

NHS Workforce Health and Wellbeing Review

NHSHealthandWellbeing
the Boorman review

Call for Evidence

August 2009

Prepared for the Department of Health



the work foundation



EUROPE



Aston Business School

To : Boorman Review
From : RAND Europe Project Team
Subject : Call for Evidence: overview of responses
Date : July 2009

1. Introduction

The promotion and improvement of the health and wellbeing (H&WB) of NHS staff has been a long term objective for the Department of Health and the NHS employing organisations. It is widely understood that the health and wellbeing of the workforce makes a major contribution to the delivery of high quality health care.

The independent Boorman Review, announced in November 2008, aims to produce a series of practical recommendations to improve health and wellbeing across the NHS workforce.

Against this background, The Work Foundation led a partnership with RAND Europe and Aston Business School undertaking the research and analysis to support the review. RAND Europe led on the synthesis of the ‘call for evidence’ presented in this memo.

As part of this review, a call for evidence from stakeholders, staff and employers was issued. A website was created through which submissions could be made to the review. The Review Team estimates that there were around 100 separate submissions in response to this call for evidence.

This memo presents the analysis of the responses and the key themes and messages emerging from that analysis.

The Work Foundation is the leading independent authority on work and its future. It aims to improve the quality of working life and the effectiveness of organisations by equipping leaders, policymakers and opinion-formers with evidence, advice, new thinking and networks. RAND Europe is an independent not-for-profit policy research organisation that aims to serve the public interest by improving policy-making and informing public debate. Its clients are European governments, institutions and firms with a need for rigorous, impartial, multidisciplinary analysis. Aston is one of Europe’s top business schools. Aston has an excellent reputation for innovative, ground breaking research.

2. Approach and methodology

RAND Europe used the software NVivo to undertake the analysis of these responses. The responses were imported into NVivo so that the submissions from each

individual respondent were stored together. Once in NVivo, responses could easily be read and ‘coded’.

Analysis and coding of responses

The following questions posed by the Review were used as the initial structure for analysis:

1. What do you think are the barriers to the implementation, or long term success of health and wellbeing practices and initiatives? What examples, evidence or reasons can you provide?
2. Do you have any statistical data or information relating to staff health and wellbeing in the NHS that you could submit? This may include, but not be limited to, sickness absence rates and the reasons for absences, and the impact of poor health on work performance.
3. Do you think workplace health and wellbeing practices and initiatives – whether driven by occupational health, management or HR – make a positive difference to staff? If so, do you have any evidence to support this?
4. Is there evidence of inconsistencies in the way staff health and wellbeing are supported and delivered across the NHS? If so, do these inconsistencies lead to inequalities in the ability of different staff groups to access health and wellbeing support and services, and are there varying outcomes as a result?
5. Do you have evidence relating to effective short term measures to improve staff health and wellbeing? What could be done to improve staff health and wellbeing in the long term?
6. What evidence do you have of NHS workforce understanding, perception, and experience of using occupational health services? What should be done to improve staff experience, perceptions or the effectiveness of these services?
7. What should ‘success’ for NHS staff health and wellbeing look like? How should it be measured?
8. How can managers and leaders across the NHS be motivated to take action to ensure that sustainable improvements are made to staff health and wellbeing in their organisation? What data or incentives should form part of the business case for change?

In addition, some respondents answered the following question, instead of question 1¹:

¹ It appears that those who submitted responses other than through the website had a slightly different set of questions, which included question nine instead of question one.

9. Do you have any examples of current or past health and wellbeing practices that have not been successful? What impeded their success?

Below this overarching structure, the sub-categories for the analysis were taken from the responses themselves. Rather than having a list of ideas or categories in advance, the ideas and categories were allowed to ‘emerge’ from the data – thus ensuring that respondents’ ideas and arguments guided the identification of themes.

Sub-categories for analysis were identified by reading through the responses and drawing out ideas and themes. Once a final list of categories had been identified the responses were read through and coded a second time to ensure consistent coding.

Counting and ranking responses

Findings from the analysis are presented below. For each sub-category or theme the number of respondents who mentioned that theme is given. Whilst a careful and systematic approach was taken to coding each response, these numbers should be taken as indications as to how popular a particular response was. It is inevitable that analysis of qualitative data relies upon the interpretation and grouping of responses by individual reviewers.

Nature, quality and reliability of the responses

The majority of submissions were based upon respondents’ opinions – supported or informed by their personal experience and professional knowledge. Some responses were based upon experience of particular health and wellbeing initiatives whilst others were based upon statistics from respondents’ service or trust area. We treated the responses as valid and reliable to the extent that they were given by well-informed individuals with knowledge of the subject of the Boorman Review. However, no claims to generalisation or representativeness can be made.

Statistics given in responses were treated cautiously in the analysis, since they could not be verified in any way. Often the sources from which data or information were taken were not cited. A more detailed analysis and interpretation of information and statistics would also require additional, contextual information which was not included in most responses.

Who responded?

In total, RAND Europe analysed the responses from 154 different respondents. Many respondents made more than one submission (for example, responding to the questions posed by the Review, submitting additional documents as well as being in email contact with the review team). The table below shows who the respondents were. Not all respondents gave an answer to every question, and on some occasions respondents’ answers did not address the issue in the question. 15 respondents entered contact details into the website, but did not then provide any responses to the consultation questions.

Table 1: Respondents to the call for evidence

Category	Number of respondents
Academics	7
Ambulance	4
Anonymous	3
Charity	7
Department of Health	2
Department for Work and Pensions	1
Health and Safety Executive	1
Food Industry Body	1
Local Authorities	10
NHS staff	90
NHS Employers	3
Patients' Organisation	1
Private sector	10
Professional bodies	7
Royal Colleges	5
Staff Unions	2
TOTAL	154

3. Findings from the analysis of the responses

Question 1: What do you think are the barriers to the implementation, or long term success of health and wellbeing practices and initiatives? What examples, evidence or reasons can you provide?

Question 9: Do you have any examples of current or past health and wellbeing practices that have not been successful? What impeded their success?

We analysed 59 responses to question 1 and 27 responses to question 9.

Management support, capability and training

The support of managers was widely perceived as crucial amongst respondents. Twenty nine respondents said lack of support from managers was a barrier to health and wellbeing initiatives. Managers were often ill-informed about issues relating to wellbeing and did not perceive health improvement as a priority.

A major barrier is a lack of senior management buy-in and a subsequent lack of ownership at all levels of management. It is important that the strategy is seen as an organisational vision rather than the sole responsibility of occupational health providers

Respondent, ANHONS

Research carried out in the NHS as part of the Health at Work in the NHS programme, run from 1992 to 2002, showed that action to improve staff health and welfare was most successful where it was high on the management's list of priorities and where the action taken was integrated with other management action

Respondent, NHS Employers

Managers are in a good position to identify actual and potential health problems suffered by staff (for example, managers are likely to know whether staff are stressed, overworked or unwell) and thus identify a need for intervention.

The attitude of managers can affect the take-up of occupational health and other services to which staff are entitled.

As a service, 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

Respondent, NHS staff

Support from senior managers ensures health and wellbeing initiatives are well resourced and promoted.

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

Respondent, Public Health Specialist, NHS Staff

One respondent submitted findings from his doctoral work in response to the call for evidence,² which indicated that inconsistency in management approach and style could itself contribute to staff stress, as could poor relationships between managers and staff.

² Morris, M. (2003) *Health at work in the NHS Confliction or Congruence?* Unpublished PhD Thesis, University of Manchester.

Resources

It is perhaps not surprising that a lack of resources was one of the most frequently mentioned barriers to health and wellbeing (18 respondents); there was simply not enough money for initiatives or to subsidise services.

There was some perceived competition for resources between patients and staff, although several respondents commented that managers failed to realise the potential future cost savings and benefits to patient care of resourcing health and wellbeing initiatives for staff.

Recently we commissioned an audit of all the NHS trusts in London. This audit was undertaken in order to establish current workplace health and wellbeing practices within London trusts. As part of the audit we asked trusts what the barriers were to implementing workplace health and wellbeing initiatives. Lack of staff time and lack of funding were the two key barriers cited by trusts

Respondent, Regional Public Health worker

Management and organisational culture

Some senior executives and managers were felt to lack genuine commitment to health and wellbeing. The culture of the NHS was one in which meeting targets and key performance indicators were the top priority. This was mentioned as a barrier to health and wellbeing by 13 respondents.

As far as the Ambulance Service is concerned the main barrier to health and wellbeing practices and initiatives is the culture and practice borne from being 'target-led'. Specifically the pursuit of the eight minute response time for 'perceived' life threatening calls at the expense of all else

Respondent, ambulance service

NHS management is too busy attending to other agendas such as meeting targets

Respondent, Local Government

A culture of long hours and high work loads, driven by senior management ('*spread from the board down*' – Respondent, NHS staff), was mentioned by three respondents in answer to question 1 and by one respondent in answer to question 9.

[We] need 'buy in' at every level - good initiatives are not appropriately 'mirrored' in the behaviours and attitudes of senior staff

Respondent, Royal College of Nursing

Another way in which organisational culture operated as a barrier to health and wellbeing was through the working practices and systems it perpetuated. In response to question 9, one respondent reported the need for broader cultural change, other respondents felt that health and wellbeing initiatives often failed to address underlying, systematic problems stemming from the working culture and were not tied into the '*bigger strategic picture*' (Respondent, Professional Body):

Whilst organisations are readily able to assist individuals suffering from difficulties [there is] often a reticence to look at deeper organisational/systemic issues that would need to be addressed for the issues to be dealt with more proactively, and preventatively, within the context of a 'whole systems' organisational culture approach

Respondent, Clinical Psychologist, NHS

Three respondents referred to bullying, which in their opinion was a facet of organisational culture. Bullying was found both to cause stress and to inhibit the take-up of health and wellbeing services. One respondent whose submission to the included a general submission, in addition to responding to the specific questions, urged the Review Team to specifically address issues of bullying, given evidence³ that its prevalence is increasing.⁴

Constant organisational change was mentioned by one respondent as a barrier both because it causes stress, and because it disrupts health and wellbeing initiatives.

Staff time and culture

The culture of front line staff might also act as a barrier to health and wellbeing, according to 19 respondents. Staff did not always take up opportunities to engage in activities. This was largely to do with time constraints; shift workers may be unable to attend health and wellbeing services or staff may simply be too busy to attend, even during a lunch break.

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 ... The concept of coming to work and being allowed some time off to pursue health and wellbeing activities every month and the activities being either free or at a really reduced cost was alien to staff and managers

Respondent, Wellbeing Advisor to a PCT

... people need extra time to take part in WPH activity ... we offer an additional half hour once a week to the lunch break for staff to use our leisure centre, or to take part in an organised activity

Respondent, Local Government

Unfortunately most staff were just too busy with clinical work to attend even a short lunchtime session.

Respondent, Lead Consultant Occupational Health Physician

3

⁴ This respondent cited The Healthcare Commission's 2007 survey, and referred the Review to a study on effective ways to reduce bullying being conducted in Kings College Hospital NHS Foundation Trust in conjunction with Institute of Health Research (Contacts: Chris Woodrow and David Guest).

Questions over what works

The lack of firm evidence about the effectiveness of health and wellbeing initiatives, in terms of long term improvements in health, attendance, productivity etc. was mentioned by about 12 respondents as a barrier to implementation and promotion of these initiatives.

[There is a] lack of strong underpinning evidence ... including longitudinal studies and cost benefit/cost effectiveness evaluations. There is a lack of clarity around the benefits for the employer, employee, for society as a whole and very importantly in the NHS, for patients

Respondent, DWP

[It is] unlikely the NHS will spend serious money on initiatives for staff unless there is firm evidence that improving their health and well being will improve their productivity or enable cheaper or better quality care to patients

Respondent, Occupational Health Physician, NHS staff

Additionally, four respondents mentioned the lack of a clear definition of health and wellbeing as a barrier. Linked to this, some believed that the aims of health and wellbeing policies were not always clear:

Research also indicated that a major barrier to the successful introduction of healthy workplace policies was the failure to identify what the aims of the policies were. There was much use of the terms health promotion, health and safety and occupational health, indiscriminately and interchangeably, and a lack of integration of the various activities

Respondent, NHS Employers

In their submission, the Royal College of Physicians argues that a fundamental problem with previous reviews of the health of the NHS workforce was the failure to embrace a formal implementation and evaluation strategy. They 'believe it is imperative that the Boorman review includes rigorous, independent evaluation of its recommendations' and they support the creation of longitudinal studies of cohorts of NHS workers. They suggest an audit methodology developed by their Occupational Health Clinical Effectiveness Unit as a model for auditing strategies for improving the health and wellbeing of NHS staff.

Initiative overload: a plethora of programmes and information.

Nine⁵ respondents mentioned too many short term, ad hoc initiatives as a barrier to health and wellbeing in response to question 1.

There is a huge amount of official guidelines, inspections and standards relating to health and wellbeing. These originate from a multiplicity of local and national organisations. For example, one respondent mentioned: NICE; NHS Plus;

⁵ Four in response to question 1, one in response to question 9.

occupational health CEU; POSHH; PMETB QA program; ANHOPS collaboration; FOM CPD process; the HSE; FOM; RCGP guidelines on back pain.

The sheer number of different initiatives (and sometimes their short life span) acts as a disincentive to staff participation and means that interventions do not have time to bed down or to be evaluated. There was concern that health and wellbeing measures were introduced as a “*knee jerk reaction*” (Respondent: Occupational Health, Local Government).

NHS initiatives for staff seem to be flash in the pan -- what happened to Improving Working Lives etc; what about the old NHS Health Education people: sometimes seems nothing ever gets followed through long term

Respondent, occupational health physician, NHS staff

Initiative fatigue - there are too many initiatives for participation ...

Respondent, Ambulance Trust

A similar point was made by one respondent answering question 9 who reported that ‘*one hit activities like no-smoking days*’ were not successful (Respondent, Royal College of Nursing).

The need for services to be responsive

Initiatives to improve health and wellbeing must be based upon a good understanding of the health needs of staff, and three respondents felt that this was often not the case. Different groups of staff have different health needs, their work patterns and roles mean that they need to be able to access services at different times and at different locations. One respondent said that online interventions such as “VieLife” are not appropriate for all, since many staff did not find time to access the internet.

Some of the initiatives launched are seen as being not relevant.

Respondent, NHS staff

What is required in the way of health and wellbeing interventions/practices needs to be assessed before measures are introduced

Respondent, Local Government

Staff Engagement

The term ‘staff engagement’ was mentioned frequently by respondents in their answers to a number of questions. In relation to the barriers to health and wellbeing, it was mentioned by nine respondents. Staff engagement is needed not only to inform staff about the services which are on offer (several respondents mentioned poor marketing or promotion of available services), but also to encourage staff to be involved in decisionmaking about those services.

Employees need to be engaged in the process through good communication systems. They need to see the benefits and advantages to them personally, of the initiatives being provided.

Respondent, Local Government

Staff engagement is tricky particularly if staff feel stressed and under pressure. Often 'not having enough time' is cited as a barrier and the mindset needs to change to allow for a culture where staff can see the benefits of time away from the desk for example for 30 minutes or so at lunchtime. Staff must be consulted at the development stage in order to promote ownership and involvement with the work. Health and wellbeing initiatives must be done with staff and not to staff.

Respondent, public health specialist, NHS

Problems with occupational health

Nine respondents mentioned the capacity of occupational health or the quality of services delivered by occupational health as a barrier to health and wellbeing. One commented that there had been insufficient investment in occupational health services, and another mentioned that doctors and nurses find it hard to develop skills in occupational health when working in small units.

There is anecdotal evidence that OH services are vulnerable to restructure, poor planning and cost reduction requirements. The ... following examples ... have been cited by members: Two trusts merged in the south of England and instead of expanding the budget to cover the larger workforce, equity of service delivery was achieved by cutting the OH physiotherapy service; Two trusts using a common occupational health service have implemented physiotherapy for their two workforces, who work alongside one another; one providing a 2-day fast-track access to physiotherapy whilst the other places staff on a several week waiting list.

Respondent, Professional Body

The need for occupational health services to be more multi-agency was stressed by three respondents, who called for increased integration between health and social care (mentioned specifically in relation to staff with disabilities) and the development of a more 'coherent' view of staff (taking into account physical, health, mental health and family circumstances, for example). A submission by the Faculty of Occupational Medicine (in addition to responses to the questions) stressed that the importance of 'positive case management by occupational health practitioners, in close liaison with Human Resources and line managers'.

Other responses

One respondent wished to draw attention to the impact of demographic change, particularly an ageing workforce, and the challenges this would pose. Two respondents mentioned that lack of flexible working and return to work arrangement were barriers to health and wellbeing, another mentioned a lack of health and safety training for staff.

Question 2: Do you have any statistical data or information relating to staff health and wellbeing in the NHS that you could submit? This may include, but not be limited to, sickness absence rates and the reasons for absences, and the impact of poor health on work performance?

We analysed 80 responses to this question. To provide an overview of responses we describe the kind of statistical information which respondents said was available.

Sickness absence

Twenty three respondents specifically mentioned that they collected and could provide sickness absence data. Many respondents talked about changes in sickness absence over time, and how this had been used to evaluate local measures and initiatives or to make comparisons with other trusts or the private sector.

Reasons for absence

Compared to information about absence rates, information about the reasons for absence appeared to be less systematically collected. Nine respondents said they could provide information about the reasons for absences.

Data about staff health and local wellbeing and activities

Eight respondents said that they had information about the health of staff within a trust or across a number of trusts. Data were available on indicators such as obesity levels, Body Mass Index, units of alcohol consumed, smoking, cholesterol, levels of stress and so on. This resulted from sources include health screening programmes, annual 'workforce health' reports, and exit interviews.

Fourteen respondents expressly mentioned the existence data about the users of local health and wellbeing services, including the numbers of people using the services, their underlying problems and characteristics, and the reasons why they accessed or were referred to a service.

Nine respondents said that they had some data about the impact of local health and wellbeing services – including from anecdotal accounts, case studies, user feedback and return to work rates. One respondent provided information about cost savings from services (although this was on a case study basis for individual service users).

Research, academic data and reports

Eleven respondents pointed to information in the public domain from academic studies, studies or reports published by their own organisation or trust (for example, reports by organisations representing NHS employees), or by other organisations. A respondent from an external consultancy could provide information collected during the course of their work with different trusts:

We have worked with large NHS trusts and have generated statistical evidence that correlates different components of staff wellbeing with drivers of absence, commitment levels and intentions to quit.

Respondent, Private sector

Staff satisfaction surveys

Stress levels, job satisfaction, perceived support from managers, staff lifestyle information and the work-relatedness of ill health were all factors which respondents said could be estimated from staff surveys. Ten respondents referred to local staff surveys.

Need for more data

Several respondents reported that their trust area have plans, or a desire, to collect better data about sickness absence. Such data will be more comprehensive (i.e. relate to all staff in an area) and more detailed (e.g. look at the causes sickness absence).

Question 3: Do you think workplace health and wellbeing practices and initiatives – whether driven by occupational health, management or HR – make a positive difference to staff? If so, do you have any evidence to support this?

We analysed 93 responses to this question.

Overwhelmingly positive responses

The responses to this question were overwhelmingly positive – the vast majority of respondents (84) thought that workplace initiatives could have a positive effect. There were five negative responses. Three of these citing negative personal experiences of health and wellbeing services, one citing a lack of empirical evidence and another expressing cynicism that unhealthy staff who were most in need of interventions would take up available services. One respondent also expressed concerns that health and wellbeing initiative were ‘PR exercises’ that were superficial and failed to address the underlying causes of poor health.

Yes and ‘yes, but’ responses

Most responses were ‘yes’ or ‘yes, but’ - the latter adding caveats about the need for sufficient funding, effective implementation, a supportive organisational culture, management support, service uptake, targeting of initiatives and the difficulty of demonstrating effectiveness.

The counselling service makes a difference in those staff who use it but it is under funded and under utilised as only by self referral.

Respondent, NHS Staff

The grounds on which respondents answered this question in the affirmative were commonly personal experience or anecdotal evidence (mentioned by 35 respondents), the following is fairly typical:

Yes I believe workplace health and wellbeing strategies make a positive difference to staff emotionally, psychologically and to the general morale of the workforce. Personally we do not have any evidence to support this as we are in the very early stages of forming our own

strategy regarding this area, but I have heard sufficient case studies from both Private and public sectors to understand the positive difference it can help to make

Respondent, Service Manager, Occupational Health Service, NHS Trust

Based on attendance, staff appear to welcome these events, however whilst it can be difficult to ascertain with complete certainty the impact on physical, mental and social well-being we do believe these activities can have an immediate and longer term positive impact

Operational Manager, Occupational Health Service, NHS Trust

Thirty respondents cited some other kind of evidence (not always quantitative or verifiable) such as staff satisfaction surveys, feedback from users of health and wellbeing services, local absence rates, academic studies and case studies of successful interventions from within the NHS and from the private sector.

For a number of years I managed a staff counselling service, organised within a NHS Trust. I have no doubt that this service was of value to many individuals

Respondent, psychologist, NHS staff

When [a health and wellbeing] project was started the organisation was undergoing a large organisational change and some staff were unsure whether it was just a gimmick to see the staff through the bad times. However staff can now see this is here to stay and is embedded in the culture. New staff actually comment they have never worked at an NHS organisation where they really do care for you

Respondent, NHS staff

As part of the audit into workplace health and wellbeing practices within NHS trusts we undertook some case studies. Case study information was gathered through telephone interviews and focus groups. Through this process a number of trusts highlighted that establishing a healthy workplace ethos and offering a range of interventions to employees was well received by staff, particularly during periods of organisational change where staff were under greater levels of pressure. It also resulted in a change in staff behaviour i.e. an increase in the proportion of staff choosing active travel methods to work, which in turn has a positive impact on an individuals' physical and mental health.

Respondent, Regional Public Health worker

One respondent pointed to the NICE review of long term sickness absence and the current NICE review Promoting Mental Wellbeing in the Workplace. The submission from the British Medical Association highlighted work undertaken by its Occupational Medicine Committee (OMC) which has published The Occupational Physician booklet, which promotes the need for better access for workers to occupational health and provides advice and support to those practicing occupation medicine.

Question 4: Is there evidence of inconsistencies in the way staff health and wellbeing are supported and delivered across the NHS? If so, do these inconsistencies lead to inequalities in the ability of different staff groups to

access health and wellbeing support and services, and are there varying outcomes as a result?

We analysed 79 responses to this question. Only five respondents thought that inconsistencies were *not* a problem (and one of those was referring particularly to equality of access within their own trust). Of the majority (70 respondents)⁶ who did think there was a problem, we can distinguish concerns about inconsistency *between* trusts and *within* trusts.

Between trusts

Respondents were clear that there were considerable differences in health and wellbeing provision across the NHS (although, as one respondent put it, many submissions stressed that there is no 'NHS' – '*there are four health systems, each operating differently and in England over 250 trusts and PCTs each with diverse approaches to health and well being*' (Respondent, NHS GP).

Respondents reported that different PCT areas have quite significantly different levels of staffing and resources for health and wellbeing. Culture and management support also varied, as did waiting times for occupational health services, the range of services and interventions available, whether those services were provided on-site, and the way that health and wellbeing services were structured.

The opinion that there were inconsistencies between areas was born out by findings from a number of reports and audits which respondents referred to:

- One respondent cited reports from the Audit Commission in 2002 and Auditor General for Wales which found wide variation in investment in health of NHS staff⁷.
- Another referred to Audits conducted by NHS Plus on back pain and mental health which show differences in health and wellbeing between Trusts.
- The NHS Staff Survey was also cited as providing evidence of variations in the availability of occupational health services.
- Faculty of Occupational Medicine referred to the first national audits of occupational health practice in the NHS, carried out by the Occupational Health Clinical Effectiveness Unit (OHCEU), which have provided evidence of variation in resourcing of NHS OH departments, with a large range in annual OH budget per head. The audits suggest that access to certain services vary between trusts (e.g. physiotherapy services for those with musculoskeletal disorders and counselling or cognitive behavioural therapy for those with mental ill health).

⁶ One respondent did not refer to inconsistencies in their response to this question.

⁷ No references were given to these reports.

One matter upon which some respondents appeared to disagree is the extent to which there should be uniformity in health and wellbeing services. The submission from the Health and Safety Executive reported that although they have found that staff health and wellbeing services are delivered differently across the NHS, *‘inconsistencies in approach are to be expected across such diverse organisations, and as such are not a matter for concern’*. They suggest that the autonomy of trusts in the field of staff health and wellbeing services might provide the opportunity to adopt *‘unique management approaches’*. Along similar lines another respondent acknowledged that:

As separate employers, NHS Trust’s are distinct from one another demographically and must therefore develop local practices to support essential local needs. This is therefore not an issue of inequality; rather it is about managing their activities to meet the local culture and roles of the employer

Respondent, Human Resources, NHS Trust

On the other hand, several respondents noted and criticised the lack of minimum requirements, absence of service-level agreements, and the general lack of standardisation in health and wellbeing services. There was a feeling that it would be helpful if there were some core standards and services which should apply across the organisation.

I know that a neighbouring trust has two WTE clinical psychologists for its staff ... we have one WTE counsellor with CBT training ...[the] numbers of staff [are] approximately equal. Another neighbour has two WTE counsellors to approx same staff

Respondent, NHS staff

Health and wellbeing initiatives in the NHS are patchy and limited. All NHS staff should have access to an occupational health service but the quality and extent of these is enormously variable

Respondent, Occupational Physician, NHS

The first national audits of occupational health practice in the NHS (carried out by the Occupational Health Clinical Effectiveness Unit (occupational healthCEU)) have provided evidence of variation in resourcing of NHS occupational health departments, with a large range in annual occupational health budget per head (Inter-quartile range £51-£93). Our impression from the occupational healthCEU audit conferences and related feedback is that access to certain services varies e.g. physiotherapy services for those with musculoskeletal disorders and counselling or cognitive behavioural therapy for those with mental ill health

Respondent, academic

This is a major issue for the NHS. It is left to each employer to decide what services should be provided to staff, including occupational health services. There is no national ‘minimum service requirement’ guidance to the 400+ employers who make up the NHS

Respondent, NHS Plus

The current fragmentation of OH provision, without common standards and practices, inevitably creates poor provision in some cases and good provision in others

Respondent, Association of OH Nurse Practitioners

Within trusts

There were also significant variations within trusts. Staff based at different locations across a trust - sometimes not based in PCT premises or based in the community - had different distances to travel to access services. Staff working side-by-side but for different employers had access to different provisions. Shift work, high workload, staff shortages and the fact that many staff do not have regular access to email were all mentioned as barriers to some groups taking up health and wellbeing services.

We have multiple sites in our organisation and although everything we offer applies to all staff, not all staff are or feel able to access everything

Respondent, HR Manager, NHS trust

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

Respondent, NHS staff

One respondent drew attention to the potential for health inequalities between professional staff and ‘*low priority for support staff like domestics or porters [and] ... the plight of migrant workers whose job insecurity in the NHS makes them more open to exploitation or bullying*’ (Respondent, Professor of Public Health). A respondent working in human resources for an NHS trust reported that her service is increasingly realising that a ‘*one size fits all approach*’ is inadequate, and that an approach which is tailored to gender, age, culture, and so on, is needed. This view was supported by the submissions from UNISON and from the Men’s Health Forum which highlighted gender differences in the prevalence of health and wellbeing problems.

Question 5: Do you have evidence relating to effective short term measures to improve staff health and wellbeing? What could be done to improve staff health and wellbeing in the long term?

We analysed 77 responses to this question. Thirty two respondents specified short term measures, 40 specified long term measures, and 48 did not specify whether the measures they suggested were short or long term. Some respondents were wary of any short term measures, fearing that they might encourage initiatives which achieved ‘quick wins’ but did not address more difficult or underlying problems (Respondent, Royal College of Nursing).

Management Support

Improving management and senior executive support, though making health and wellbeing more important to managers and improving their training, was the most frequently given response to this question – mentioned by nine respondents as a

short term measure, by ten respondents as a long term measure and by 15 respondents who did not specify short or long term.

Respondents perceived that some people in management positions had no formal management training, and that this inhibited their ability to prevent work-place health problems, conduct proper risk assessment, manage absence, recognise stress, and so on. Respondents called for managers to receive training on health and wellbeing to improve their ability to spot the signs of health problems and deal with them in a proactive and supportive way.

I remain of the view that quality leadership and quality management is very important -- how many NHS managers have formal management qualifications?

Respondent, Occupational Physician, NHS Trust

Better training of Managers re[garding] their responsibilities in health and well being, preventing work place health problems including risk assessment and the management of sickness absence cases. Managers are sometimes promoted into positions without any management training - a good Nurse or Physiotherapist does not necessarily make a good Manager

Respondent, Head of Occupational Health for an NHS trust

There needs to be a commitment to compulsory management training for all staff with supervisory/management responsibilities, on dealing with the 'human' side of management e.g. fair and professional approach to sickness absence management and performance management, and how to apply evidence based principles of control, demand and support

Respondent, Royal College of Physicians

Line managers need more support, training and development on a number of issues (absence management, rehabilitation, flexible working options disability discrimination, performance management etc) and be given the time to effectively manage their staff. Investment in management training and time to manage, will free up occupational health time and allow them to focus on prevention

Respondent, NHS Employers

Staff engagement

Staff engagement and communication was mentioned by five respondents as a short-term measure, by three respondents as a long term measure, and by seven respondents who did not specify long or short term. Staff are more likely to participate in initiatives which they have had some role in planning, which they know they are entitled to use, and of which they feel a degree of 'ownership'. Staff should be engaged in organisational change processes which aim to improve health and wellbeing.

We also attach every month to the wage slips a HWB newsletter ... [this] gives advice on a health topic and ... will give the programme of events for the forthcoming month ... This actually gets received by every staff member.

Respondent, Wellbeing Advisor to a PCT

In the short term, it is necessary to ensure that the messages in public health campaigns are being understood and implemented by healthcare professionals.

Respondent, HEART UK

It must be remembered that health and well-being is not something that employers do to staff; they do it with staff.

Respondent, Local Government Employers

HSE is also of the view that greater workforce involvement helps improve staff health and well-being through the generation of ideas and discussion of approaches to particular problems.

Respondent, Health and Safety Executive

In the short term we need to engage with staff and listen to what they want to improve health and wellbeing in the workplace. It is likely to have a greater impact if they are engaged.

Respondent, Occupational Health Consultant, NHS

Benchmarking and research

Three respondents thought that better use of available data to understand and benchmark health and wellbeing should be used in the short term, one respondent mentioned this but didn't specify whether it was a long or short term measure and three respondents suggested this as a long term measure. Another suggested that annual staff surveys should be amended to capture better data about changes in health over time and the relationship between staff health and organisational factors. Linked to this, five respondents said that more research and evaluation was needed in the long term to investigate the effectiveness of interventions.

[there is] no need to re-create the wheel in terms of frameworks and systems already in place, but there is a need to be smarter in having objectives and evaluating the effectiveness of measures.

Respondent, Occupational Health Physician, NHS

In the long term it is important to gain additional information about NHS worker health so there is improved evidence on NHS worker health and evaluation of measure[s] that improve health

Respondent, Occupational Health Consultant, NHS

Improving the quality and quantity of occupational health, occupational therapy and health and wellbeing services

Health and wellbeing services should be well-resourced, proactive and provide integrated case management - nine respondents recommended this in the long term and another ten respondents recommended it without specifying whether it was a short or long term measure and six mentioned it as a short term measure.

One respondent said that occupational health services should be staffed by better qualified practitioners and ‘embedded’ within the NHS and another said that occupational health should be open for ‘walk in’ patients (this respondent did not specify whether this was long or short term). The role of occupational therapy was stressed by one respondent.

We would like to see multidisciplinary, competent and well resourced occupational health services which include physiotherapists, OTs, counselling, occupational therapist, health promotion experts, and health and safety specialists as well as nurses and physicians ... occupational health services should also focus on health and wellbeing and develop links between the local health economy for delivering or accessing health and wellbeing options

Respondent, NHS employers

There is a need to invest in multidisciplinary occupational health services pulling together the expertise that exists with in the NHS. Services should provide expertise in case management, rehabilitation and support fast tracking ... Occupational Health services should also provide a strategic lead on the prevention of ill health and promotion of wellbeing

Respondent, Royal College of Nursing

With their knowledge and skills Occupational Health specialists could be well-placed to support health and wellbeing initiatives, co-ordinate an organisations approach to health and wellbeing issues and facilitate links between human resources, managers and risk managers, as long as they appropriately resourced for this role

Respondent, Occupational Health Consultant, NHS

Other interventions

A host of other interventions were mentioned, as set out in Table 2.

Table 2: Effective interventions to improve staff health mentioned by respondents

Intervention	Number of respondents and whether intervention is short term, long term, or unspecified term.
Fast tracking ⁸	Short term: 3 Unspecified: 4
Increasing the scope for flexible working and phased return to work	Short term: 2 Long term: 3

⁸ One submission to the review noted that there are ‘public relations and local ‘political’ considerations’ around fast tracking NHS staff. (Respondent, Director of Commissioning and Planning, NHS Trust)

	Unspecified: 3
Providing healthy food and drink	Short term: 5 Long term: 3 Unspecified: 3
Smoking cessation services	Short term: 4 Long term: 1 Unspecified: 1
Health checks and screening	Short term: 2 Unspecified: 3
Training in stress management and awareness/ reduce stress	Short term: 6 Long term: 2 Unspecified: 2
Counselling	Unspecified: 2
Interventions for back pain, ergonomics,	Unspecified: 1 Long term: 1
Cognitive behavioural therapy	Unspecified: 1

In addition to these interventions, a number of organisational measures were also suggested, as set out in Table 3.

Table 3: Effective organisational measure to improve staff health mentioned by respondents

Measure	Number of respondents and whether measure is short term, long term, or unspecified term.
Cultural change	Long term: 7 Unspecified: 2
Introducing service level agreements/ national standards for occupational health services	Short term: 2 Long term: 3 Unspecified: 3
Sharing best practice	Short term: 1 Not specified: 1
Making health and wellbeing part of performance indicators	Short term: 1 Unspecified: 2

Preventing over-work (sufficient breaks, work-life balance, prevent staff shortages)	Unspecified:21 Long term: 4
Providing sufficient cover for sickness and maternity	Unspecified: 2
Address problems of bullying	Short term: 1 Long term: 1 Unspecified: 1

Question 6: What evidence do you have of NHS workforce’s understanding, perception, and experience of using occupational health services? What should be done to improve staff experience, perceptions or the effectiveness of these services?

We analysed 76 responses to this question. Thirty six of those were classified as broadly negative and 22 as broadly positive. Three respondents thought that perceptions differed considerably between areas⁹.

Awareness of occupational health services

Twenty one respondents perceived a pressing need to raise awareness amongst staff about the role of occupational health and the services they provide to ensure that staff know what they can and cannot expect. Some staff “*have incorrect expectations of the service so are disappointed when these are not met*” (Respondent, Occupational Physician, NHS).

Users tend to perceive the reactive elements of the service but have less clarity about the more adventurous and less obvious proactive interventions which could potentially be offered.

Respondent, ANHONS

A range of positive and negative responses

There were 22 broadly positive responses. Some of these stemmed from good personal experience with particular occupational health professionals.

My own individual experience is of receiving a good service.

Respondent, Local Government

Occupational health services were reported to be particularly good in some respondents’ employing trusts. Some respondents cited positive feedback from users of occupational health services and positive findings from staff surveys. Other

⁹ Other respondents did not specifically address the issue of perceptions.

respondents expressed confidence that their occupational health services would maintain confidentiality and provide a good service.

Staff feel that they receive a good service from Occupational health and realise that nothing gets disclosed without prior consent. As staff can self refer to the occupational health, physio and counselling services this is never really an issue. Staff feel well supported in this area. They also feel well supported by the Health Well Being and Backcare Adviser.

Respondent, Wellbeing Advisor to a PCT

Many respondents had positive perceptions of occupational health, but added a caveat. For example, some respondents stated that occupational health staff were caring and provided a good service, but that the service was under-resourced, or that staff efforts were damaged by poor management support in other areas of the organisation

I can only say that the staff do sterling work, often in very limited space treatment rooms... physiotherapists that I have used are excellent, caring individuals struggling to provide a quality service in extremely difficult conditions - e.g. lack of privacy as there are only curtains to divide treatment areas.

Respondent, Health Improvement Specialist, NHS

On an individual level, most appreciate the help and advice they receive but there is still suspicion and misunderstanding about the role, particularly amongst those who have not used the service.

Respondent, Occupational Physician, NHS

Among the 36 negative responses there was a perception that occupational health could be used punitively, as a “*management tool*” (Respondent, Professor) or as an instrument of control or moderator of attendance (Respondent, NHS Plus).

Some managers say to staff 'you must improve your sickness absence otherwise I will send you to occupational health.'

Respondent, Occupational Physician, NHS

It is possible that occupational health is seen as punitive rather than supportive - you get sent there if you are off sick. It should be a much more proactive service.

Respondent, anonymous

HSE is aware of a perception amongst some NHS employees that Occupational Health Departments are used as a management tool to keep staff in work, rather than as a source of benefit to themselves.

Respondent, Health and Safety Executive

Respondents complained about the limited range of services offered, about problems with access to occupational health (no telephone helpline, short opening times, poor communication, for example) and about the often unsuitable accommodation for

occupational health services – with little space or privacy. Several respondents mentioned occupational health was too reactive. Concerns about the length of waiting times and breaches of confidentiality were also listed, and one respondent said that the variation in occupational health services across the country reduced staff confidence in the services.

The submission from the Health and Safety Executive referred to an evaluation of Occupational Health services within the NHS in London in 2004, which found that there seemed to be little use of occupational health needs analysis or risk assessment to determine what kind of service was required for each trust, that staffing levels varied across the trusts, and that OH provision in the trusts which were surveyed were not performing to the standard set out in Department of Health guidelines.

Question 7: What should 'success' for NHS staff health and wellbeing look like? How should it be measured?

We analysed 86 responses to this question

Vision statements for the health and wellbeing of staff

Many respondents (31) gave a headline statement or overarching vision of success in the first part of their answer to this question, before going on to mention specific measures. These statements referred to staff that feel valued, happy, fulfilled, and so on.

'Success' should look like a proud, dedicated, positively motivated, professional, happy workforce

Respondent, Ambulance Service

'Success' would be happy / healthy / effective / efficient staff

Respondent, Director of Human and Corporate Resources, NHS trust

Staff who are happy and healthy and want to be at work, they view their employer as a good place to work and perceive that their employer supports them in achieving health and wellbeing

Respondent, HR manager, NHS trust

Measures of success

The most commonly suggested measure of success was the level or rate of sickness absence (suggested by 51 respondents), although the sense from the responses was that this was a basic measure used because data on this were habitually collected, which should ideally be supplemented by other measures.

No single measure will assess success for NHS staff health and well-being satisfactorily. Instead it should be measured by a combination of factors, including self-reported health measures from staff surveys and objective measures such as long term absence rates, turnover (changing jobs or leaving for health reasons) and ill health retirement rates.

Respondent, Faculty of Occupational Medicine

Other measures of success mentioned by respondents included:

- Recruitment, retention and staff turnover (20 respondents)
- Ill health retirement rates (six respondents)
- Accidents and injuries at work (nine respondents)
- Levels of stress (eight respondents)
- Levels of smoking/ obesity/ heart problems/ cholesterol etc. (seven respondents)

Staff satisfaction and wellbeing surveys were the most commonly mentioned methods of measurement (34 respondents). Some suggested the use of existing surveys, some advocated the addition of questions to currently used surveys, and others believed that specific, new staff questionnaires should be created. One respondent suggested that staff satisfaction statistics should be benchmarked against other organisations or businesses. Another suggested that a health index might be used to measure health and monitor the impact of activities to improve wellbeing (this respondent referred to work conducted by Prof. Cary Cooper at Lancaster Business School).

Question 8: How can managers and leaders across the NHS be motivated to take action to ensure that sustainable improvements are made to staff health and wellbeing in their organisation? What data or incentives should form part of the business case for change?

We analysed 89 responses to this question.

The business case for change

The most popular response, given by 38 respondents, was to promote the 'business case' and the economic benefits of investing in staff health and wellbeing.

Sustainable improvements to staff health and wellbeing should be monitored and correlated with service improvements as and where they occur. The provision of data that demonstrates that improved staff health and wellbeing positively impacts on service provision should be incentive and motivation enough for managers to sustain and value measures that support the workforce

Respondent, Ambulance Service

Being able to demonstrate to managers and leaders the benefits that accrue from improvements to staff health and wellbeing

Respondent, Director of Human and Corporate Resources, NHS trust

We would suggest there needs to be a strong evidence base to demonstrate what wellbeing initiatives result in what benefits for the individual and for the employer

Respondent, DWP

Incentives and performance indicators

The second most common response, given by 32 respondents, related to the use of incentives and performance targets for individual managers and trusts. These included:

- Performance-related pay linked to staff absence or turnover
- Financial incentives for trusts to increase take up of occupational health services
- Inclusion of management of occupational health and H&WB in the measures used to assess trust management and trust performance (KPIs)
- Introduction of a league table of accidents
- Creation of an award for the trust with the ‘best staff health’
- Inclusion of H&WB issues in managers’ appraisals

Awareness, information and training

Eight respondents felt that better training of managers in their responsibilities in relation to the H&WB of staff would be a good starting point, and a further two respondents said that the H&WB of managers themselves should be addressed.

Top-level executives should lead and take action on health and wellbeing initiatives to encourage managers lower down the organisation to fulfil their obligations (two respondents). It was suggested that publishing examples of best practice may help (one respondent).

Occupational health

Five respondents suggested that changes to occupational health services - such as ringfencing budgets, ensuring they are better funded, encouraging a more proactive approach, and introducing service level agreements - might impact upon managers’ attitudes to H&WB.

Larger organisational changes

Shifts in culture were mentioned by nine respondents in relation to question 8. Respondents perceived that only once concern for staff H&WB became ‘embedded’ within the organisation, ‘corporately’ owned, and more strongly protected in the NHS constitution, would individual managers change their attitude and practice.

It [staff health and wellbeing] should factor in all job descriptions of line managers of people, which means that they will be accountable when it comes to engagement, wellbeing, evaluation and appraisal of their staff

Respondent, Assistant Director of Human Resources for an NHS trust

Managers and leaders must align health and well-being strategies with wider business plans and allocate and protect resources to introduce, evaluate, refine and sustain initiatives to promote a culture of health and well-being

Respondent, Chartered Society of Physiotherapy

Some respondents were sceptical about the speed at which this could occur, but others were more optimistic that increased awareness of health and wellbeing and increased publicity for available services could drive change in the organisational mindset.