one of the NHS values that 'should inform and shape all that we do'. This applies as much to NHS staff as to the wider population. As part of good governance, all NHS bodies need to be able to demonstrate how they are promoting staff health and well-being. This involves ensuring that they comply with statutory health and safety requirements in order to minimise risks to their staff, tackling work-related conditions and illnesses such as musculoskeletal disorders and mental health problems, and acting to promote good health in its widest sense, including tackling poor management practices and behaviours.

4.3 They should be doing this not simply to respond to the pledge in the NHS Constitution but because this is an area in which the NHS should naturally be taking a leadership role. Dame Carol Black's report *Working for a healthier tomorrow* stresses:

**“There is a compelling case for organisations of all sectors and sizes to move beyond the traditional health and safety agenda to embed health and well-being at their heart and to create an empowering and rewarding work environment for all employees.”**

Given the nature of their business, it is clear that NHS bodies should be at the forefront of supporting and improving staff health and well-being. Doing so is central to their duty of care to employees and a vital part of proper governance. At a time when tackling major lifestyle issues, such as lack of exercise, smoking, obesity and excessive drinking, and responding to rising concerns about mental well-being are ever more important, it is ironic that many NHS bodies have not treated their own staff's welfare with the same concern as that of the wider population. It is incumbent on NHS bodies to be exemplary employers in this regard and to model the practices that they would want to see other employers adopt.

4.4 There are other benefits for the NHS from tackling health and well-being issues for its staff. Firstly, and most obviously, the NHS employs more than 1 million people. Improving their health, and that of their families, will make a significant contribution to the overall goal of improving the health of the population. Secondly, improving NHS workplace health and well-being will help to embed the concept of prevention as a core skill for all NHS staff. Finally, effective action to improve the health and well-being of NHS staff will help to make them champions of a proactive and committed approach to health improvement.

4.5 An example of this is the decision by NHS Stoke, in partnership with Stoke City Council, to commission a health and wellness programme for their staff, working with Humana as providers of the scheme. In total, 7,000 places have been provided on the scheme, which means that over its 2-year course the programme will be able to benefit a significant proportion of the 14,000 employees of the 2 organisations. Although the programme has only been launched recently, the interest that it has generated demonstrates both the potential power of local public services leading the health and wellness agenda by example with their own staff and the contribution that the PCT and council, as significant local employers of local people, can make to the health of their population by commissioning such a service.

4.6 But if the NHS is to adopt and advocate high-quality health and well-being support for staff, it will want to be confident about, and able to demonstrate, the benefits such action brings to employers as well as to individuals. The rest of this chapter shows how adopting best practice in this area can improve NHS performance, both financially and in terms of delivering high-quality care to patients.

## NHS finances

4.7 The Treasury has not yet set departmental allocations beyond 2011, but health remains a key government priority. However, given that the outcome of the next spending review is not yet known, the NHS Chief Executive has asked the NHS to prepare for a range of funding scenarios. This includes asking the NHS to plan to deliver efficiency savings of between £15 billion and £20 billion over the 3 years from 2011. Tackling the costs of poor health and well-being among NHS staff will help to achieve these savings both directly, through reduced costs, and indirectly, through increased productivity from healthy staff.

4.8 As indicated in Chapter 3, NHS staff absence rates are high compared with other parts of the public sector, and are not reducing. To put the facts clearly and starkly:

- ▶ **10.3 million working days are lost in the NHS in England each year.**
- ▶ **This is the equivalent of 45,000 whole-time equivalent (WTE) staff or some 4.5% of the current workforce.**
- ▶ **The annual direct cost of absence is some £1.7 billion a year.**

These are very significant numbers and show the scale of the direct cost savings that can be made by tackling workplace health.

Table 4.1: Variations in sickness absence rates

Trust type	Current position	
	Rate of absence	Range across Trusts
Overall	4.48%	1.75% – 7.42%
Acute	4.17%	1.75% – 6.17%
PCT	4.43%	1.91% – 6.17%
Mental health	5.24%	1.95% – 6.91%
Ambulance	5.76%	4.17% – 7.42%

Source: *The Work Foundation, RAND Europe and Aston Business School*

- 4.9 These figures mask wide variations in absence rates between different types of NHS body and within the same type of organisation. Table 4.1 above shows the variations. While some of these variations may be explained by differences in size or geography, the extent of variation suggests that significant savings are possible by improving the performance of the poorer performers. As Table 4.2 shows, for an average-sized Trust, moving from the lower to the upper quartile of the distribution for absence rates has the potential to result in significant savings in the direct costs of staff absence. Improving performance in this area would be easier if there were better mechanisms available for understanding the reasons for performance variations and for sharing good practice, which would enable interventions to be targeted effectively.

Table 4.2: Potential benefits for Trusts from improving sickness absence rates

Trust type	Potential gain for average-sized Trust moving from lower to upper quartile	
	Additional FTEs per year	Annual savings
Overall	48	£1.8m
Acute	42	£1.6m
PCT	14	£485,000
Mental health	39	£1.4m
Ambulance	37	£1.3m

Source: *The Work Foundation, RAND Europe and Aston Business School*

4.10 Similarly, improving the health and well-being status of staff may reduce sickness absence and associated costs. Table 4.3 shows the variation in expected absence rates for Trusts assessed as performing well, averagely and poorly on a range of factors that affect sickness absence, namely staff injury rates, stress levels, job satisfaction and turnover intentions, as measured in the NHS Annual Staff Survey for 2007.

Table 4.4 shows the possible financial benefits of improving performance. For the NHS as a whole, a move from average to good staff health and well-being status may be associated with an extra 840,000 staff days per year and a saving in direct costs of £13.7 million a year.

Table 4.3: Expected sickness absence rates related to health and well-being status

Health and well-being status	Expected absenteeism rate			
	Acute	PCT	Mental health	Ambulance
Poor	4.43%	4.67%	5.45%	6.09%
Average	4.15%	4.42%	5.24%	5.62%
Good	3.90%	4.18%	5.02%	5.21%

Source: The Work Foundation, RAND Europe and Aston Business School

Table 4.4: Potential savings from reducing sickness absence by improving health and well-being status

Trust type	Potential saving (absence)	
	Low-performing → average	Average → high-performing
Overall	£356,643	£350,590
Acute	£383,167	£355,739
PCT	£106,580	£107,226
Mental health	£172,140	£184,519
Ambulance	£448,112	£426,892

Source: The Work Foundation, RAND Europe and Aston Business School



4.11 Much bigger savings are possible by reducing sickness absence across the NHS. Clearly there will always be an element of absence as a result of ill-health in any organisation, but there remains scope for reducing current absence rates in the NHS, especially in relation to major causes of sickness absence such as musculoskeletal disorders and mental health conditions. By way of illustration, if absence were to be reduced by a third across the board, it would bring major benefits:

- ▶ a gain of 3.4 million working days a year
- ▶ equivalent to 14,900 extra WTEs
- ▶ with an estimated annual direct cost saving of £555 million.

Experience in other organisations suggests that such savings are not unrealistic. Royal Mail reduced sickness absence by 40% between 2004 and 2009, to a rate of 4.2%, and BT reduced sickness absence by 30% between 2003 and 2008, to a rate of 2.43%. At Centrica, the introduction of a rehabilitation programme in 1998 reduced sickness absence among British Gas engineers by 39% in the first 3 years.<sup>13</sup> Sickness absence across the private sector is 6.4 days a year, some 40% below current NHS levels. And within the NHS, NHS Scotland has set a target absence rate of 4%, which, if achieved in England, would deliver an additional 1 million working days a year, equivalent to some 4,500 extra WTEs and a saving of £185 million.

4.12 Trusts also incur indirect costs from sickness absence and poor staff health and well-being. These accrue from:

- ▶ the use of agency and other temporary staff to cover staff absence (some £1.45 billion a year)
- ▶ recruitment costs to replace staff who leave because of illness or stress. Estimates from the Chartered Institute of Personnel and Development are that it costs more than £4,500 to fill a vacancy and this is likely to be substantially higher for senior clinical and managerial staff
- ▶ ill-health retirement, which the NHS Employers Partnership Review of Ill-health Retirement estimated to correspond to an additional cost to the NHS of £150 million a year<sup>14</sup>
- ▶ overtime costs and the costs of employing staff for additional discretionary hours, with the associated risks of stress on staff working long hours.

4.13 It is not possible to quantify all the savings in indirect costs arising from improving staff health and well-being, but we have been able to look at the scope for savings in some areas.

<sup>13</sup> It is important to note that the Royal Mail and Centrica workforces have different demographics from that of the NHS, with a significant number of men undertaking manual work who might be expected to display higher levels of sickness absence with more scope for reduction. But Royal Mail achieved similar reductions among white-collar workers.

<sup>14</sup> Available at [www.nhsemployers.org](http://www.nhsemployers.org)

## Agency staff costs

4.14 Agency staff are used to cover staffing gaps caused by sickness absence and staff turnover, as well as for other reasons such as maintaining a flexible workforce. Spending on agency staff is closely related to sickness absence and staff turnover. On average, the spend on agency staff is 3.85% of the wage bill across all Trusts (some £1.45 billion). Spending on agency staff is closely related to sickness absence and staff turnover. Table 4.5 shows the expected

proportion of staff costs being spent on agency staff for Trusts with good, average and poor scores on turnover intentions from the NHS Annual Staff Survey. Table 4.6 shows the potential financial benefits from improving performance. Even allowing for some costs arising from employing substantive rather than agency staff, this data suggests that there are very real savings to be made in agency staff spend by tackling NHS staff health and well-being issues.

Table 4.5: Expected proportion of wage bill spent on agency staff related to health and well-being status

Health and well-being status	Expected proportional agency spend			
	Acute	PCT	Mental health	Ambulance
Poor	3.21%	6.21%	4.66%	2.88%
Average	2.61%	5.20%	4.14%	1.91%
Good	2.11%	4.67%	3.65%	1.07%

Source: The Work Foundation, RAND Europe and Aston Business School

Table 4.6: Potential savings in agency staff spend from improving health and well-being status

Trust type	Potential saving	
	Low-performing → average	Average → high-performing
Overall	£609,372	£511,235
Acute	£864,760	£717,561
PCT	£356,355	£231,531
Mental health	£457,947	£442,709
Ambulance	£989,203	£839,500

Source: The Work Foundation, RAND Europe and Aston Business School

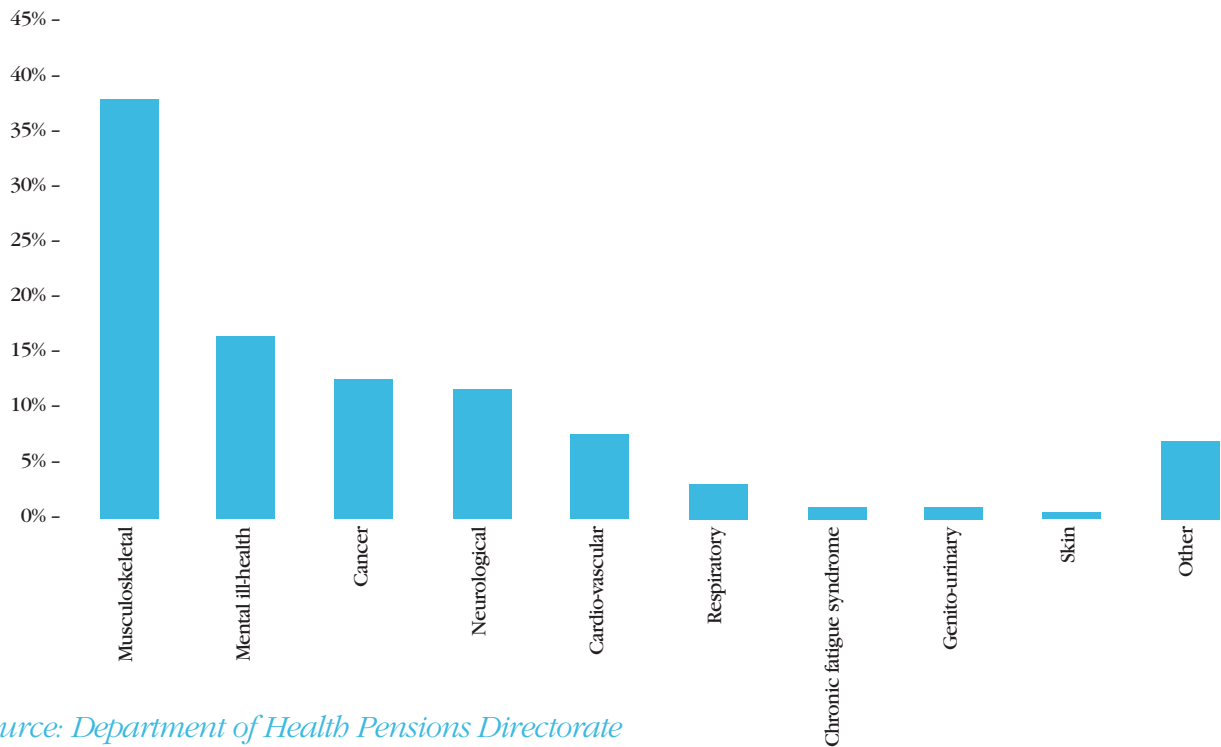
### Ill-health retirement

4.15 There are approximately 2,500 ill-health retirements each year and the additional costs of these compared with normal retirement is some £150 million a year to the NHS as a whole. As Figure 4.1 shows, more than half of these ill-health retirements are caused by musculoskeletal disorders or mental health problems. These conditions respond well if treated effectively with appropriate, and preferably early, interventions. Advisers to the NHS Employers Partnership Review of Ill-health Retirement considered that proactive management and preventative measures could have avoided about half of these retirements (ie some 25% of the total

ill-health retirements). Under current arrangements, the saving from this would accrue to the NHS pension scheme but would indirectly benefit NHS Trusts by reducing financial pressures on scheme contribution rates. If all excess costs of ill-health retirement were retained within the control of the employer, as suggested by the NHS Employers Partnership Review, potentially this could result in savings in the region of £40 million per annum for NHS employers.

4.16 In short, improving employee health and well-being can translate into real benefits to the NHS bottom line both nationally and for individual Trusts.

Figure 4.1: NHS ill-health retirements by cause



Source: Department of Health Pensions Directorate

## NHS performance

- 4.17 Important as they are, demonstrating the NHS's commitment to health and well-being for all, being seen as an exemplary employer and delivering cost savings are not the only reasons why Trusts should invest in improving health and well-being services for their staff. There may also be significant benefits to the quality of service to patients, with better outcomes and improved patient experience.
- 4.18 Our analysis showed a clear relationship between staff health and well-being and patient satisfaction. Table 4.7 shows that patient satisfaction in acute Trusts (as measured by the Healthcare Commission's 2007 in-patient survey) was markedly higher in Trusts where staff health and well-being (as measured by injury rates, stress levels, job satisfaction and turnover

intentions) was higher. To set the figures in context, a score of 80.6 would be in the top 30% of Trusts, a score of 74.0 in the bottom 25%.

- 4.19 There was also a link between staff health and well-being and meticillin-resistant *Staphylococcus aureus* (MRSA) infection rates (for acute Trusts at April 2008) as shown in Table 4.8. Again for context, a score of 0.82/10,000 bed days would be in the top third of Trusts, a score of 1.41/10,000 bed days in the bottom 30%. However, it is important to note that the causal relationship here is not clear. Poor health and well-being may lead to practices that allow higher infection rates, but it may be that high rates of MRSA infection contribute to poorer staff health through a variety of mechanisms.

Table 4.7: Patient satisfaction in acute Trusts related to staff health and well-being status

Health and well-being status	Expected patient satisfaction
Poor	74.0
Average	77.5
Good	80.6

Source: The Work Foundation, RAND Europe and Aston Business School

Table 4.8: MRSA rates at acute Trusts related to staff health and well-being

Health and well-being status	Expected MRSA infections per 10,000 bed days
Poor	1.41
Average	1.09
Good	0.82

Source: *The Work Foundation, RAND Europe and Aston Business School*

Table 4.9: Relationship between Annual Health Check ratings and staff health and well-being status

Health and well-being status	Annual Health Check ratings – quality of service/use of resources			
	Acute	PCT	Mental health	Ambulance
Poor	2.7/2.5	2.0/2.0	3.2/2.8	2.1/1.4
Average	3.0/3.0	2.4/2.5	3.5/3.1	2.6/2.3
Good	3.3/3.4	2.7/2.9	3.7/3.5	3.0/3.0

Key: 1 = Weak, 2 = Fair, 3 = Good, 4 = Excellent

Source: *The Work Foundation, RAND Europe and Aston Business School*

4.20 Finally there is a clear relationship between staff health and well-being and Trusts' assessment in the Annual Health Check ratings. Using data for 2007/08, Table 4.9 shows the relationship between measures

of staff health and well-being and health check ratings. It will be important that any replacement for the Annual Health Check can be clearly related to staff health and well-being.



## The overall picture

4.21 While there is more work to do, the analysis that we have presented in this chapter provides compelling and convincing evidence that investing in improving workplace health and well-being is not only the right thing to do in itself but it can also bring real and substantial benefits to the NHS and to patients. Healthier staff, teams that are not disrupted by sickness, or where staff are not under undue stress, and lower turnover rates all contribute both to the quality of care given to patients and to patient

satisfaction. By contrast, where staff are unhappy and unhealthy, where there are high sickness rates, high turnover and high levels of stress, there are likely to be poorer outcomes and poorer patient experience.

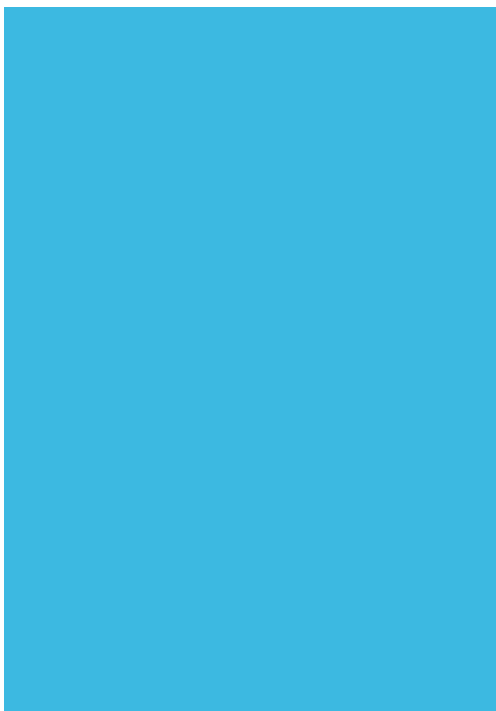
4.22 Table 4.10 illustrates this vividly by comparing the outcome measures for 4 non-specialist acute Trusts, 2 of which score highly on staff health and well-being (as measured by injury rates, stress levels, job satisfaction and turnover intentions) and 2 of which score poorly. With few exceptions, the difference in performance is marked and clear.

**Table 4.10: Outcome measures for 4 acute Trusts with high and low staff health and well-being measures**

	Trust A	Trust B	Trust C	Trust D
Absence	4.21%	4.04%	4.58%	4.70%
Turnover	10.50%	9.79%	11.65%	17.02%
Agency spend	1.70%	2.96%	1.71%	4.57%
Patient satisfaction	78.9	76.4	77.4	67.5
MRSA cases per 10,000 bed days	0.65	0.88	1.56	0.95
Standardised patient mortality rate	87.5	100.2	110.0	100.2
Annual Health Check: Quality of services	Excellent	Excellent	Weak	Fair
Annual Health Check: Use of resources	Excellent	Excellent	Weak	Weak

Note: Green figures represent Trusts which are performing well on health and well-being indicators; blue figures represent Trusts which are performing poorly on health and well-being indicators; health and well-being measures in the above table relate to responses in the Annual Staff Survey.

Source: *The Work Foundation, RAND Europe and Aston Business School*



# NHS staff health and well-being services





5.1 This chapter looks at the services the NHS currently provides to support and improve the health and well-being of its staff and some of the cultural and other issues which hinder their development. Respondents to our survey believed that providing good health and well-being services made a real difference to staff and through them to patient care but indicated considerable frustration with the services currently available. Perhaps inevitably, the comments reflected here tend to focus on concerns about current services as those who are satisfied with them may be less vocal. However, it should be stressed that many respondents commented positively on aspects of the service, even if they felt that there was much more that a well-organised, properly funded staff health and well-being service could achieve. It was clear from the comments that, while there were areas of good practice, these were not always shared or learnt from and there is a long way to go to ensure that NHS health and well-being support for staff is of a uniformly high standard. It was also clear that initiatives with potential impact on staff health and well-being are not always recognised as part of a wider health strategy – staff benefit and recognition schemes, management practices and training, opportunities for personal development and career progression were among examples cited.

## Occupational health services

5.2 Occupational health services play a key role in tackling issues of employee health and well-being. They perform a range of functions, including undertaking pre-employment health screening, supporting strategies preventing illness and injury,

assisting staff to return to work as quickly as possible when they are ill and working with others as part of a comprehensive structure of health promotion and prevention in NHS bodies. Overall, the NHS has a good record in delivering these core services, with strong vaccination programmes, effective action to deal with needlestick injuries and good surveillance programmes for biological, chemical and radiological hazards, though the benefits of this work in avoiding costs from staff absence and ensuring Trusts meet their duty of care to their employees is often not fully recognised or evaluated. However, the current organisation of services does not make the best use of available resources. For instance, as we discuss in paragraph 7.22 below, pre-employment screening could be more effectively organised, so releasing resources for other high-priority work.

## Occupational health workforce and resources

5.3 There are some 175 occupational health units in England, with 112 (at June 2009) in membership of the NHS Plus network. Fifteen NHS organisations choose to contract externally for their occupational health service. A recent report on the NHS occupational health workforce gives key information on the workforce, drawn from a survey completed by 75 units.<sup>15</sup> They reported a workforce of some 1,360 staff (994 whole-time equivalent (WTE)) with significant variations between regions. Some 45% of the staff from the units responding to the survey were nurses, and about 12% were doctors. Other staff came from a range of professional backgrounds. Respondents indicated a vacancy rate of 7.3% rising to

<sup>15</sup> NHS Occupational Health Workforce Mapping Report. Winchester: NHS Workforce Review Team, 2007.



nearly 10% for nurses (25% in London) and over 13.5% for non-consultant medical staff. Consultants and nurses in occupational health were generally older than those working in other specialties, which may reflect either that staff are attracted into the specialty later in life or that there are difficulties in recruiting younger staff.

5.4 The units responding to the survey employed some 77.7 WTE medical consultants (nearly 8% of total staff) and the number of medical consultant staff with occupational health qualifications continues to increase. However, not all occupational health units employ suitably qualified consultant staff. We understand that, despite longstanding Department of Health guidance that occupational health units which do not employ a consultant occupational health physician should make arrangements with a neighbouring service to provide some input, this does not always happen. This inevitably limits the quality of service which these units can provide to staff. We are concerned both about the relatively low numbers of medical consultants in occupational health medicine and about their distribution. **We recommend that continued priority is given to attracting doctors to pursue careers in occupational health medicine so as to ensure that sufficient consultant resource is available to enable all NHS employers to access specialist advice when needed. In the meantime, consideration should be given to establishing regional specialists in occupational health medicine who could provide input to units without access to consultant support.**

5.5 The survey also identifies a shortage of nurses and suggests that, while most of the

nurses working in occupational health have a relevant qualification, this is not the case for all of them. It is important that the NHS can attract and retain qualified nursing staff if it is to provide the quality of occupational health service its staff deserve, especially at a time when it faces competition for such staff from the private sector. We are concerned that current medical and nursing staff shortages may result in some units not sourcing advice from appropriately qualified staff, not only placing staff at risk but also leading to potential liabilities for employers. We welcome the increasing number of consultant occupational health nurses and their leadership of occupational health services in some places. We believe that such nurse consultants have a critical role to play in developing services and should increasingly be employed in all units. In the meantime, **we recommend that there should be a regional consultant nurse in occupational health in each region to provide leadership to the function and advice to individual units.**

5.6 There were concerns about the current funding of occupational health services. A recent study by the Occupational Health Clinical Effectiveness Unit (OHCEU)<sup>16</sup> found that the median spend on occupational health per member of staff was less than £71 with an interquartile range of £51 to £93. The median budget for a unit was some £218,500, or 0.13% of Trust budget, with an interquartile range running from 0.05% to 0.18% of budget. This was confirmed by information we received. One organisation which responded to our call for evidence said that:

**“We have a turnover of £175 million, but only a £300k OH [occupational health] budget.”**

<sup>16</sup> Occupational Health Clinical Effectiveness Unit, *Back pain management – occupational health practice in the NHS in England: a national clinical audit*. London: Royal College of Physicians, 2009.



It is unsurprising that lack of funding was often mentioned as a constraint on delivering high-quality services, or that a regional public health worker said that an audit of workplace health and well-being practices in Trusts in London showed that when it came to implementing initiatives in this area:

“lack of staff time and lack of funding were the 2 key barriers cited by Trusts”.

There was little evidence that budgets for occupational health services – or for wider staff health and well-being support – were related to the current needs of the organisation as opposed to being historically determined. There was also some concern about the general funding arrangements for the service. There is, as one respondent said:

“lack of an SLA [Service Level Agreement] and costed service budget for work with our lead Trust, poor retention of income generated – hence outside work done to [the] detriment of in-house service”.

## Service effectiveness

- 5.7 There is considerable variation in the level and extent of services provided, not directly related to NHS staff need:

“I know that a neighbouring Trust has 2 WTE clinical psychologists for its staff ... we have one WTE counsellor with CBT [cognitive behavioural therapy] training ... [the] numbers of staff [are] approximately equal. Another neighbour has 2 WTE counsellors to approx. [the] same [number of] staff.”

Furthermore, there was a lack of expertise in key issues such as ergonomics, which can play a key role in helping to prevent musculoskeletal disorders. The 75 Trusts responding to the Workforce Review Team survey referred to earlier employed just 4.15 WTE ergonomists, though some may have looked to occupational therapists to provide ergonomic and workstation assessments.

- 5.8 While many respondents to our survey and call for evidence commented positively on occupational health services, there were widespread concerns about various aspects of the service. In particular, there was a view that the service was essentially reactive to presented problems rather than proactive in seeking to promote staff health and well-being, with often lengthy delays in seeing staff. One respondent commented:

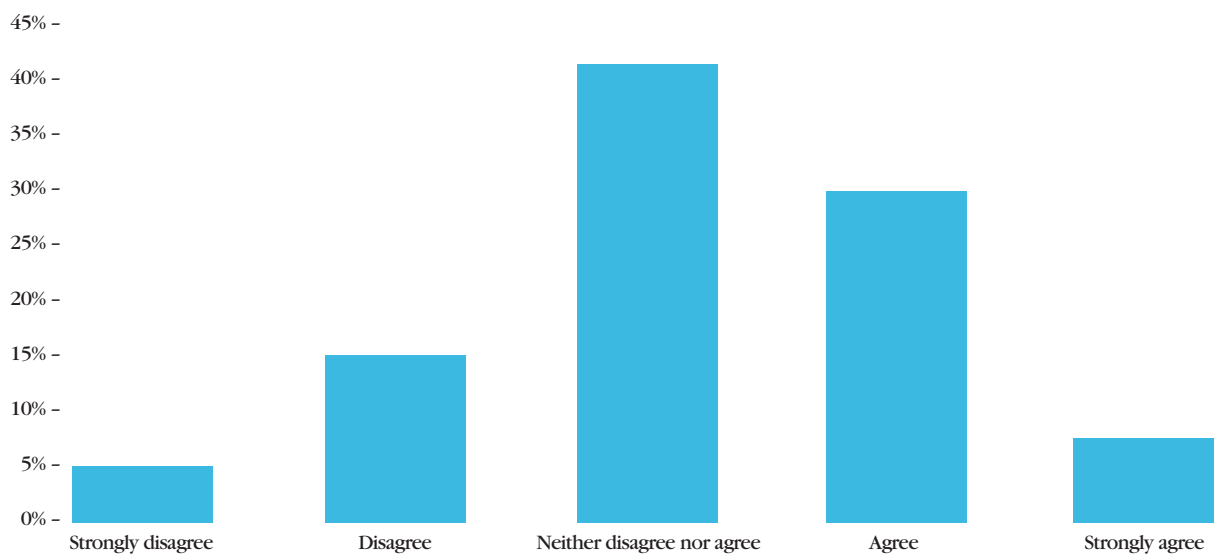
“Anecdotal evidence from staff from my previous role within local government, where we used the NHS occupational health service was that it was very reactive, with a referral taking 6–8 weeks.”

As Figure 5.1 shows, less than 40% of staff responding to our survey believe that their service proactively tries to improve staff

health and well-being: while perception may belie reality, this is an important perception to address.

**Figure 5.1: Staff views on the extent to which occupational health services proactively seek to improve workforce health and well-being**

**My local occupational health service proactively tries to improve the health and well-being of the NHS workforce**



*Source: The Work Foundation, RAND Europe and Aston Business School*

## Service focus

- 5.9 In our view, successful occupational health services need to balance the needs and demands of staff and management but it was clear from the feedback we received that this was not always felt to be the case in the NHS. Staff at our focus groups raised concerns about the work of occupational health services, with one saying that:

“occupational health has lost its brand”

and another that it had become:

“an illness service – if your [sickness absence] is high, then you’re ‘punished’ with a referral to occie health.”

There was a widespread view that occupational health services were centred more on the needs of employers than of staff, summed up in the comment of one respondent that:

“occupational health used to be for employees, but now it’s a tool for management.”

- 5.10 There were widespread concerns that, in many parts of the NHS, occupational health services could only be accessed through a managerial referral rather than by self-referral. This was likely to discourage staff, particularly those presenting with drug, alcohol and other mental health problems, from seeking early help and advice. And there were concerns about the quality of advice given and its confidentiality. One respondent commented on:

“lack of expertise particularly in advising on return-to-work processes, failures to communicate, breaches of confidentiality and lack of appropriate boundaries”.

We know that confidentiality is an issue taken very seriously by competent providers of occupational health and anecdotal information we received suggested that often when concerns arose the information had come from other sources. However, staff perception and trust does need to be improved, particularly in certain staff groups.

- 5.11 We were concerned to hear of cases where managers sought confidential information from occupational health staff. This is unacceptable and it is important that all managers recognise the confidentiality of occupational health advice to staff and do not seek such information. **We recommend that management training and induction should include material to ensure that managers are aware of the role of occupational health services, referral routes, information required for referral and the confidentiality issues involved.**

- 5.12 There were other comments about the difficulty of accessing occupational health services, which were seen as not well located and with short opening hours which made it difficult for many staff, especially those working shifts, to access them during their working hours.

- 5.13 To some extent, the reactive and limited role of many occupational health services reflects their resourcing constraints, which do not permit them to take a more active role. It also reflects the narrow view taken of the role of occupational health services by some of those commissioning services – that occupational health is essentially concerned with pre-employment screening, immunisation and dealing with persistent

sickness absence. This, when combined with setting unrealistic income-generation targets, restricts the scope for occupational health to take a more proactive approach to staff health and well-being. Occupational health services cannot themselves, of course, provide all the skills and expertise needed to deliver a comprehensive staff health and well-being service, but they do have an important role in co-ordinating such services, which is not currently being fully exploited.

## Wider health and well-being services

- 5.14 As indicated earlier, while occupational health has a central role to play in improving staff health and well-being, there are other services that also need to be deployed to support staff in this area. These include occupational therapists who can provide lifestyle management advice, counselling services, particularly for those with mental health problems, and wider prevention and health improvement services, including smoking cessation, health screening and anti-obesity services as well as the use of services of groups such as health trainers.
- 5.15 Again, the views we received suggested that investment in such areas was often patchy and benefits were not fully recognised. Even where initiatives were being taken, there was sometimes a failure to implement good practice effectively. One worker in a Mental Health Trust commented on the fact that, while the Trust had introduced a Cycle to Work initiative, it had failed to provide bicycle racks or shower/changing facilities. In general terms, the NHS performs poorly in this area, especially when compared with

other organisations. One local authority that is taking a more proactive approach told us that:

We organised a quit smoking group and most people succeeded and have continued to quit. We also organised 2 weight management groups using a local Rosemary Conley rep. We have had significant results from this with up to 20 staff taking part, losing 14 stone between them. We run staff cycling groups, subsidised gym membership, a regular yoga group, a football club, a badminton club, a staff health fair providing information and free taster sessions and more.

- 5.16 More generally, some major public health campaigns are poorly deployed in the NHS. For example, well-being co-ordinators have been put into a number of Trusts but not properly linked to occupational health services, and health promotion activities are often poorly co-ordinated with occupational health, leading to a dissipation of benefit and little clear measurement or assessment of value added. Also there is relatively little use of third sector health promotion initiatives. Use of existing public health campaigns and third sector resources can enable Trusts to deliver services more cost-effectively than would otherwise be the case, as exemplified at the recent launch of the Coalition for Better Health.
- 5.17 Some of the concerns that have been identified with staff health and well-being services may also apply to patients' experience of such services when they are referred for care. These issues will be addressed through the NHS prevention strategy which is due to be published this autumn.

## Management attitudes

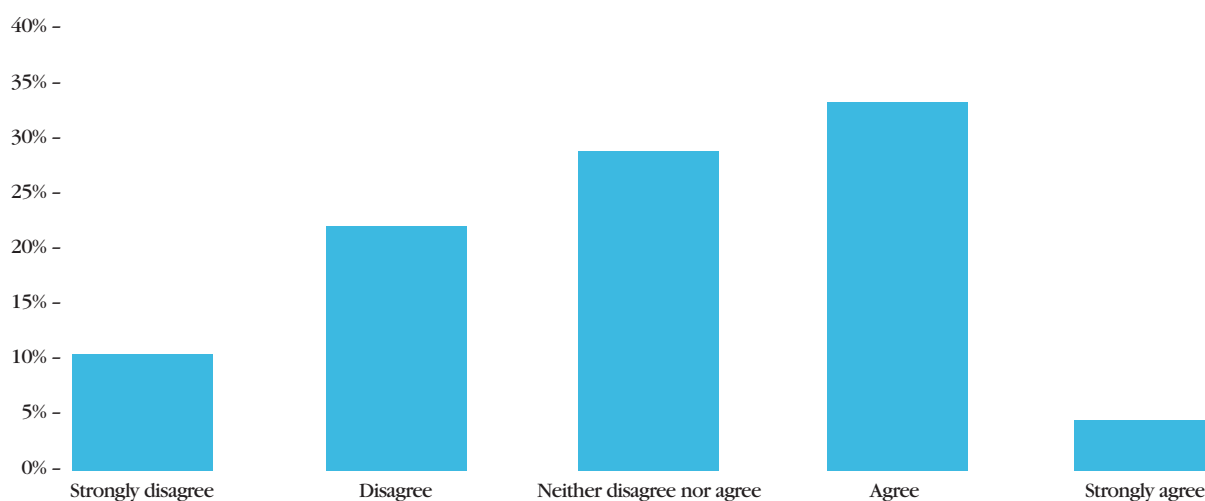
5.18 One of the key factors affecting the provision of staff health and well-being services is the attitude of local management. As indicated earlier in this report, staff responding to our survey generally did not believe that senior managers were interested in their health and well-being and, as Figure 5.2 shows, only some 40% believe that their employers listened to their concerns about their working environment. This view of managers as unsympathetic to staff concerns about their health and well-being is reflected in anecdotal information about their responses to the introduction of new initiatives in this area. For example, one organisation said:

“we offered weight management sessions to PCT staff. Their managers would only allow staff to attend in lunch breaks - the sessions take an hour each and staff get a half-hour lunch break - they then have to make up lost time. Community staff could not participate either, because of travelling, high case loads etc. A valuable service was withdrawn as a result.”

While there may be concerns about the immediate cost of staff attending such sessions, for instance in terms of downtime, it is important that managers look at these costs in a wider context, particularly the significant costs of staff absence through ill-health, and plan how to provide services in ways that allow staff to access health and well-being support.

Figure 5.2: Percentage of staff who believe that concerns about their working environment are listened to

### Employee concerns about their working environment are listened to



Source: *The Work Foundation, RAND Europe and Aston Business School*

5.19 More generally, staff health and well-being was not seen to command any priority at board or senior manager level, where there were few champions for the subject:

“A major barrier is a lack of senior management buy-in and a subsequent lack of ownership at all levels of management.”

In part at least this was seen to stem from the priority given to other agendas, in particular meeting centrally driven service targets:

“As far as the Ambulance Service is concerned, the main barrier to health and well-being practices and initiatives is the culture and practice borne from being ‘target led’.”

This view was reflected by other respondents. However, it is important to stress that delivery of key targets should not be seen as precluding the development of a strong staff health and well-being culture – indeed, as this report argues, such a culture is a key enabler to delivering wider service goals.

5.20 There was also a perception that participating in staff health and well-being activities was counter-cultural and inappropriate for the NHS and that time at work should be devoted to caring for patients not improving staff health:

“The culture of the NHS generally is that staff come to work and they will work very hard at their jobs, often taking work home and the majority of staff working hours in excess of their contracted hours. So the concept of coming to work and

being allowed some time off to pursue hwb [health and well-being] activities every month and the activities being either free or at a really reduced cost was alien to staff and managers.”

We strongly believe that this attitude must change and that all staff and their managers must give priority to staff health and well-being. Staff need to take responsibility for their health and managers need to take the health and well-being of their staff seriously. We turn later to possible ways of incentivising them to do so.

5.21 The lack of commitment among managers to staff health and well-being programmes reflects, in part, a failure by some Trusts to analyse and use information about the extent and causes of staff ill-health. One respondent said that:

“The Trust gathers only data on amount and durations/calendar patterns of SA [sickness absence] centrally, not about reasons, even grouped into systems such as MSD [musculoskeletal disorders], MH [mental health], Surg [surgical], CVD [cardio-vascular disease], minor ailments.”

Although good information is available from the Electronic Staff Record, it is not being fully exploited by Trusts, and may be recorded and collated in different ways. This limits the scope to target key issues, to link the information to case management and to provide comparable information for benchmarking purposes.



5.22 Furthermore, there are often no or poor service specifications for occupational health services, or wider staff health and well-being services, with no minimum standards or performance metrics. As a result, there is uncertainty about what Trusts are getting for their money and how the service provided aligns with need. It is all too easy for managers and boards to see staff health and well-being as a cost rather than an investment in service improvement. While Chapter 4 set out the benefits in overall terms, local managers lack clear and measurable links between spending on staff health and well-being and improvements in patient care. They need to be convinced both that such spending will:

“improve their productivity or enable cheaper or better quality care to patients”

and that failure to invest in these services will be detrimental to patients who are treated by “unhealthy, insufficiently trained, stressed and demoralised workers”.

### Staff attitudes

5.23 While managers may not properly value, and be willing to invest in, staff health and well-being services, there is evidence that staff themselves do not always make effective use of them:

“The resistance and barriers came from the staff in some quarters, especially the really busy staff who have direct patient contact, as they felt initially they were letting their patients down.”

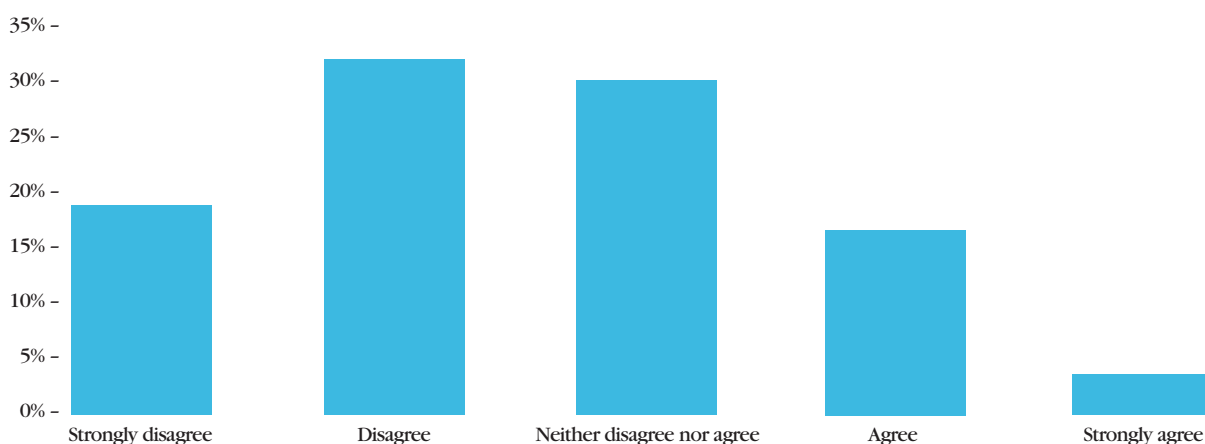
Another respondent said that to inculcate health and well-being in staff as a whole:

“would require a massive culture change to the effect that it is a professional duty to take care of ourselves and each other”.

5.24 This lack of commitment to their health and well-being can be exacerbated if staff are not involved in the design of services and if they are not delivered in ways which take account of their circumstances. One such case that we heard of was the launch of a flu vaccination scheme in an Ambulance Trust which had only a 10% take-up because of insistence that a nurse administer the scheme who was not available for most shifts. We also received other examples of low uptake of seasonal influenza vaccination programmes, which benefit staff in avoiding illness and patients by ensuring that staffing levels can be more reliably maintained during periods of epidemic. Feedback suggested that staff were suspicious of or did not accept the personal health benefits and did not understand the wider service benefits that accrued. In this context it is striking that, as illustrated in Figure 5.3, barely 20% of NHS staff who responded to our survey believed that they had the ability to influence changes to the organisation which affect them.

Figure 5.3: Staff ability to influence changes in their working environment

**I have the ability to influence changes to the organisation that will affect me**



Source: *The Work Foundation, RAND Europe and Aston Business School*

5.25 While there have been suggestions that staff, particularly clinical staff, believe they already have all the information they need to maintain and improve their health and well-being, the evidence suggests otherwise. For example, HEART UK reported that when they hosted a stand at a conference for clinical staff which offered vascular checks they were surprised at the high demand for testing from clinical professionals, many of whom said they felt insufficiently knowledgeable about heart health and the lifestyle changes that can affect it. This both affected their own health and limited their effectiveness in advising patients and the public. Respondents to our call for evidence also suggested that when staff health and well-being services are established there is no shortage of willingness to take them up. Indeed, there are examples of staff being willing to pay to join high-quality, professionally organised health promotion services such as the St Charles fitness suite in Westminster which provides facilities for NHS staff and the wider public as well as exercise rehabilitation for

staff referred by occupational health and other professionals. Lack of response is more likely to be due to difficulties in accessing the service rather than lack of interest.

### NHS good practice

5.26 It will be clear from what is said above that there is a long way to go to deliver high-quality staff health and well-being services consistently and comprehensively across the NHS. There are, of course, many examples of good practice, of which we have selected 2.

#### Worcestershire Acute Hospitals NHS Trust

Two-day self-care courses were developed by the Working in Partnership Project and implemented with Worcestershire Acute Hospitals NHS Trust. Of those employees referred onto the course due to high sickness levels, the early results are that an average 21 days per person are saved (ie 21 fewer days of sickness absence) in the year following the course as compared with the year prior to the course.

This has been collected for 23 individuals so far, and ongoing data also supports this positive trend. The course is well received by individuals and 100% of the participants to date have responded that they would recommend the course to others.

The introduction of telephone triage/case management of occupational health referrals/electronic (email) reporting enables individuals to access occupational health input, physiotherapy or counselling services in a more timely manner. The telephone system has improved contact with occupational health professionals from an average wait of 13.4 days to 3.4 days. Electronic reporting provides managers with instant occupational health advice and recommendations.

The Trust provides up to 6 free sessions of counselling. Currently, the evidence is subjective via an evaluation form. Feedback from these is extremely positive, as demonstrated by statements such as 'find the service invaluable', 'could not afford to go privately', 'I have gained lots of confidence', and 'gave me the ability to cope with work and life in general'. Work is ongoing to introduce a meaningful objective assessment.

### North Tees and Hartlepool NHS Foundation Trust

The Trust has a number of workplace health and well-being practices and initiatives encouraging partnership working between management, human resources, occupational health and staff side. These range from health and well-being steering groups, an early intervention referral scheme, graduated return-to-work programmes and other health-related initiatives in conjunction with the Trust's Occupational Health Service. These include

smoking cessation, counselling services, CBT, exercise and weight loss support and stress management, and are supported by management training and advice. The Trust is committed to the regional Better Health at Work award scheme.

## Conclusion

5.27 Generally, however, the provision and development of high-quality staff health and well-being services is hampered by:

- ▶ staff shortages and a lack of investment in skilled staff
- ▶ inadequate resourcing not linked to need
- ▶ inconsistent and, in some cases, inadequate occupational health services
- ▶ lack of visible board and top management commitment to tackling staff health and well-being issues
- ▶ a failure to analyse and use information both on the extent and costs of poor health and well-being in individual organisations and on the benefits of investing to improve services
- ▶ uncertainty over the role and function of occupational health services and the balance between supporting staff and managers
- ▶ cultural barriers to investing money in services for staff and to enabling staff to access services effectively
- ▶ lack of consistent line management support to enable staff to benefit from health and well-being programmes.

# Prevention



- 6.1 It will be clear from what has been said in earlier sections of this report that a key future role for NHS staff health and well-being services will be health promotion and prevention of ill-health. As indicated, NHS occupational health units have considerable expertise in preventing work-related illness, accidents and injuries, but there is a need for a wider and more fundamental approach that tackles the underlying causes of ill-health.
- 6.2 There are 3 aspects to this work. Firstly, and most fundamentally, there is a need to tackle some of the deep-rooted cultural practices in the NHS and to challenge the management practices and behaviours that underpin the way in which many NHS Trusts operate. This includes the prevalent long-hours culture, the view that it is inappropriate to invest in staff health and well-being services or to organise work in ways that will allow staff to participate in programmes intended to improve their health, and the high levels of bullying and harassment to which staff are subjected.
- 6.3 Secondly there is a need to look critically at the ways in which jobs are designed and to develop them into 'good jobs' with meaningful work that will help staff to feel valued. This will require serious engagement with staff in order to understand and be able to respond to their views about their current roles and responsibilities and how these could be developed in ways that they will find beneficial and that will increase their sense of well-being at work.
- 6.4 Thirdly there is a need to understand the current patterns of ill-health and presenteeism in individual organisations in order to develop sustained and effective programmes of interventions targeted at the real problems facing the Trust. While there are likely to be common issues that affect NHS staff, particularly the lifestyle issues discussed earlier in this report, it will be important that programmes are sensitive to local needs and to the preferences of local staff – they need to be 'tailor made' rather than 'off the peg'. Designing such programmes will require the investment of time on the part of Trust Boards and management in partnership with trade unions and staff. Simple tools such as the developing Business Healthcheck Tool may help to evaluate the business case to underpin resource investment decisions in order to prioritise these actions.
- 6.5 We propose to work up material on the actions that Trusts can take in these areas as part of the development of our final report and we would welcome suggestions and examples of good practice that would help us in this work.





# Exemplar approaches





7.1 The previous chapter looked at the current state of NHS staff health and well-being services. In this chapter we set out some exemplar approaches to providing high-quality health and well-being support for NHS staff, drawing on best practice in the NHS and other sectors.

## Service vision

7.2 At the heart of our vision for a new NHS staff health and well-being approach is a service that is:

- ▶ focused on prevention and health improvement as well as providing excellent support for staff who present with ill-health and sickness
- ▶ proactive in tackling the causes of ill-health, both work related and lifestyle related, and responding effectively to cases presenting for treatment. This should include the provision of early intervention services where these are of clear benefit to individuals, patients and the Trust. This issue is discussed further in the next chapter
- ▶ centred on, and responsive to, staff and their concerns, as well as providing responsive advice to management, with services available to staff through both self-referral and managerial referral
- ▶ holistic, bringing together the variety of initiatives in occupational and public health into a single approach
- ▶ embedded as a core element of Trust business, with appropriate resourcing, routine monitoring and reporting to the Board
- ▶ supported by a service specification setting out clear expectations of the service

▶ fully connected with wider NHS provision, especially general practice and public health.

7.3 To achieve this will require a number of things to be put into place. These include:

- ▶ commissioning services on a strategic basis, linked to wider organisational goals and values and recognising the benefits both to individuals and to the quality of services to patients that investment in staff health and well-being can bring
- ▶ ensuring that service delivery meets the levels agreed in a Service Level Agreement (SLA), setting out clear expectations of the service
- ▶ commissioning integrated services through a single process rather than on an ad hoc basis. There should be a common minimum service specification for all Trusts but with the flexibility to address local needs and priorities that will vary between organisations
- ▶ engaging with staff on the range of services that they want to see and how they should be provided, particularly through self-referral facilities



- ▶ ensuring that services meet accredited standards such as those currently being developed by the Faculty of Occupational Medicine and the competency framework for occupational health nurses developed by the Royal College of Nursing
- ▶ delivering staff health and well-being services to a consistently high standard throughout NHS organisations
- ▶ ensuring that services are available to staff when and where required, including on different Trust sites and at times that are convenient for all workers, including those working on night shifts
- ▶ ensuring that management training and internal communications give clear and consistent messages on the importance of support for staff health and well-being
- ▶ funding services on the basis of regular assessments of the needs of staff, with monitoring of return on investment rather than spending being the central measure of service effectiveness
- ▶ recognising high-quality staff health and well-being services as a key part of the NHS brand in order to attract, motivate and retain staff
- ▶ ensuring that managers throughout the Trust recognise their responsibility to support employees who need or wish to access staff health and well-being services
- ▶ establishing clear lines of responsibility and accountability for staff health and well-being services.

## Strategic commissioning

7.4 The evidence we received suggested that, in many NHS organisations, staff health and well-being services were not perceived as being connected to the wider aims of the Trust. They were not seen as adding value or as contributing to the achievement of improvements in quality of care. They were seen as a marginalised service rather than core business. As one focus group participant put it:

“OH [occupational health] – the forgotten department, operating on 0.13% of the hospital budget.”

The key to providing a high-quality service is the recognition both of the contribution that staff health and well-being can make to delivering Trust objectives and that spending on this service represents investment not cost. The evidence that we have presented in Chapter 4 makes a clear case for this. The best external organisations already recognise this and develop their staff health and well-being services on a strategic basis that is integrated with wider organisational plans and goals.

For example:

Centrica has developed measures to support staff who develop musculoskeletal problems because their specialist skills are difficult to replace in the event of sickness absence.

To minimise the potential impact on both the individual and the company, British Gas (part of Centrica) decided to improve its normal occupational health case management with company-funded medical interventions for its gas engineers where appropriate. The aim of the scheme was to enable employees to remain at work or, in the event of sickness absence, to help them to return to work more rapidly. The company has since extended the programme across the whole of the Centrica workforce.

We recommend that all NHS Trusts should take action to draw up and publish strategic commissioning plans for staff health and well-being services that are fully integrated with wider service development plans and recognise the contribution which a healthy and engaged workforce can make to improving patient care and financial performance.

## Commissioning services and engaging staff

- 7.5 There is a wide range of staff health and well-being services that Trusts can provide for their staff. Some of these have been at the heart of occupational health practice for many years, such as the provision of pre-employment checks for recruits, vaccinations, advice to staff on prevention of illness and injury (eg on lifting and handling techniques to avoid musculoskeletal problems) and tackling cases of ill-health and injury. But others reflect increasing concern with wider lifestyle and well-being issues. These include annual health checks for staff, support for cycle to work and other physical activity schemes, advice on healthy eating, smoking cessation clinics, guidance and counselling on stress management and on major life changes, and lifestyle management advice. The list is long and many examples already exist within the NHS.
- 7.6 There is no consistency in the provision of staff health and well-being services, particularly of these wider services, and there is evidence that some NHS organisations commission services on an ad hoc basis from different parts of Trusts without regard to how the overall package of initiatives fits together. This can lead to both initiative fatigue from staff and cynicism about the underlying motivation for some initiatives. For example, in one Trust a cycle to work initiative was led by the estates department because its aim was to free up car parking spaces, rather than to improve staff health and well-being.



- 7.7 It is important that staff health and well-being services are developed and branded in a consistent way. There needs to be clear leadership for these services which should be positioned to be responsive to staff as well as management needs. It is also important to tackle the stigma that surrounds some current services where, as one focus group participant put it, 'I worry what my colleagues will think of me if I go to occupational health'. To this end, we recommend rebranding occupational health services with a more positive well-being focus and a consistent identity, such as 'NHS Staff Health and Well-being'. This would give a better picture of what these services are there to provide. This service should be responsible for commissioning the full range of staff health and well-being support for a Trust and drawing together and integrating the range of different initiatives into a single programme that is clear to staff and management.
- 7.8 However, branding in itself will not convince staff that services are being provided to support them. To do this, a number of things needs to be put in place, starting with the range of services to be made available. We believe that staff in **all** Trusts should have access to a common core of services and **we recommend that there should be a national minimum service specification for the staff health and well-being services to be provided by Trusts**. This should have a multidisciplinary focus (eg consideration should be given to including input from the Royal Society for the Promotion of Health with its expertise on prevention) and be developed at national level by an expert group involving professional organisations, NHS management, trade unions and professional staff working in the health and well-being field. It should draw on information on effective services and initiatives, such as Health England's work on the effectiveness of health and well-being interventions, for example. The group should ensure that the core service meets legal requirements and fulfils the pledge in the NHS Constitution. **The core service specification for NHS staff health and well-being services should prioritise effective proactive services and should include common, simple performance metrics (relating to standards of delivery, client and customer satisfaction, and quality of service through audited outcomes) to enable benchmarking and monitoring.**
- 7.9 Part of the remit of the group should be to recommend what services should be available in all Trusts through the provision of on-site clinics and other support services and what should be available at larger regional centres. In doing this, it should take account of the changing pattern of provision of staff health and well-being services through telephone and internet advice and the need to make best use of the available expert resource. It will, of course, remain the responsibility of each Trust to commission the services that it requires and to decide whether to provide these services in-house or from external providers. The expert group could also offer advice on a wider range of effective health and well-being interventions that Trusts might want to make available to staff. In commissioning such services it may be more efficient to have fewer well-resourced providers able to deliver the broader range of specialist advice/support required, although this should not occur at the expense of local delivery/availability.
- 7.10 **We also recommend that individual Trusts should engage with their staff on the range**

of additional health and well-being services which they believe should be given priority in their organisation. This work should be led by the local NHS staff health and well-being service in partnership with staff and local staff-side organisations. Trusts should be required to explain why proposals for services have not been adopted.

- 7.11 We know that some Trusts already engage effectively with staff and trade unions on this issue. For example, Salisbury Foundation NHS Trust told us that having asked staff what they would like the Trust to provide in order to support their health and well-being, it launched a number of initiatives that are blossoming and developing a greater sense of community. And at Trafford Healthcare NHS Trust staff were surveyed to ascertain what kind of health and well-being activities they would participate in before proposals were taken to the Chief Executive and Board. Similarly, at University Hospitals of Leicester NHS Trust, a Well-being@Work initiative was launched in 2008 based on ideas presented by staff in 2007. Staff are currently being re-surveyed to establish their views on the existing scheme and ideas on what they would like to see happen in the future.
- 7.12 As part of providing a staff-centred service, it is important to provide for self-referral to health and well-being services. As one focus group respondent asked:

**“Why does your manager have to refer you? It’s embarrassing, and word often gets back to them.”**

While managers felt that management referral was helpful because it enabled them to be aware of staff health and well-being issues, it was clear that staff did not consider that management referral in all

cases was appropriate or necessary – they wanted and expected to be able to access health and well-being services themselves. **We recommend that in future all such services should have self-referral access as well as access through management referral.**

- 7.13 Self-referral is particularly helpful for staff with drug, alcohol or mental health problems. These conditions can have a significant impact on patient safety as well as on the individual and need to be tackled quickly and effectively. Self-referral enables individuals to receive help before a crisis prompts much more serious intervention, and without the stigma of having to disclose personal information to managers, with the risk of loss of confidentiality. It is important that services in this area meet proper standards of clinical quality (such as the evidence-based standards available for some conditions from the Occupational Health Clinical Effectiveness Unit) and are subject to clear protocols on confidentiality and governance in order to enable issues that are relevant to patient safety and professional registration to be dealt with safely and sensitively.
- 7.14 In this context we are aware that there are very real complexities in dealing with sick doctors and other clinical staff who may be reluctant to admit to serious health problems, such as drug or alcohol addiction, or to seek early advice from occupational health services. It is important that staff with such problems have sufficient confidence in local services to seek the support that they require; however, we recognise that some cases may raise issues that go beyond the capacity of occupational health units. In such circumstances, it is important that advice is sought from relevant national bodies such as the National Clinical Assessment Service.



## Staff communication

- 7.15 As well as responsibility for commissioning services, the NHS staff health and well-being service should work with Trust internal communications staff to engage with and communicate to staff and their representatives on the range and availability of staff health and well-being services in order to encourage participation, using a range of techniques that reflect the needs of different staff groups. This should reflect best practice in other organisations that have a complex and fragmented workforce.

For example, in BT:

The challenge is to achieve high levels of participation and engagement among its staff. This is a particular challenge given that more than 75% of its staff are male aged 42–44 years and work in the ‘Openreach’ line of business (ie they are out and about constantly). BT therefore needs to sell initiatives to its staff as something that makes sense to them. In practice, each line of business turns an initiative around to make it work for the group of staff (eg for ‘Openreach’ staff, the material for these initiatives is made available in hard copy because they are less likely to use the internet/computers on a regular basis. They also co-brand their material with the union to give it more legitimacy as well as tailor the content and delivery methods of the messages).

In Royal Mail there is a range of staff engagement techniques. The general message from staff had been to ‘talk to us, and not to give out leaflets’ and this was supported by other approaches to communicate lifestyle messages:

Royal Mail established a Well-being Board to manage its ‘Feeling First Class’ well-being programme, including membership from trade unions and staff from a range of backgrounds (including communications specialists) to develop and agree priorities and test ideas. The award-winning programme is designed carefully in order to reach staff who are widely scattered geographically and working in a variety of roles.

NHS Trusts should look at innovative approaches to communicating the availability of health and well-being services to staff and supporting this with more general staff health and well-being messages. This should include making use of material that is produced within public health and in third sector organisations with expertise in health and well-being.

- 7.16 As well as communicating information about the services that are available to staff, it will be important for Trust health and well-being services to support staff to understand the role of the services that are provided, how they can be accessed, and that the advice they receive will be both impartial and confidential in order to overcome some of the suspicions that staff currently have about the purpose of these services.
- 7.17 Finally we are aware that even where a good range of services is available to staff, the services are not always taken up, particularly by those who would most benefit from them. In part this is because of management reluctance to release staff, and we return to this issue later. But it also reflects an unwillingness on the part of individuals to take responsibility for their



own health and to participate in activities with health benefits. Trusts should explore the scope for introducing incentives in order to attract staff to participate in health and well-being programmes. In BT, for instance, if staff register for a particular event, the organisation enters them in a draw for health-related prizes. Spending in such areas is likely to be significantly outweighed by the benefits that accrue from improving staff health and well-being and should deliver a significant return on investment.

## Service quality

7.18 There is, at present, little by way of agreed and accepted standards for staff health and well-being services. The Royal College of Nursing has developed a competency framework for occupational health nurses, which we welcome. Also the Faculty of Occupational Medicine is currently developing service standards in collaboration with other organisations, including the Royal College of Nursing, and **we recommend that they should be adopted by NHS bodies when available.** We recognise that these standards will cover only part of the spectrum of health and well-being services that should be available to staff and **we recommend that relevant professional groups develop standards for their services.**

## Consistent provision

7.19 The evidence that we received suggested that, as well as inconsistencies in the provision of staff health and well-being services between Trusts, there were inconsistencies within Trusts. In multi-site Trusts, services were not available at all sites, and limited opening hours meant it was difficult for staff working at night

or over weekends to access support when they needed it. As one focus group participant said, “occ health locations are often miles away,” which inhibits access. Another respondent commented:

“We have direct access, fast-track physio for staff in half our area where our lead trust employs physios, not in the other half where they are PCT staff.”

A third said that work in their Trust suggested that services did not

“... engage sufficiently with particular target groups such as shift work nurses, porters, junior doctors and domestics”.

7.20 Given the range of comments that we received about equitable access to staff health and well-being services, we are also concerned that current provision may not meet the needs of different groups, such as those from minority ethnic populations and those with disabilities or caring responsibilities. In this context we welcome the efforts that are being made in some Trusts to target specific groups, such as Lambeth PCT’s men’s health initiative, which resulted in 162 men having ‘MOT’ checks at local bus garages, 20–30% of whom were referred for lifestyle support because of their cardiovascular risk. More generally **we recommend that an equality audit should be undertaken to assess how far current services are responsive to issues such as gender, age, sexual orientation, ethnicity and other aspects of diversity.**



**7.21** We also recommend that staff health and well-being services should be provided on an equitable basis for all Trust staff, wherever and whenever they work, and regardless of occupational group. This can be facilitated by making use of modern methods of accessing and providing advice such as email, internet and telephone-based access. There are existing examples of these arrangements, such as the DrThom.com internet-based genito-urinary medicine advisory service. Providing services outside traditional hours will, of course, require occupational health staff to be flexible in terms of working patterns, although they will benefit by becoming increasingly familiar with the working environment of staff and by being able to undertake workplace visits and assessments. The introduction of self-referral arrangements alongside management referral to health and well-being services can also help here.

**7.22** One approach that can help to provide quick, efficient and consistent services is the greater use of systems technologies. Such technologies include recall and scheduling systems to enable more effective management of programmes such as health surveillance and vaccination. Such ‘intelligent’ protocols (which may or may not be IT based) can enable occupational health technicians to undertake much of the routine work and free more senior staff to deliver higher value interventions. For example, we are aware that current approaches to pre-employment screening in many NHS organisations use a significant amount of senior occupational health resource. Improved protocols could enable screening to be undertaken to consistent

standards using alternative staff and systems, thus enabling senior staff to deal with only the more complex cases. Effective data transfer between employers could also reduce the need for repeat checks in different NHS organisations. The need for repeat screening of this nature is not only inefficient, it also results in unnecessary clinical interventions at times and helps to reinforce a negative staff perception of occupational health services as essentially being part of a time-consuming, and often negatively regarded, screening process. **We recommend that the Department of Health explores the scope for introducing and implementing such systems. We also recommend that steps should be taken to improve the transfer of information between occupational health services in order to avoid the need for repeat screening of staff moving between Trusts.**

**7.23** While we are conscious that our remit was limited to considering the health and well-being of staff employed by NHS Trusts and similar bodies, we believe that it is important that other groups – members of the contractor professions and their staff, staff working for independent and third sector organisations, and self-employed staff – have access to high levels of health and well-being support and are clear about the arrangements for providing it. Many of the lifestyle and other challenges that face employed NHS staff are relevant to these groups also, and the loss of staff from preventable illness or injury in often small teams can have a significant impact on service delivery. Work should be put in hand to ensure that proper provision is made for these groups.

## Funding for health and well-being services

7.24 It is clear that in many cases funding for services is based on historic levels of provision rather than on any current assessment of what is required by the workforce, whose size, composition and work patterns may have changed radically. This was reflected in comments that we received, which also raised concerns that current occupational health services were often seen as a potential income generator rather than as a driver for delivering high-quality services to NHS staff. As one person put it:

“NHS-based OH [occupational health] departments are distracted from their core purpose by the drive to income generate (often unprofitably), and deliver services that are developing in response to the DWP’s [Department for Work and Pensions’] initiatives on long-term benefits.”

7.25 We believe that the first purpose of NHS staff health and well-being services should be to help and support NHS staff and that they should not be seen primarily as a way for Trusts to generate income for other service developments. We are concerned that in some cases the use of marginal costing for external service provision has not resulted in any benefit to the Trust and that the use of skilled and experienced staff to provide such services, however beneficial in terms of their development, has affected the provision of services to NHS staff. However, we commend the trading model developed by NHS Plus (a network of 112 NHS occupational health

providers) under which occupational health services trade on a proper commercial basis and any surpluses realised are used to expand the services it provides. We recommend that all NHS organisations should review their current funding for staff health and well-being services and ensure that:

- ▶ adequate funding is provided to enable services to deliver both the minimum package of services recommended above and those additional services commissioned to meet priorities identified by staff as described in paragraph 7.8–7.10
- ▶ funding is based on an assessment of the costs of delivering services to the current staffing of the Trust and is regularly reviewed to ensure that it meets changing needs
- ▶ income-generating external service provision is reviewed in order to be sure that marginal costing does not result in such services being delivered without profit and that NHS staff are aware of the benefits to them in terms of enabling high-quality health and well-being services
- ▶ external service provision should not reduce the availability of consistent, high-quality support to NHS staff.

## Service reporting

7.26 As indicated earlier, Trusts do not all make good use of information on current patterns of ill-health or on the effectiveness of existing health and well-being services. Without this information it is impossible to manage services effectively or to support managers and staff. One person said:

“I asked our HR department how many staff, on any given Monday, might be returning from sick leave and what re-induction/retraining (if necessary) arrangements were in place for them; they do not have that kind of information.”

7.27 Much information is potentially available to Trusts, for example through the Electronic Staff Record (ESR), but other information, for instance on the effectiveness of services and return on investment, is not well developed. In our work to develop the case for change, we used a simple benefit evaluation model but we are aware that although this is effective at national level it may not be suitable for evaluating benefits at a local level. Work is under way within the Department of Health to simplify the Business Healthcheck Tool that was originally developed in response to Dame Carol Black’s report *Working for a healthier tomorrow*, and this may be suitable for use by the NHS. We recommend that:

- ▶ information on sickness absence from existing systems should be routinely collected and reported to Trust boards and should be capable of aggregation to regional and national level and of analysis by staff group and grade

- ▶ work should be put in hand to agree routine metrics for monitoring service effectiveness and return on investment, which should again be used for local and national reporting, using the simplified Business Healthcheck or other, properly evaluated, models. These should include both process measures, such as waiting and response times, and measures of client/customer satisfaction and service quality
- ▶ the concept of ‘health and well-being accounts’, linked to quality accounts, should be explored.

Data should also be used for benchmarking purposes. We are aware of benchmarking organisations that already provide comparative information on private sector organisations, and it would be valuable for NHS bodies to benchmark performance not only against other NHS organisations but also against best practice in other sectors.

7.28 Furthermore, as set out in paragraphs 7.33–7.38, there is evidence that management practices, including such things as undertaking return-to-work interviews and completing staff appraisals properly, can have a significant effect on sickness absence and on staff health and well-being more widely. **We recommend that Trusts make use of ESR and other HR data to inform themselves of the effectiveness of local management in this area.**



## Leadership

7.29 One concern that was expressed to us repeatedly was about the lack of board and senior management engagement with the staff health and well-being agenda. When discussing barriers to effective services, one respondent cited:

“Lack of top-level support, well-being programmes need a committed champion at director level.”

Another commented on:

“A lack of commitment to H&S [health and safety] at board level – the focus being heavily weighted to HCAI [healthcare-acquired infections]. A culture spread from the board down at least as far as band 8a of working long hours beyond 40 and expecting the same of others.”

These comments typified a widely held view that boards and senior management do not have staff health and well-being high on their agenda, a view reinforced by our survey results, which show that only about a quarter of staff believed that their employer and its senior managers were interested in their health and well-being. A change of culture is needed if NHS staff health and well-being is to take its place at the heart of Trust business.

7.30 The culture of an organisation comes from the top, and many of our examples of good practice in NHS organisations show the effect of board leadership in this area. Boards need to prioritise staff health and well-being issues and provide clear and visible leadership on the subject. To that end, **we recommend that each board should appoint an executive director to champion**

this issue who should be charged, among other things, with reporting regularly to the board on progress with implementing a comprehensive staff health and well-being strategy. The board should ensure that such issues are discussed and that action is taken to tackle existing and emerging problems.

7.31 Strategies are not, of course, delivered by board members alone, and it will be important that responsibility for driving through the board’s strategy is clearly identified at senior management level. Many parts of a Trust have an interest in improving staff health and well-being: HR departments that wish to see a reduction in ill-health absence, occupational health departments that are responsible for tackling ill-health and injury, public health departments that are committed to improving the overall health of the population, and health at work teams focus on tackling workplace health issues. **We recommend that Trust boards identify a single senior manager to be responsible for co-ordinating the organisation’s action in this area.**

7.32 Boards of NHS provider organisations have a responsibility to ensure that they are implementing and delivering on staff health and well-being strategies, linked to appropriate assurance processes and external performance monitoring at national, regional and PCT level. NHS commissioning organisations have similar responsibilities and investing in staff health and well-being may lead to improvements in World Class Commissioning competencies, in particular competency one ‘Recognised as a local leader of the NHS’.



NHS commissioning organisations also have a critical role to play in helping to deliver on the staff health and well-being pledge in the NHS Constitution by ensuring that services are only commissioned from NHS bodies that are demonstrably committed to improving staff health and well-being. **We recommend that these commitments be built into future contracts and monitored through normal contract management arrangements.** NHS commissioning organisations may wish to ensure that the above responsibilities are also reflected in contracts with non-NHS providers. Nationally it is important that staff health and well-being is embedded in planning and governance frameworks and **we recommend that it be included as a priority in the NHS Operating Framework for future years.** The Care Quality Commission and Monitor should be asked to include targets on, and measurement of, staff health and well-being in their monitoring processes to ensure that Trusts take action. The SHA Assurance Framework should also incorporate staff health and well-being.

## Management responsibility

7.33 Line managers also have a critical role to play in championing staff health and well-being. Analysis of the staff perception survey showed that management practices are associated with all 4 health and well-being variables for which information exists within the Annual Staff Survey (work-related injury, work-related stress, job satisfaction and turnover intentions). In particular, the quality of job design, perceptions of work pressure, support for work-life (or work-home) balance, and the prevalence of well-structured appraisals and

well-structured team working are strongly related to health and well-being. However, it is clear from our work that in many places local managers are not engaged with these issues and are seen as a barrier to, rather than an enabler of, staff health and well-being. One respondent commented adversely on:

“... management making false economies and not accepting clearcut business cases for access of staff to essential services to improve their health.”

Another said:

“Managers need to empower staff to become involved; they need to appreciate and understand the crucial role they need to play in encouraging and empowering staff. Ideally they should be leading by example!”

7.34 There was a widely held view that managers were not properly trained and supported to help them handle health and well-being issues among their staff. Other organisations have started using toolkits to assist management and staff to identify and address problems of health and well-being. These interventions target the individual and lines of accountability in the workplace. For instance:

BT has an ‘Achieving the Balance’ tool, which helps managers to address issues around the work-life balance of staff. Centrica has taken an approach of training line managers so that they are comfortable dealing with and managing underlying health conditions and needs of employees in the workplace, for instance mental health, flu and back problems.

This is complemented in some organisations by more direct counselling and problem management.

BT uses a self-assessment online tool called STREAM (based on the Health and Safety Executive management standards for stress risk assessment). It provides an assessment of the stress level of employees through a traffic light system. If the traffic light rating is red or amber, the line manager is alerted and required to hold a one-to-one meeting with the employee to discuss the issue. Line managers are trained through a computer-based program called STRIDE which informs them about the responsibilities that they have towards their employees and also tells them about other training programmes related to stress management.

After identifying the crucial role that management behaviours and practice contribute to successful staff welfare, Royal Mail commissioned research with Cardiff University. Working with large numbers of managers, the research identified the need for simple support tools to help managers to support staff when sick, and a simple 'desktop aid' support programme has been developed and successfully piloted.

STREAM has been piloted in the NHS and consideration should be given to rolling it or similar tools out more widely as part of an integrated approach to skilling managers to deal effectively with staff health and well-being issues.

7.35 Managers may be particularly unsure of how best to respond to signs of mental health problems among their staff. Again there are resources available that can help. For example:

Department of Health managers participated in the Sainsbury Centre's pilot of the *beyondblue* National Workplace Programme, a 3-hour training session to build staff and managers' understanding and knowledge of common mental health problems and to increase their skills and confidence to support and manage a member of staff.

The impact of the training was evaluated through pre- and post-training questionnaires. These showed that managers' knowledge and confidence increased. For example, after the training, managers felt more confident to encourage a member of staff to seek help, to disclose a personal experience and to effectively manage a member of staff on an on-going basis.

In total, more than 250 managers from across the private and public sectors participated in the Sainsbury Centre *beyondblue* pilot. These significant changes in knowledge, attitudes and confidence were combined with high levels of satisfaction; nearly all managers said that the training was highly relevant and that they would recommend it to others.

As importantly, managers need to be seen to challenge prevailing attitudes and cultures in their organisations, for example in relation to long-hours working, work-life balance and harassment of staff, which contribute to staff stress and ill-health.

7.36 Some NHS organisations are already taking steps to provide managers with support and training on staff health and well-being issues.

At North Tees and Hartlepool Foundation NHS Trust, there is a programme of Trust-wide mandatory training for current and in-coming managers. It is supplemented by one-to-one coaching and attendance ‘surgeries’ for managers requiring intensive support reviewing case files and strategies for more complex cases. The training also covers action planning for sickness reduction strategies and there is a facilitated, comprehensive, half-day learning programme for those managers who require a more in-depth knowledge of policy and practice application. The Trust is also committed to being a ‘mindful employer’ in terms of its approach to mental health issues.

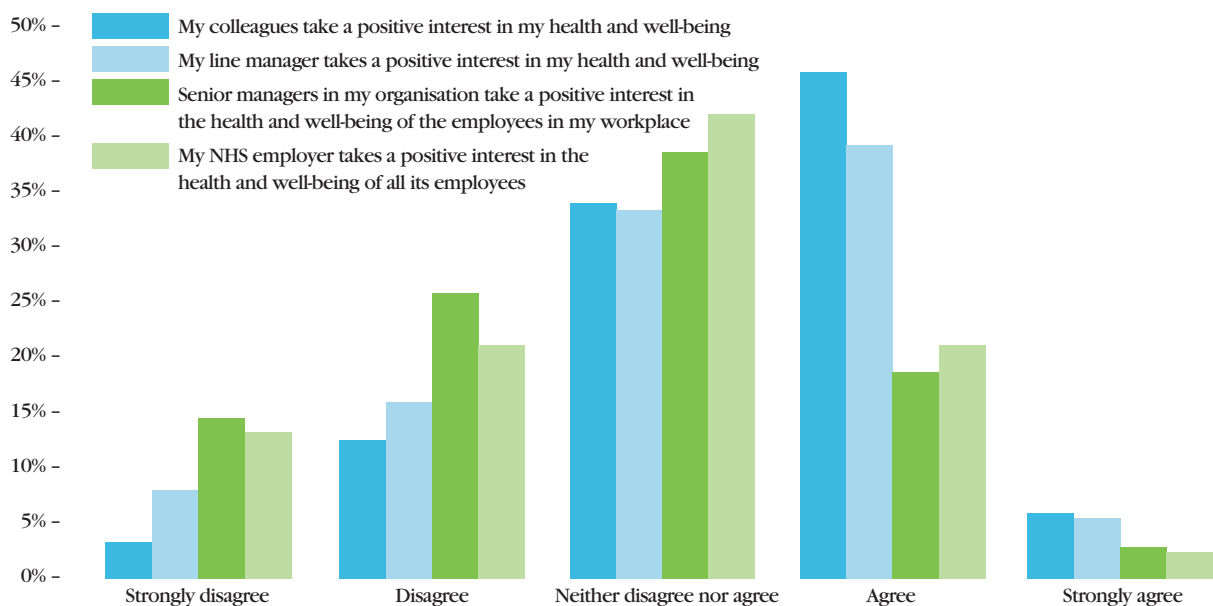
7.37 We recommend that all NHS organisations should take active steps to raise the profile of staff health and well-being issues among managers and should ensure that managers are properly equipped to support staff and tackle their health and well-being issues. This should be a central part of national and local NHS management training, including for clinical staff with management responsibilities. Furthermore, management appraisals and incentives, such as bonus payments and consideration of managers for more senior appointments, should take full account of their support for staff health and well-being.

7.38 It will be important that management performance in this area is routinely measured and monitored. As Figure 7.1 shows, staff responding to our survey were sceptical about the extent of management commitment to their health and well-being.

We believe that all Trusts should take this sort of comprehensive approach.

Figure 7.1: Employer and manager interest in staff health and well-being

Interest in health and well-being



Source: The Work Foundation, RAND Europe and Aston Business School

We recommend that questions about this issue should be included in the NHS Annual Staff Survey in future years in order for the position to be monitored over time.

## The wider healthcare system

- 7.39 It is important that NHS staff health and well-being services are properly connected to wider healthcare provision and particularly general practice given the GP's pivotal role in the care of individuals. In designing staff health and well-being services, NHS bodies should ensure that proper discussions are held with GPs and their representatives on how information on staff health and well-being, including interventions by employers, is communicated to them.
- 7.40 It is also important that NHS staff health and well-being services support and promote wider health improvement campaigns and engage fully with Regional Public Health Directorates. There would be merit in using similar approaches to target interventions for staff as are used to target the wider public. This will provide a consistent, coherent and joined-up approach between the way in which health improvement and promotion services are marketed to staff and to the general population, helping to reinforce the importance of the message.

## Conclusion

- 7.41 This chapter has identified some of the key characteristics that we believe should underpin a modern, forward-looking staff health and well-being approach for the NHS, and that will help to deliver the financial savings and quality of care improvements outlined in Chapter 4. Such a service will assist Trusts in recruiting, motivating and retaining high-quality staff and in becoming exemplary employers. We do not underestimate the challenges that implementing such a service will pose to Trusts, but we are clear that these challenges must be met. Unless the NHS does this, its reputation and its performance will suffer, to the detriment of us all.





# Tailored and early intervention programmes







8.1 As Chapter 7 makes clear, our vision for a new approach to NHS staff health and well-being support encompasses a proactive service that puts maintaining and improving the health of NHS staff at the centre of its work. This chapter looks at how early and tailored intervention services might be organised so as to deliver rapid improvements for NHS staff health and to support improved care for the local population.

## The benefits of early intervention

8.2 There is good evidence, as summarised in Dame Carol Black's report *Working for a healthier tomorrow*, that early intervention in tackling sickness absence pays dividends in enabling staff to return to work quickly. Such interventions can be particularly helpful where illness has the potential to become chronic and long lasting if not dealt with quickly. Musculoskeletal disorders and common mental health conditions, which are frequent causes of sickness absence, are examples of such conditions, and Dame Carol's Report pointed out:

**“For employees with lower back pain, interventions have been shown not only to return employees to work up to 5 weeks earlier than under normal care, but also to reduce the recurrence of back pain in the following year by up to 40%.”**

Work published last year stressed the importance of early intervention in vocational rehabilitation, because “the longer anyone is off work the greater the obstacles to return to work and the more difficult vocational rehabilitation

becomes”.<sup>17</sup> Work is in hand to establish ‘fit for work’ services to pilot access to early intervention services in order to maintain individuals’ fitness to continue in work. The NHS should ensure that it takes advantage of the opportunity to participate in such programmes.

8.3 Early intervention has a range of benefits:

- ▶ It helps the individual by returning them to health quickly, relieving pain and distress, and reducing the risk of continuing and chronic illness that may lead to ill-health retirement.
- ▶ It helps the employer by bringing skilled and experienced staff back into the workforce quickly, saving costs from employing temporary staff, reducing the avoidable loss of staff through ill-health retirement, and the associated costs this brings, and providing a stable working environment.
- ▶ It helps the service user because services are provided by healthy staff who are familiar with colleagues and the wider working environment. In the case of the NHS, evidence earlier in this report showed a clear link between staff health and well-being and patient satisfaction.

Furthermore, such an approach:

- ▶ reduces the potential for symptoms of medical conditions to result in presenteeism, and reduces the risk of further sickness absence at a later date
- ▶ enables staff to be treated quickly and effectively in or near where they work, making it easier for them to obtain treatment when they need it.

<sup>17</sup> Waddell, Gordon, Burton, A. Kim and Kendall, Nicholas A. S., *Vocational rehabilitation: What Works, For Whom and When?* London: The Stationery Office, 2008.

8.4 Our research identified a number of organisations that have put in place programmes to provide early support for staff, particularly for conditions such as musculoskeletal disorders and common mental health problems. Typically these programmes will combine the provision of advice on how to prevent problems with rapid access to treatment. One example is BT, which has put arrangements in place to tackle musculoskeletal disorders in its workforce.

BT provides its staff with information and support to protect themselves against musculoskeletal problems. They teach staff how to sit properly and use mobile equipment to minimise the risk of them developing musculoskeletal problems. They also provide them with ergonomic seating supplied by a third-party supplier. Staff are able to access advice on musculoskeletal disorders over the phone or in writing, and are able to request physiotherapy appointments, also provided through third parties. Such programmes may be considered as delivering statutory duties of care under legislation such as the Display Screen Equipment Regulations.

Centrica has introduced and funded a wide-ranging service aimed at ensuring that staff presenting with health problems benefit from early interventions to enable them to recover quickly and return to work.

Centrica Occupational Health provides a full range of advisory services and, although individuals may contact occupational health directly, it is normally their line manager who makes the initial referral. If it is considered that a medical intervention would increase the likelihood of an employee remaining at work or would hasten their return to work, Centrica will consider funding the intervention from an extensive portfolio of providers covering both physical and mental ill health and including consultations, treatment and rehabilitation.

For example:

- ▶ orthopaedic consultation and investigations followed by surgery, physiotherapy and 6 weeks of gym-based exercises to enable full rehabilitation
- ▶ musculoskeletal functional capacity assessment for an individual with shoulder problems, followed by physiotherapy
- ▶ physiotherapy for neck pain because of poor workplace posture
- ▶ one-day back care workshop followed by 6 weeks' gym membership and back exercise regime for an individual with a chronic history of well-documented and fully investigated back pain.

8.5 There is clear evidence of the financial benefits of such services. For instance, Royal Mail's workplace rehabilitation programme for musculoskeletal conditions now has over 3 years of evaluation data and has achieved a 98% reduction in comparative sickness absence for cases referred to treatment: 67% of those with long-term sickness from significant back pain have returned to unmodified work and 73% of individuals previously restricted in work function have achieved return to unrestricted work. A thorough cost-benefit analysis has shown a £2.50 return on every £1 invested.

- 8.6 In short, early intervention programmes are a key part of modern, high-quality health and well-being provision.

## Early intervention programmes in the NHS

- 8.7 While early intervention is an important feature of staff health and well-being programmes in the wider economy, the picture in the NHS is mixed. There are some examples of good early intervention arrangements, particularly for musculoskeletal disorders, such as at West Suffolk Hospital NHS Trust and Gloucestershire Hospitals NHS Foundation Trust.

West Suffolk Hospital NHS Trust introduced a system of priority treatment referrals to a local physiotherapist for injured staff. For a cost of £21,000, it achieved savings in the direct cost of musculoskeletal injuries of over £170,000 and a 40% reduction in days lost as a result of sickness absence due to this cause.

Gloucestershire Hospitals NHS Foundation Trust introduced an occupational health department-based physiotherapy musculoskeletal disorder assessment service for NHS staff. This resulted in a reduction in sickness absence from 13.6 to 6.8 days, a decrease in waiting times for musculoskeletal disorder appointments, and the majority of patients being assessed and managed by physiotherapists without the need for medical input, with significant cost savings for the Trust.

We were also told that Southampton University Hospitals NHS Trust has funded a multidisciplinary rehabilitation service based on an early intervention case-management approach which accesses a

range of interventions, both physical and psychological for employees who have been off work for 4 weeks. Funding has been secured to evaluate this approach, although this work has not yet started.

- 8.8 However, it is clear from the occupational health specialists who contributed to our review that while, in some Trusts, good access to diagnostic and treatment services is simply and routinely available, in others such interventions are regarded with suspicion and staff feel that their health needs are not only not being given proper priority but also, in some cases, delayed by complex commissioning models.
- 8.9 Most of the early intervention programmes of which we are aware relate to musculoskeletal disorders and we heard less about such programmes for mental health conditions, although some Trusts did tell us about counselling and cognitive behavioural therapy (CBT) support for staff. This may reflect fears among NHS staff that they will be marginalised or discriminated against if they admit to having a mental health problem. In order to overcome this:
- ▶ NHS organisations need to create safe spaces for staff to tell their managers, supervisors and colleagues if they experience mental distress, without fear of being treated unfairly
  - ▶ **all** staff need information on mental health conditions, including prevalence, how to identify early signs and symptoms and most importantly training to enable them to have the confidence to approach a colleague or someone whom they manage who is showing signs of distress and signpost them to appropriate help

- ▶ **basic training for managers should include advice on how to provide effective and supportive management for someone recovering from mental ill-health.**

This can be achieved through:

- ▶ **training for managers and supervisors in dealing appropriately with staff experiencing the early signs of distress**
- ▶ **expert advice and help from human resources and occupational health departments**
- ▶ **leadership from the top, including signing up to and acting upon the Mindful Employer Charter.<sup>18</sup>**

In the course of the review, we noted a number of interventions and support approaches developing outside the employing Trust to provide care and advice to groups of staff, such as doctors or dentists, who are reluctant to seek help locally. It is important to ensure that such services link appropriately with employers, while maintaining confidentiality, to ensure that rehabilitation and fitness to work issues are adequately dealt with, which will be most effectively achieved by involving the local occupational health provider.

- 8.10 The arguments for providing early intervention services are at least as strong for the NHS as for other industries. Apart from the moral argument that the NHS, as a good employer, should be looking after the health of its staff, there are clear financial benefits as well as benefits to patient care from increasing the availability of trained and skilled staff and so reducing delays to treatment and the risk of adverse outcomes.

However, there have been concerns that giving priority to the treatment of NHS staff will be seen as ‘queue jumping’ and will be resented by patients and by employers who may believe that their key staff are being disadvantaged, though this may be less of an issue as waiting times reduce.

- 8.11 Some degree of prioritisation is already given to NHS staff and accepted by the wider population. For example, NHS Employers has published guidance on the human resource implications relating to a flu pandemic, which includes the ability to prioritise staff for treatment with antivirals or vaccinations and the need for specialist preventative occupational health interventions including continual health assessments for staff and their immediate families, counselling and communications. Additional specific measures may be developed based on the clinical need for early intervention, and also to support staff health, safety and well-being. This guidance recognises that it is clearly sensible to ensure that those charged with providing care to the wider population are fit to do so. Similar arguments can be deployed in support of other early intervention programmes.

- 8.12 We strongly believe that all NHS Trusts should ensure that early intervention programmes are an integral part of their staff health and well-being programmes so that they can reap the financial and patient care benefits which they provide, as well as reinforcing their role as good employers. However, these programmes need to be appropriately designed by Trusts to ensure that they are effective. In particular, it is important that they provide access to

<sup>18</sup> Run for employers by employers and hosted by the Devon Partnership NHS Trust.

early, confidential, specialist assessment services for professional staff. Such services should be delivered by suitably qualified and competent staff and should have due regard to confidentiality and the sensitivity of the issues such staff may raise.

## What might an early intervention service look like?

8.13 Using the models that apply in other organisations, we recommend that early intervention programmes should be:

- ▶ routinely available for illnesses and injuries that are common in the NHS, suitable for effective early treatment and liable to result in long-term or recurrent absence if not treated quickly. These should include musculoskeletal disorders and mental health conditions
- ▶ available on a case-by-case basis for other illnesses or injuries where the benefit to the NHS Trust clearly outweighs the cost to the organisation
- ▶ easily accessible to staff. There should be a mix of telephone and internet advice, using standard protocols for common illnesses and injuries, and face-to-face assessment. Such an approach would make best use of the range of skills and expertise available in occupational health departments and ensure that staff received the most appropriate advice for their condition
- ▶ supported by high-quality advice on prevention of illness and injury and on health improvement action
- ▶ funded from within the overall budget for staff health and well-being

- ▶ properly integrated with general practice, which retains overall responsibility for the health and care of registered patients. It would be the responsibility of the Trust staff health and well-being service to inform the relevant GP that it was seeing their patient and to seek agreement to any proposed treatment or to refer the patient to their GP if preferred
- ▶ routinely monitored and reported on as part of the Trust's overall package of staff health and well-being services to ensure that they continue to meet need and deliver a return on investment
- ▶ supported by high-quality communications to ensure that staff are aware of the availability of early care and support for common health issues and how this can be accessed. They should be encouraged to understand and take responsibility for their own health and to seek early help rather than delaying until sickness absence is inevitable
- ▶ properly evaluated to ensure that the costs and benefits are fully and widely understood.

## Conclusion

8.14 We believe that high-quality early intervention services with the characteristics we outline above would have real benefits for both NHS staff and their employers, and would help to address the concerns expressed by staff in our survey about the role and purpose of occupational health services and the lack of employer interest in their health and well-being.



# 9 Developing the workforce



9.1 This chapter considers the need for improved education in staff health and well-being. It starts from the position reported in Dame Carol Black's report *Working for a healthier tomorrow* that occupational health has traditionally been separated from mainstream healthcare and is "a specialty unknown to most trainee healthcare professionals" and has "a small and declining academic base". At a time when significant investment is needed to improve workplace health and well-being in the NHS, and elsewhere in the economy, it is important that there is an adequate, skilled workforce with knowledge of, and access to, high-quality and up-to-date evidence.

9.2 But, if our vision for NHS staff health and well-being services is to be met, it will require more than a strong cadre of occupational health specialists. Rather it will need all NHS professional staff to have a good understanding of staff health and well-being issues which they can use both in working with patients and the wider public and to advise and support colleagues.

### Occupational health staff

9.3 Like the Black report, we believe it is crucial that staff health and well-being are included in the core curriculum of trainee health professionals and that occupational health is seen as a mainstream option for staff on qualification. There should be clear leadership from the Faculty of Occupational

Medicine, the Royal College of Nursing, the Chartered Society of Physiotherapy, the College of Occupational Therapists and other professional bodies to promote occupational health as a career option, to encourage and support recruitment into the specialty, and to show that there are clear pathways for career development. We are conscious that occupational health is a small specialty and has limited capacity to participate in careers fairs and other events to encourage young professionals to train and work in the field. However, it is important that best use is made of all opportunities to do this and that all relevant professions work together to encourage staff to see occupational health as a valid career choice.

### Professional staff outside occupational health

9.4 While the role of occupational health staff is crucial, they will not be the sole or even the main source of advice and support for NHS staff on health and well-being issues. Nor should they be. Much advice will come from the wider community of healthcare professionals and it is important that they are equipped for this role. To achieve this, it is vital not just that other professional staff are exposed to staff health and well-being issues as part of their basic training but that they have opportunities to build on and refresh their training throughout their careers.

9.5 In this context, we welcome the work that the Royal College of Surgeons has undertaken in developing training and reference materials in relation to return to work and occupational health issues after surgery and the work that the Royal College of General Practitioners has taken forward with the Faculty of Occupational Medicine



and the Department for Work and Pensions (DWP) in developing training materials for GPs on fitness for work. We also welcome the work that the Royal College of Nursing has undertaken in conjunction with DWP to develop *Health, Work and Well-being*, an online learning resource for nurses. We are also aware of the positive interest and support being shown for developing the 'fit for work' services and consider it important that these services are organised to reflect a broader model of care than the traditional medical model. However, we believe that more needs to be done to support staff in other medical disciplines and in other professions that contribute to health and well-being, particularly nurses, occupational therapists and physiotherapists. This should also include health and safety professionals who are increasingly concerned with the health of staff at work as well as their safety. **We recommend that there should be joint work between professional bodies to develop common training and educational support programmes for staff in order to ensure an integrated approach and broaden and deepen the skills base.**

9.6 A key element of professional staff training and development should be training to improve self-awareness and resilience for common medical conditions and to recognise, and take action on, lifestyle risk factors. Too often clinical staff fail to recognise, or respond to, emerging health problems at an early stage, or take appropriate action when they do. Better training in self-help would pay dividends in preventing illnesses or injuries becoming chronic and requiring more serious interventions and jeopardising the ability to resume work quickly, if at all. It would also help to minimise the risk of health problems having an adverse impact on the quality of patient care and the safety

of patients. For doctors, of course, the revalidation process requires them to certify that they are in good health and it is vital that they both recognise and act on emerging health and well-being concerns. Other healthcare professionals also have obligations to their regulatory bodies which require them to respond appropriately to emerging health problems. There is a fine line between appropriate self-care and self-treatment, which clinical staff may be tempted to pursue for a number of reasons. This can be harmful and, as indicated earlier, it is important that clinical staff have confidence in the measures in place to provide good workforce care, reducing the need to self-medicate or avoid taking action on problems.

9.7 It is also important that good use is made of the skills of the range of staff, such as ergonomists and health trainers, who fall outside the normal scope of NHS professional staff training and support, to maximise the skills base available to support NHS staff. As indicated in Chapter 5, there is little evidence of good use being made of ergonomists by the NHS, and we are also not aware of much use being made of occupational health technicians, who are increasingly being used by other organisations to enable occupational health units to make best use of scarce resources of skilled staff.

9.8 As indicated in Chapter 7, it will also be important to ensure that managers receive proper training to recognise and handle health concerns among their staff and can signpost them to the most appropriate professionals for help and advice.

## Research and dissemination

9.9 It is important that the evidence base on effective interventions is strengthened and we fully support the recommendations in the Black report on this. We believe that consideration should be given to ensuring that the National Institute for Health and Clinical Excellence (NICE) and other bodies such as the Occupational Health Clinical Effectiveness Unit (OHCEU) are used to continue to develop evidence-based standards for effective care and support.

9.10 As important, however, is disseminating information and research findings on a systematic and comprehensive basis. Too often at present information sharing is undertaken on an ad hoc basis, with different parts of the NHS developing their own systems for identifying and communicating good practice or developing protocols for treating staff who present with common problems. This is costly in terms of staff time, quality of care given to patients and consistency of response. Groups such as the Royal College of Nursing's Public Health Forum are well placed to help here, given its access to occupational health nurses.

9.11 In this context, we welcome the work that OHCEU is undertaking to make evidence-based guidelines and implementation strategies available. We also welcome the NHS Employers' *Healthy Workplaces Handbook* which brings together information to support employers. But we believe that there is scope for doing more. In particular, **we recommend the establishment of an electronic health and well-being library for the NHS**, perhaps as part of NHS Evidence which includes the former NHS Library for Health. This could contain:

- ▶ up-to-date studies on effective health and well-being interventions
- ▶ guidance on the range of materials available to support occupational health professionals and the wider professional workforce in their work
- ▶ case studies from within and outside the NHS
- ▶ protocols and best practice guidance for treating particular conditions, illnesses or injuries.

Such an approach would assist health and well-being practitioners in Trusts to maintain and improve practice and help to avoid the need to reinvent the wheel. By making it widely available to all occupational health staff and organisations such as the Faculty of Occupational Medicine, the Royal College of Nursing, the Association of National Health Occupational Physicians (ANHOPS) and the Association of NHS Occupational Health Nurses (ANHONS), such a library could help to ensure that consistent standards are achieved in the delivery of occupational health services across the NHS.

9.12 We believe that there is an important role for trade unions and other groups, such as the Social Partnership Forum and the Partnership for Occupational Safety and Health in Healthcare (POSHH) – the health and safety sub-group of the NHS Staff Council – to support the development and particularly the dissemination of information on effective interventions, quality standards and best practice. These groups already perform a valuable role in bringing together key organisations and helping to ensure a cohesive approach to health, safety and well-being issues, and we believe that they have an important role to play in ensuring the effective implementation of our recommendations.



# 10

## Next steps





10.1 The earlier chapters of this report have made a number of recommendations for action. This chapter sets out what we believe are the next steps that need to be taken in delivering an NHS staff health and well-being service which is fit for the 21st century, and who should take action.

## Department of Health

10.2 The Department of Health should:

- ▶ ensure that staff health and well-being is included as a key NHS priority in the Operating Framework for future years
- ▶ ask the Care Quality Commission (CQC) and Monitor to include targets on, and measurement of, staff health and well-being in their monitoring processes, to ensure that Trusts take action
- ▶ ensure that the issue of staff health and well-being is high on the agenda of the Social Partnership Forum and the NHS Staff Council through its Partnership for Occupational Safety and Health in Healthcare (POSHH) sub-group
- ▶ take steps to establish a cohort study of NHS staff, drawing on experience from other such studies. This should look widely at health and well-being issues and wider lifestyle factors
- ▶ put in place arrangements to collect and publish annual data on sickness absence in the NHS, drawn from the Electronic Staff Record (ESR), to enable long-term monitoring of trends. To ensure comparability, all Trusts should collect and report ESR data in a consistent and comparable form with the opportunity to analyse data by staff group and grade

- ▶ work with the CQC to ensure that specific questions on staff health and well-being are included in the NHS Annual Staff Survey in future years and that measures of staff health and well-being are included in the assessments of Trust performance carried out by the Commission and by Monitor
- ▶ establish an expert group to draw up a minimum service specification for NHS staff health and well-being services
- ▶ ensure that staff health and well-being management forms a core element of NHS management training
- ▶ pilot the use of intelligent systems to support staff health and well-being services.

## Professional bodies

10.3 The range of professional bodies should work together to:

- ▶ develop, publish and publicise standards for workplace health and well-being services
- ▶ improve the coverage of staff health and well-being issues in basic and continuing professional education
- ▶ develop and disseminate the evidence base of effective health and well-being interventions.



## Trade unions

10.4 Trade unions should be:

- ▶ actively consulted and involved in developing staff health and well-being approaches and strategies, nationally and locally
- ▶ fully engaged with the national staff health and well-being agenda, in particular through the proposed expert group to develop a minimum service specification for NHS staff health and well-being services and through partnership working in the Social Partnership Forum and NHS Staff Council
- ▶ fully engaged in partnership with Trust staff and management to develop plans for local services to be provided and to communicate the importance of health and well-being issues to staff.

## Strategic Health Authorities and other NHS healthcare organisations

10.5 Strategic Health Authorities should:

- ▶ ensure that performance on staff health and well-being in their areas is monitored effectively.

They and all other NHS organisations should:

- ▶ ensure that they meet minimum requirements for health and well-being services for their staff.

## NHS Trusts

10.6 In order to meet obligations relating to the staff pledge in the NHS Constitution, all types of NHS Trusts are committed to supporting staff health, well-being and safety, and they should:

- ▶ as a matter of urgency, review their current staff health and well-being provision and prepare and publish properly resourced strategic plans for developing services and working with staff and staff organisations
- ▶ resource and implement new services that meet the specifications outlined in Chapter 7 of this report. In particular, such services should:
  - provide for staff self-referral
  - be readily accessible to all staff, regardless of location, working pattern and occupational group
- ▶ identify an executive board-level champion for staff health and well-being services and clear lines of management responsibility and accountability
- ▶ ensure that performance on staff health and well-being is regularly reported to and discussed at board meetings, and action is taken on any existing and emerging problems
- ▶ ensure that staff health and well-being is at the heart of manager training, development and appraisal - this should include clinical staff with management responsibilities
- ▶ introduce early intervention arrangements for staff where these benefit staff, patients and the organisation. It may be appropriate to pilot these on a regional basis initially
- ▶ improve communication of health and well-being services to staff and engage actively with staff and staff organisations on areas for development and improvement.

## Primary Care Trusts

- 10.7 In addition, Primary Care Trusts have a dual role in monitoring the performance of provider organisations, as well as supporting their own staff health and well-being, and they should ensure that they:
- ▶ commission from NHS Trusts which are demonstrably committed to improving staff health and well-being
  - ▶ meet minimum requirements for health and well-being services for their staff.

## APPENDIX 1: Summary of recommendations

### Chapter 2 – Our key health priorities

- ▶ We recommend that the scope for the NHS setting itself an ‘activity challenge’ should be explored further.
- ▶ We recommend that NHS organisations should ensure that staff avoid obviously visible public areas when they smoke and should challenge their staff to reduce smoking next year, measuring progress against current national targets.
- ▶ We recommend that the NHS plays an active role in the Coalition for Better Health, to identify successful strategies to reduce harmful drinking by NHS staff and their families.
- ▶ We recommend that all NHS organisations should work to improve the healthiness of food served in their restaurants and staff awareness of healthy food choices, and should set a widely communicated target for reducing obesity among their own staff.
- ▶ We recommend that the Social Partnership Forum should continue to give high priority to addressing the underlying issues that may serve as risk factors for mental ill-health.

### Chapter 3 – The current health and well-being of NHS staff

- ▶ We recommend that all NHS bodies should give priority to implementing the forthcoming National Institute for Health and Clinical Excellence guidance on promoting mental well-being at work as a sign of their commitment to staff health and well-being. We also recommend that all NHS bodies ensure that their management practices are in line with the Health and Safety Executive’s management standards for the control of work-related stress.

- ▶ We recommend that further research should be undertaken into presenteeism to identify in more detail its causes, variations between occupational groups and impact on patient care and safety.
- ▶ We recommend that the Department of Health should put in place arrangements to collect and publish annual data on sickness absence in the NHS, drawn from the Electronic Staff Record (ESR), to enable long-term monitoring of trends. To ensure comparability, all Trusts should collect and report ESR data in a consistent and comparable form.
- ▶ We recommend that specific questions on staff health and well-being be included in the NHS Annual Staff Survey to enable trends to be monitored over time.
- ▶ We recommend that a longitudinal survey of the health and well-being of a representative cohort of NHS staff should be established.
- ▶ We recommend that the Department of Health should put in place arrangements for independent evaluation of the effectiveness of the interventions recommended in our review.

### Chapter 5 – NHS staff health and well-being services

- ▶ We recommend that continued priority is given to attracting doctors to pursue careers in occupational health medicine so as to ensure that sufficient consultant resource is available to enable all NHS employers to access specialist advice when needed. In the meantime, consideration should be given to establishing regional specialists in occupational health medicine who could provide input to units without access to consultant support.

- ▶ We recommend that there should be a regional consultant nurse in occupational health in each region to provide leadership to the function and advice to individual units.
- ▶ We recommend that management training and induction should include material to ensure that managers are aware of the role of occupational health services, referral routes, information required for referral and the confidentiality issues involved.

## Chapter 7 – Exemplar approaches

- ▶ We recommend that all NHS Trusts should take action to draw up and publish strategic commissioning plans for staff health and well-being services that are fully integrated with wider service development plans and recognise the contribution which a healthy and engaged workforce can make to improving patient care and financial performance.
- ▶ We recommend rebranding occupational health services with a more positive well-being focus and a consistent identity, such as 'NHS Staff Health and Well-being'.
- ▶ We recommend that there should be a nationally specified minimum service specification for the staff health and well-being services to be provided by Trusts. The core service specification for NHS staff health and well-being services should prioritise effective proactive services and should include common, simple performance metrics (relating to standards of delivery, client and customer satisfaction, and quality of service through audited outcomes) to enable benchmarking and monitoring.
- ▶ We recommend that individual Trusts should engage with their staff on the range of additional health and well-being services which they believe should be given priority in their organisation.
- ▶ We recommend that in future all NHS staff health and well-being services should have self-referral access as well as access through management referral.
- ▶ We recommend that service standards currently being developed by the Faculty of Occupational Medicine, in collaboration with other organisations including the Royal College of Nursing, should be adopted by NHS bodies when available and that relevant professional groups develop standards for their services.
- ▶ We recommend that an equality audit should be undertaken to assess how far current NHS staff health and well-being services are responsive to issues such as gender, age, sexual orientation, ethnicity and other aspects of diversity.
- ▶ We recommend that staff health and well-being services should be provided on an equitable basis for all Trust staff, wherever and whenever they work, and regardless of occupational group.
- ▶ We recommend that the Department of Health explores the scope for introducing and implementing intelligent protocols for handling routine issues such as pre-employment screening. We also recommend that steps should be taken to improve the transfer of information between occupational health services in order to avoid the need for repeat screening of staff moving between Trusts.



- ▶ We recommend that all NHS organisations should review their current funding for staff health and well-being services and ensure that:
  - adequate funding is provided to enable services to deliver both the minimum package of services recommended above and those additional services commissioned to meet priorities identified by staff
  - funding is based on an assessment of the costs of delivering services to the current staffing of the Trust and is regularly reviewed to ensure that it meets changing needs
  - income-generating external service provision is reviewed in order to be sure that marginal costing does not result in such services being delivered without profit and that NHS staff are aware of the benefits to them in terms of enabling high-quality health and well-being services
  - external service provision should not reduce the availability of consistent, high-quality support to NHS staff.
- ▶ We recommend that:
  - information on sickness absence from existing systems should be routinely collected and reported to Trust boards and should be capable of aggregation to regional and national level and of analysis by staff group and grade
  - work should be put in hand to agree routine metrics for monitoring service effectiveness and return on investment, which should again be used for local and national reporting, using the simplified Business Healthcheck or other, properly evaluated, models. These should include both process measures, such as waiting and response times, and measures of client/customer satisfaction and service quality
    - the concept of 'health and well-being accounts', linked to quality accounts, should be explored.
- ▶ We recommend that Trusts make use of ESR and other HR data to inform themselves of the effectiveness of local management in undertaking return-to-work interviews and completing staff appraisals properly given their impact on staff health and well-being.
- ▶ We recommend that each NHS board should appoint an executive director to champion staff health and well-being who should be charged, among other things, with reporting regularly to the board on progress with implementing a comprehensive staff health and well-being strategy. The board should ensure that such issues are discussed and that action is taken to tackle existing and emerging problems.
- ▶ We recommend that Trust boards identify a single senior manager to be responsible for co-ordinating the organisation's action in relation to staff health and well-being.
- ▶ We recommend that NHS commissioning organisations only commission services from NHS providers that are demonstrably committed to improving staff health and well-being, and that this be built into future contracts and monitored through normal contract management arrangements.
- ▶ We recommend that staff health and well-being be included as a priority in the NHS Operating Framework for future years. The CQC and Monitor should be asked to include targets on, and measurement of, staff health and well-being in their monitoring processes to ensure that Trusts take action.

The SHA Assurance Framework should also incorporate staff health and well-being.

- ▶ We recommend that all NHS organisations should take active steps to raise the profile of staff health and well-being issues among managers and should ensure that managers are properly equipped to support staff and tackle their health and well-being issues. This should be a central part of national and local NHS management training, including for clinical staff with management responsibilities. Furthermore, management appraisals and incentives, such as bonus payments and consideration of managers for more senior appointments, should take full account of their support for staff health and well-being.
- ▶ We recommend that questions about management performance should be included in the NHS Annual Staff Survey in future years in order for the position to be monitored over time.

### Chapter 8 – Tailored and early intervention programmes

- ▶ We recommend that early intervention programmes be routinely available in all Trusts for illnesses and injuries that are common in the NHS, suitable for effective early treatment and liable to result in long-term or recurrent absence if not treated quickly. These should include musculoskeletal disorders and mental health conditions. They should also be available on a case-by-case basis for other illnesses or injuries where the benefit to the NHS Trust clearly outweighs the cost to the organisation.

### Chapter 9 – Developing the workforce

- ▶ We recommend that there should be joint work between professional bodies to develop common training and educational support programmes for staff in order to ensure an integrated approach and broaden and deepen the skills base.
- ▶ We recommend that the evidence base on effective interventions be strengthened and we fully support the recommendations in the Black report on this.
- ▶ We recommend the establishment of an electronic health and well-being library for the NHS.

## APPENDIX 2: List of acronyms

The following acronyms are used in this Interim Report.

Acronym	Definition
ANHONS	Association of NHS Occupational Health Nurses
ANHOPS	Association of National Health Occupational Physicians
BT	British Telecommunications
CFS	chronic fatigue syndrome
CIPD	Chartered Institute of Personnel and Development
CQC	Care Quality Commission
CVD	cardiovascular disease
DWP	Department for Work and Pensions
ESR	Electronic Staff Record
FTE	full-time equivalent
GP	general practitioner
GUM	genito-urinary medicine
H&S	health and safety
HCAI	healthcare-acquired infections
HR	human resources
HSE	Health and Safety Executive
ITU	intensive therapy/treatment unit
MH	mental health
MMR	measles, mumps and rubella
MRSA	meticillin-resistant <i>Staphylococcus aureus</i>
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
PCT	Primary Care Trust (UK National Health Service)
OH	occupational health
OHCEU	Occupational Health Clinical Effectiveness Unit
SA	sickness absence
SLA	Service Level Agreement
WHO	World Health Organization
WTE	whole-time equivalent

## APPENDIX 3: Advisory groups

During the development of the Interim Report of the review, the following groups of people worked closely with the review team.

### NHS Health and Well-being Review – Project Board

- ▶ Dr Steven Boorman, Lead Reviewer
- ▶ Mrs Flora Goldhill (Chair), Director, Workforce Capacity and Analysis
- ▶ Mr Nic Greenfield, Director, Non-Medical Education, Pay and Pensions
- ▶ Mrs Siobhan Smith, Project Manager
- ▶ Mr Stephen Welfare, Workforce Director, East of England Strategic Health Authority

### NHS Health and Well-being Review – Review Team

- ▶ Dr Steven Boorman, Lead Reviewer
- ▶ Ms Sophie Best, Project Support
- ▶ Mr Jeremy Dawson, Benefit Evaluation Model Workstream Leader
- ▶ Dr Emmanuel Hassan, Literature Review Team Member
- ▶ Dr Michelle Mahdon, The Work Foundation, RAND Europe and Aston Business School Research Team Leader
- ▶ Mr Campbell McDonald, External Communications Leader and Media Adviser
- ▶ Mr Richard Murray, Case for Change Team Member
- ▶ Ms Pat Pegg Jones, Case for Change Workstream Leader
- ▶ Ms Danielle Roberts, Project Management Support
- ▶ Mrs Siobhan Smith, Project Manager

- ▶ Dr Tony Starkey, Staff Perception Research Team Member
- ▶ Mr Stephen Windsor-Lewis, Staff Perception Research Workstream Leader
- ▶ Dr Christian Van Stolk, Literature Review and Call for Evidence Workstream Leader
- ▶ Mr Steve Wood, Internal Communications Leader

### NHS Health and Well-being Review – Advisory Board

- ▶ Professor Dame Carol Black, National Director for Health and Work
- ▶ Mr Peter Blythin, Workforce Director, West Midlands Strategic Health Authority
- ▶ Dr Steven Boorman (Chair), Lead Reviewer
- ▶ Miss Mary Brassington, Head of Occupational Health and Well-being
- ▶ Mr Peter Brown, Health and Safety Executive
- ▶ Ms Liz Carter, NHS Institute for Innovation and Improvement
- ▶ Dr Will Cavendish, Director for Health and Well-being
- ▶ Mrs Clare Chapman, Director-General, Workforce
- ▶ Mr Jim Easton, Chief Executive Officer, South Central Strategic Health Authority
- ▶ Mrs Flora Goldhill, Director, Workforce Capacity and Analysis
- ▶ Dr Patrick Geoghegan, Chief Executive, South Essex Partnership University NHS Foundation Trust
- ▶ Dr Bill Gunneyon, Health, Work and Well-being Executive
- ▶ Dr Bob Grove, Sainsbury Centre for Mental Health

- ▶ **Dr Kit Harling**, NHS Plus
- ▶ **Mr Jeremy Hughes**, National Voices Co-Chair
- ▶ **Mrs Jan Maw**, Royal College of Nursing
- ▶ **Dr Hamish Paterson**, Member, Improving the Health of the NHS Workforce Expert Group
- ▶ **Mr Tim Sands**, Deputy Director Pensions Policy, Department of Health
- ▶ **Ms Julia Scott**, Chief Executive, College of Occupational Therapists
- ▶ **Dr Julia Smedley**, Faculty of Occupational Medicine
- ▶ **Dr David Snashall**, Chair, Improving the Health of the NHS Workforce Expert Group
- ▶ **Ms Kim Sunley**, Senior Employment Relations Adviser, Royal College of Nursing
- ▶ **Professor Alan White**, Professor of Men's Health, Leeds Metropolitan University
- ▶ **Mr Keith Johnston**, Project Manager, NHS Plus
- ▶ **Ms Katy Peters**, Head of Choice and System Management Levers
- ▶ **Mr Mike Pyrah**, Chief Executive, Central and Eastern Cheshire Primary Care Trust
- ▶ **Ms Jane Raven**, Director of HR, Knowsley Primary Care Trust
- ▶ **Miss Jane Riley**, Associate Director of Public Health
- ▶ **Mr Dean Royles**, Workforce Director, North West Strategic Health Authority
- ▶ **Mr Andrew Rundle**, Divisional Manager (Health Policy Development)
- ▶ **Mr Timothy Sands**, Deputy Director, NHS Pensions Policy
- ▶ **Mr Surinder Sharma**, National Director of Equality and Human Rights
- ▶ **Mrs Lyn Simpson**, Director of Operations, NHS Finance, Performance and Operations

### **NHS Health and Well-being Review – Reference Group**

- ▶ **Mr Martin Barkley**, Chief Executive, Tees, Esk and Wear Valleys NHS Foundation Trust
- ▶ **Dr Steve Bevan**, Managing Director, The Work Foundation
- ▶ **Mr Steve Bunce**, Physiotherapy Manager, North Bristol NHS Trust
- ▶ **Ms Karen Charman**, Head of Employment Services, NHS Employers
- ▶ **Miss Catherine Deakin**, Executive Officer, Council of Deans
- ▶ **Mr Bob Deans**, Chief Executive, Southampton City Primary Care Trust
- ▶ **Mr Tony Good**, Director of Workforce and Organisational Development
- ▶ **Ms Helen Issitt**, Associate Director of HR, Derby City Primary Care Trust
- ▶ **Mrs Rebecca Smith**, Associate Director of Strategic HR
- ▶ **Mr Paul Sutton**, Chief Executive, South East Coast Ambulance Trust
- ▶ **Mrs Julie Waldron**, Chief Executive, Oxfordshire Mental Health Trust
- ▶ **Mr Stephen Welfare** (Chair), Workforce Director, East of England Strategic Health Authority
- ▶ **Mr Rob White**, Portfolio Manager, North East Strategic Health Authority

### **Improving the Health of the NHS Workforce Expert Group**

- ▶ **Ms Claire Armstrong**, Department of Health, Workforce Directorate
- ▶ **Dr Anil Adishes**, Occupational Physician
- ▶ **Ms Margaret Barrett**, representing NHS Employers



- ▶ **Mr Robert Baughan**, representing UNISON
- ▶ **Professor Dame Carol Black**, National Director for Health and Work
- ▶ **Dr Steven Boorman**, Director of Corporate and Social Responsibility, Royal Mail
- ▶ **Ms Clare Chapman**, Director General, NHS Workforce
- ▶ **Ms Nicky Coates** (Secretariat), Faculty of Occupational Medicine
- ▶ **Dr Kit Harling**, NHS Occupational Physician and Director of NHS Plus
- ▶ **Ms Cathy Harrison**, Occupational Health Nurse, representing Department of Health
- ▶ **Professor Matthew Hotopf**, Occupational Psychiatrist and Epidemiologist, London
- ▶ **Dr Paul Litchfield**, Occupational Physician and Chief Medical Officer, BT Group
- ▶ **Dr Ira Madan**, NHS Occupational Physician and Director of Clinical Standards, NHS Plus
- ▶ **Dr Geraldine Martell**, NHS Occupational Physician, Cambridge
- ▶ **Ms Mandy Murphy**, NHS Occupational Health Service Manager, representing ANHONS
- ▶ **Professor Sir Anthony Newman-Taylor**, Deputy Principal, Faculty of Medicine, Imperial College London
- ▶ **Dr Hamish Paterson**, NHS Occupational Physician, Newcastle and Chair of ANHOPS
- ▶ **Dr Roger Pollard**, NHS HR Director
- ▶ **Dr Julia Smedley**, Faculty of Occupational Medicine
- ▶ **Dr David Snashall** (Chair), NHS Occupational Physician, London
- ▶ **Dr Tony Steele-Perkins**, NHS Occupational Physician, Somerset
- ▶ **Ms Kim Sunley**, representing Royal College of Nursing
- ▶ **Dr Eugene Waclawski**, NHS Occupational Physician, Scotland
- ▶ **Ms Eileen Walsh**, NHS Trust Director of Assurance, London
- ▶ **Dr Sian Williams**, NHS Occupational Physician, London and Head of Occupational Health Clinical Effectiveness Unit

## **APPENDIX 4: Technical appendices**

As part of the review, a number of research reports were commissioned. These are listed below and can be found on our website at: [www.nhshealthandwellbeing.org](http://www.nhshealthandwellbeing.org).

- ▶ Staff Perception Research: Quantitative Research, RAND Europe
- ▶ Staff Perception Research: Qualitative Research, Boorman Review Team
- ▶ Call For Evidence Summary, The Work Foundation and RAND Europe
- ▶ Literature Review, The Work Foundation and RAND Europe
- ▶ Business Evaluation Model, The Work Foundation and Aston Business School

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