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Acknowledgements

This report has been co-authored by the trust support team which includes:
- Val Rhodes, Project Manager
- Beth Dodson – Senior Trust Support Officer, NHS Employers
- Carol Hunt – Senior Trust Support Officer, NHS Employers
- Victoria Small – Senior Trust Support Officer, NHS Employers (Sept 2012–July 2013)
- Christine Budd – Senior Trust Support Officer, NHS Employers (July–Oct 2013)

The team wish to acknowledge the involvement of Chris Young [NHS Employers] who created the initial assessment template and user guide prior to the team commencing work in September 2012.
EXECUTIVE SUMMARY

The Department of Health (DH) commissioned a project to reduce sickness absence levels and improve staff health and wellbeing in 102 NHS trusts. The project, known as the Trust Support Project, worked with a cross-section of NHS organisations, including acute, mental health, specialist and ambulance services. The project was part of a series of actions to support NHS organisations achieve the quality, innovation, productivity and prevention (QIPP) target for reducing sickness absence.

The Department of Health’s five high impact changes were used by the project team to assess the current practice of each trust, develop a feedback report to identify areas of strength and development and produce an individual improvement action plan based on local evidence.

A significant amount of good, innovative practice was identified, including:

– the identification of health needs of staff
– performance dashboards linking workforce and patient safety data
– effective use of the Electronic Staff Record (ESR) and e-rostering self-service system with close to real-time reporting
– planning and communicating of initiatives to coincide with national public health campaigns.

Some trusts demonstrated that health and wellbeing was an integral part of delivering trust services, with board members acting as champions or becoming personally involved in health and wellbeing activities. The team also found examples where managerial capacity to take full ownership of sickness absence and staff health and wellbeing was expected and supported, including within the appraisal process and development of core line management skills for aspiring managers.

Eighty-eight per cent of trusts were Safe Effective Quality Occupational Health Service (SEQOHS) accredited or going through the process. The team saw many examples of proactive occupational health departments, the use of staff health and wellbeing champions, a range of locally provided health and wellbeing initiatives and some examples where trusts were encouraging personal responsibility.

However, the project team also found a variable approach to sickness absence management with differing levels of senior support, financial investment and health and wellbeing initiatives in place.

The data available to line managers varied considerably, with some having access to live data from such systems as e-Roster and pro-Roster, and others relying on data around six weeks old. An area identified for further improvement is support for managers to enable them to make the best use of the real-time data.

There were many differences in the quality and quantity of trust-wide data used and how this was presented at board and senior management level, for example what was included in dashboards. A few trusts triangulated sickness absence and health and wellbeing data with wider workforce or clinical data, patient outcomes, temporary staffing and costs, whilst some trusts triangulated sickness absence data with staff survey results and evaluated events and initiatives. Very few trusts included occupational health data and public health priorities in any performance data. In some trusts the use of ‘unknown’ and ‘other known’ ESR sickness reasons (in some cases as high as 30 per cent) skewed their understanding of the top sickness absence reasons, the cost to the trust of each sickness absence reason, and therefore where to focus resources most effectively.

Thirty-two per cent of trusts had branded their health and wellbeing communications and the majority of trusts used a range of communication methods, although most agreed that there was an over-reliance on electronic methods. Very few had made use of social media platforms.
In the majority of trusts there was less evidence of active board engagement in the health and wellbeing agenda. This was demonstrated in the limited range of information presented at board level, limited commitment to funding health and wellbeing business cases and few examples of personal board involvement in local health and wellbeing initiatives.

Based on the findings of the project the team have made 13 recommendations to be considered at local and national level:

**National level**

1. Continue to provide trusts with support and good quality worked examples to develop health and wellbeing strategies.
2. Provide support for trusts to help them evaluate their health and wellbeing programmes to inform future plans.
3. Continue with the focus and drive to improve board engagement on staff health and wellbeing.
4. Develop further support for mental health issues for both staff and managers.

**Local level**

5. Robustly evaluate health and wellbeing programmes to inform future plans.
6. Improve the quality of the sickness absence and health and wellbeing data provided to trust boards.
7. Continue with the focus and drive to improve board engagement on staff health and wellbeing.
8. Make connections between public health data, staff health and GP’s.
9. Focus on embedding staff health and wellbeing into the culture of trusts.
10. Consider how to improve staff training in sickness absence and supporting health and wellbeing.
11. Develop further support for mental health issues for both staff and managers.
12. Extend health and wellbeing into the appraisal process and strategic objectives of the trust.
13. Encourage staff personal responsibility for their own health and wellbeing.
INTRODUCTION

In 2009 Dr Steve Boorman led a review into the health and wellbeing of the NHS workforce. This highlighted the links between the wellbeing of staff and key indicators such as patient satisfaction and performance measures. The report made clear that 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.”

One of the key messages from the report is that staff health and wellbeing should be at the heart of the NHS and should form part of the NHS challenge to improve the quality of care without increasing costs.

In 2012 the Department of Health (DH) commissioned a project to work with NHS trusts to implement evidence-based strategies in order to reduce their sickness absence levels and improve staff health and wellbeing. The project is known as the Trust Support Project.

The project initially worked with 57 trusts. Following the success of this work, the project was extended to support a further 45 trusts [known as cohort 2] with a completion date of October 2013. In total, 102 trusts from across England were involved with the project. See Appendix 1 for a list of all the trusts that participated.

There was a mix of acute, mental health, community, ambulance, integrated and specialist trusts which varied in size from 420 to 15,500 staff and geographically spread from Cumbria to Cornwall.

Each trust received dedicated support from a project team member who worked with health and wellbeing/sickness absence leads to identify areas of strengths and developmental needs. Project work was framed by the DH’s five high impact changes (5HICs) evidence-based strategies, tools and resources to address the specific needs of each organisation.

Each trust developed actions and intervention plans based on their individual organisational needs and relevant to the community they served. This resulted in an individual evidence-based improvement action plan which if implemented effectively could have a positive effect on improving staff health and wellbeing and make considerable savings.
The assessment... “focused us on which direction we should be going in terms of the interface between wellbeing and sickness absence.”

Project participant

**PROJECT METHODOLOGY**

The DH developed the 5HICs to provide a supportive framework for NHS trusts to implement health and wellbeing actions. These centred on enabling NHS organisations to develop and embed health and wellbeing, meet the targets set for reducing sickness absence and to give their staff a healthy and positive experience of working in the NHS.

The 5HICs are:

1. Develop local evidence-based improvement plans
2. With strong visible leadership
3. Supported by improved management capability
4. With access to better, local high quality accredited occupational health (OH) services
5. Where all staff are encouraged and enabled to take more personal responsibility.

The 5HICs were used by the project team as a framework for a three-stage process which was developed and applied to all trusts:

**Stage 1. The assessment**

The purpose of the assessment was to identify current practice in the trust around sickness absence and health and wellbeing. A series of questions under each of the 5HICs aimed to draw out information about strategies and policies:

- How data was presented and used by board members and managers
- Communication and engagement
- Staff organisation involvement
- Management capability and development
- Appraisal processes
- Occupational health activity and services
- Whether personal responsibility is explicit.

The face-to-face assessment lasted around two hours and took place on Trust premises with a senior member of the HR team, often the HR director and/or health and wellbeing lead(s). Some trusts included OH and managers’ staff side representatives in the discussions.
Stage 2. The feedback report
Following each assessment a report was compiled and returned to the trust. Under each change, the report identified areas of strength and high impact areas for development.

To enable trusts to consider what interventions they might find useful and appropriate, links to good practice, policy, toolkits, briefing papers and other evidence were included in the report.

Stage 3. The improvement planning session
The purpose of the session was to support each trust to develop an improvement plan based on the feedback report and using the 5HICs as a framework.

Each improvement planning session was individually tailored to meet the precise needs of the organisation and so varied significantly in content, delivery and format. Sessions varied from small round-table ‘critical challenges’ with senior staff, to focus groups and large scale planning workshops with OH, clinical, staff side and corporate staff.

The outcome of the session was a plan of actions relating to sickness absence and health and wellbeing which could be used as the basis of a standalone document or integrated into existing plans and processes.

“The feedback report has been very helpful and formed the basis of a revision of the health and wellbeing strategy and a new sickness absence action plan to implement a reduction in time off.”

Project participant

“I wanted to thank you again for the support you provided earlier this year and to share with you the progress we have made... our year to date performance is 3.74%; it is the first time in over two years that sickness absence has been below 4%!”

Project participant

“This project has been the driver in getting cogs whirling around health and wellbeing.”

Project participant
THE FINDINGS – GOOD PRACTICE

Working directly with such a wide range and number of trusts has uncovered a significant amount of excellent and innovative practice in managing sickness absence and improving the health and wellbeing of staff.

The examples of good practice were recorded by the team under the 5HIC headings and some organisations also shared their developmental work in more detail as described below.

High impact change 1 – Developing local evidence-based improvement plans

All the trusts provided a regular board report on sickness absence. These varied in the quality and quantity of the data presented and few trusts linked sickness absence and health and wellbeing data to clinical data or patient outcomes.

The following example from Maidstone and Tunbridge Wells NHS Trust describes a performance dashboard which links workforce and patient safety data.

Maidstone & Tunbridge Wells NHS Trust

Maidstone & Tunbridge Wells NHS Trust has developed a performance dashboard that combines workforce performance data with patient safety data - looking at infection rates, A&E waiting times, dementia screening and other key indicators.

It includes information on organisational development, patient satisfaction data, education and development, flexible workforce information which shows the ratio of temporary to substantive posts in the organisation. The trust also includes the adherence to policies and procedures by reporting on the numbers of staff undergoing capability management, tribunals and dismissals. A section on staff remuneration and rewards highlight staff getting promotion or receiving an award.

All this information is presented in an easy one-page format and an example of the dashboard is shown in Appendix 3.

Some trusts used the ESR to its full potential as well as using e-rostering self-service systems with close to real-time reporting (i.e. maximum of 15 days old) to provide support to managers to enable them to produce accurate sickness absence data.

Several trusts sought to identify the health needs of staff to drive the direction of their health and wellbeing strategy and to ensure they delivered the most appropriate interventions. Ways of doing this included:

- the use of software to identify where staff live so this can be matched to the general health needs of the population
- developing specific staff health and wellbeing focus groups
- internal surveys
- the commissioning of a local university to complete an in-depth health needs assessment of staff.

The following example shows how Avon Partnership Occupational Health Service developed a health and wellbeing strategy framework across three NHS trusts.
Avon Partnership Occupational Health Service (APOHS)

Avon Partnership Occupational Health Service (APOHS) is one of the largest fully integrated NHS occupational health services within the NHS in England and Wales. It is a founding member of the NHS Health at Work Network [www.nhshealthatwork.co.uk] providing a comprehensive occupational health service to its partner trusts, the local health community, private sector business, education establishments and local councils.

APOHS trust partners commissioned the development of a health and wellbeing strategy framework for delivering maximum support to staff. This was intended to improve the quality of life for staff, provide a better working environment and provide cost savings, following reduced sickness absence and greater productivity. The framework was adapted to meet local needs.

The document summarised the advice available at the time from the UK Government, including:
- the ‘Public health responsibility deal’
- the Department of Health
- NICE guidelines
- NHS advice
- the Boorman Review
- NHS Health and well-being improvement framework.

Common themes running through all of this advice were brought together in the form of the combined framework for the partner trusts.

Within the framework, advice and recommendations were divided into nine separate domains:
1. Senior management and commitment
2. Physical activity
3. Diet
4. Mental wellbeing
5. Workplace
6. Training
7. Lifestyle
8. Inclusivity
9. Environmental

Each domain includes a number of commitments with subsequent actions. The lead from each workstream form the health and wellbeing steering group. While some of the activity needs to be confined to a particular trust or site (e.g. facilities) much of the work can be undertaken pan-partnership.

Early benefits of this coordination include:
- the further development of the APOHS website [www.apohs.nhs.uk] to include self-help tools, advice and external sources of support and advice
- the piloting of Lighten up [www.lighten-up.co.uk], an NHS developed, resilience programme within the partner trusts
- APOHS is in the process of setting up and coordinating money advice clinics with the “Money Advice Service” [www.moneyadvice-service.org.uk] across partner trusts.

For further information, contact barry.lane@nhs.net
Trusts have developed a number of ways to plan and communicate their health and wellbeing initiatives. Some trusts chose their health and wellbeing initiatives to coincide with national campaigns relevant to public health profiles, for example, Diabetes Awareness Week.

**Dartford and Gravesham NHS Trust**

Dartford and Gravesham NHS Trust has an occupational health work plan which connects their health and wellbeing campaigns, initiatives and events for the year to an annual calendar of national campaigns which is handed out at induction. An example of the plan is in Appendix 4.

**High impact change 2 – Strong, visible leadership**

Trust boards have developed a number of ways in which they engage with staff on general and health and wellbeing issues. These include dedicated anonymous email inboxes and phone lines to the chief executive or the running of groups where between 250 and 350 staff members are invited to generate health and wellbeing ideas following which the top five ideas are implemented.

There were examples in trusts of board members being personally involved in the health and wellbeing agenda by making personal health and wellbeing pledges or being actively involved in initiatives such as staff challenges, fun runs and pedometer challenges.

**North East London NHS Foundation Trust**

North East London NHS Foundation Trust has a strategic health and wellbeing group, chaired by the chief executive demonstrating senior level commitment and involvement.

**Dorset Healthcare University NHS Foundation Trust**

Dorset Healthcare University NHS Foundation Trust has introduced an i-Matter innovation platform – a social media intranet based tool which allows staff to see and interact on organisational challenges.

Staff are encouraged to participate and submit and share their ideas, comment or vote on the ideas presented and contact each other to promote collaboration and discussions.

Staff can post profiles of themselves and blog about projects, developments, interests, studies and research. The types of activity so far includes:

- how to boost ward to board engagement
- keeping patients hydrated and healthy
- electronic patient record development
- improved joined-up working amongst groups of professionals.

For further information, contact jodi.brown@dhuf.t.nhs.uk
High impact change 3 – Improved management capacity

A number of trusts have developed resources for managers to enable them to manage sickness absence effectively. One example included the development of a managers health and wellbeing toolbox on the intranet which pulled together resources such as sickness absence guidelines and policies, ‘how to’ guidance and signposts to useful information, such as training documents.

Some trusts have established staff champions to provide ground level support and communications on health and wellbeing issues. The following examples show how two trusts have taken different approaches to implementing health and wellbeing champions in their organisations.

The development of diversity and wellbeing champions at South Essex Partnership Trust (SEPT)

From its work to promote NHS Employers’ Personal, Fair and Diverse (PFD) campaign, South Essex Partnership Trust decided that the PFD champions would promote health and wellbeing alongside equality and diversity, as the two were so inextricably linked.

The essence of the champions network is that employees know and understand where to go for help and advice and to get their voices heard. The purpose of the champions is to provide first hand practical knowledge about issues which could affect other staff. This means they are able to support colleagues, but also give the organisation a better understanding of the real issues staff face and provide practical solutions to encouraging continued employment or return to work. The champions are asked to specify personal experiences which are then maintained in a database and act as a point of reference if an employee or manager contacts the wellbeing/diversity department for support.

At all staff inductions the trust’s Employee Experience team promotes healthy lifestyles for all and has been very successful in signing up champions. New staff are joining all the time bringing a fresh look and strong commitment to diversity and wellbeing in the workplace.

A couple of examples of the champions’ impact include:

- The Activity Coordinators (also champions) now have a range of exercise equipment that can be used by the disabled – this was an issue raised by one of the champions with a disability.

- A lesbian employee made the trust aware of a Stonewall campaign. Through her role as a champion, she worked to share her work and passion with all staff through executive-level briefings. She is now becoming recognised across the trust as an avenue of support for other lesbians or staff who need a better understanding of lesbian issues at work or in patient care.

The trust’s view is that health and wellbeing means different things to different people and that those with ‘lived experiences’ are much better placed to advise on support and design of processes – ultimately supporting a more inclusive working environment.

For more information, contact Jo.Debenham@sept.nhs.uk
For more information on NHS Employers Personal, Fair, Diverse campaign, see www.nhsemployers.org/PFD
Training staff as health and wellbeing champions at Royal Wolverhampton NHS Trust

Loughborough College approached the occupational health and wellbeing service at Royal Wolverhampton NHS Trust in September 2013 to offer its staff the opportunity to apply for a distance learning course called Step into Health.

Step into Health is a nationally recognised qualification in health, lifestyle and fitness which aims to help people of differing health and fitness levels to improve their wellbeing and empower them to achieve their own personal health objectives at no cost. 70 staff from a range of departments across the trust have enrolled onto the course.

In May 2014, a final report is expected from the college. The trust will then bring all those that have successfully completed the course together to explore the potential of forming a health and wellbeing network.

For further information, contact marybrassington@nhs.net

Another trust had a health and wellbeing intranet site, giving staff information on protecting their health, the support available, what to do if they were sick or at risk of becoming ill. It also highlights ways to reduce stress at work and at home with advice on family and finance issues. It also includes a direct link to booking into occupational health, training and development and into an onsite nursery. A section for managers includes all health and wellbeing policies, guidelines about domestic violence, alcohol and drugs.

High impact change 4 – Access to local, high-quality accredited occupational health services

Occupational health (OH) departments vary in size and type with some provided internally and others a shared external resource. Some of the proactive OH departments have provided interventions such as:

- onsite and virtual gyms
- free fitness classes and videos
- sports tournaments
- pedometer challenges
- ‘vital check’ pods to enable staff to drop in and have checks completed
- annual health MOTs completed for all staff members and linked with personal health plans.

Some OH departments have developed programmes for staff having four or more episodes of sickness which involves a healthy lifestyle session based around personal responsibility, setting change goals and resilience, such as the example here from 5 Boroughs Partnership NHS Trust.
5 Boroughs Partnership NHS Trust

Occupational health services at 5 Boroughs Partnership NHS Trust – a mental health trust – include a functional restoration programme aimed at staff suffering with both musculo-skeletal issues and stress, particularly those who need to undertake control and restraint on a regular basis and are suffering medium-term or complex sickness absence.

The programme includes tests and then a decision about which staff members will most reap benefits from inclusion in the course. The programme is a combined bio-psycho-social initiative with counsellor and physiotherapist interventions; it can be run with groups which is more cost effective than as an individual programme.

For further information, contact the occupational health manager Phil.Waterworth@5bp.nhs.uk

High impact change 5 – Encouragement and enablement of staff to take personal responsibility

Only a few trusts had examples of good practice to share and most did not make personal responsibility explicit from the start to end of the working relationship. However, to encourage staff, most trusts did provide some access to services including gyms, health and wellbeing programmes, nutritional improvements and corporate fitness challenges. Examples of these are described below.

- **Portsmouth Hospitals NHS Trust** has a facility called the Oasis Centre, a state-of-the-art facility combining gym, swimming and treatments available to staff through salary sacrifice.

- **Rotherham NHS Foundation Trust** provides a 7am-7pm flu vaccination programme which resulted in an increased uptake and University Hospital South Manchester received 90 pedal cycles as a donation from the local police.

- **Dorset County Hospital NHS Foundation Trust** runs a Lighten Up programme combining diet, exercise and support with mental health issues, and Stockport has a Feel Good Factor programme linking personal health and wellbeing and OH services.

- Healthy food options were taken to a higher level at **Tameside General Hospitals NHS Foundation Trust** which has a computerised nutritional identification system.

- Profits from sales of healthy food to external schools and organisations allows **Wrightington Wigan and Leigh NHS Foundation Trust** to offer five-star staff canteens with RAG-rated foods. Regular fruit and vegetable vans, stalls and markets were available in several trusts.

- **West Suffolk Hospitals NHS Trust** demonstrated innovation in getting teams of staff involved in competitive health and wellbeing activities by converting hours of team exercise in air miles which was displayed as a virtual journey round the world on a map on the way to the staff restaurant and organising ‘It’s a Knockout’ style health and wellbeing fundraiser in conjunction with a local college and local authority.
The information gathered throughout the project has given an overview of some of the strengths and challenges that organisations face. A set of specific questions was built into the assessment process to help create an overview of all the 102 trusts’ position regarding key sickness absence and health and wellbeing initiatives.

As this data (along with the general information from the assessment process) was gathered, common themes and trends started to emerge. These were captured in a spreadsheet and were shared in monthly stakeholder reports and in team meetings with colleagues in the NHS Employers health and wellbeing team.

**High impact change 1 – Developing local evidence based improvement plans**

**Variation in sickness absence rates across types of trusts**

Although national sickness absence statistics show ambulance and mental health trusts as having higher sickness absence rates, the team did not find evidence that would indicate any significant differences in policy, health and wellbeing initiatives, board engagement etc. which would impact on sickness absence. Anecdotally, some of the ambulance trusts cited large geographical localities, dispersed teams and impacts on winter pressures on staff and managers as key issues.

Integrated trusts had challenges working through change management processes post-merger which impacted on health and wellbeing. There appeared to be differences in sickness absence rates and in the health and wellbeing challenges facing trusts with newly acquired community services. The community services tended to have higher sickness absence with reduced access to health and wellbeing initiatives where they were centrally rather than locally provided.

**Health and wellbeing strategies and trust policies**

Sixty eight per cent of trusts taking part had health and wellbeing strategies either in place or in draft although these varied considerably in content, how up to date they were, and whether or not they had action plans.
In terms of driving the strategy forward, a number of trusts used existing committees or groups, whilst other trusts had dedicated health and wellbeing groups. In many cases it was not clear if specific consideration had been given as to whether the membership of these groups ensured that staff views were heard, that there was sufficient seniority to drive agreed actions forward, or that there were clearly-defined roles and responsibilities for managers, human resources and occupational health in driving through improvements in sickness absence management and staff health and wellbeing.

The majority of trusts had a wide range of supportive policies such as managing stress and wellbeing, flexible working and smoking. With regards to absence policies the team noted a move away from ‘sickness absence’ to ‘managing attendance’, with some trusts also including ‘promoting wellbeing’ in the title.

**Building local evidence into health and wellbeing initiatives and activities**

Most trusts had put health and wellbeing activities and programmes in place without conclusive evidence that outcomes would be beneficial locally. Research into cohort 2 shows that 27 per cent of trusts carried out assessments or surveys of staff health needs to drive improvement plans.

When asked about this, trusts explained that they were concerned about raising unrealistic expectations, confidentiality issues, or it being seen as a ‘tick box’ exercise. Some trusts did not wish to commit to the costs and resources required whilst others suspected they may get poor quality results from ‘quickie’ health checks with only the worried well getting involved.

Trusts that undertook assessments found numerous non-intrusive ways to gain insight into staff health and wellbeing needs and wants. Examples included:

- voting on single questions placed on their intranet homepage
- simple and in-depth surveys involving questions such as “If we offered a smoking cessation service, would you attend?”
- networking with regional and local organisations
- using software to identify where staff groups live to match up with public health data.

**Evaluating the effectiveness of health and wellbeing initiatives and activities**

The majority of trusts had health and wellbeing interventions in place, including national programmes and campaigns, regional activities and trust-based activities. Forty eight per cent (of cohort 2) evaluated the impact of these interventions.

Ring-fenced budgets for health and wellbeing were unusual with three of the 45 trusts in cohort 2 having dedicated budgets. Some trusts provided salary sacrifice arrangements for staff to take part in specific health and wellbeing activities, but most trusts paid for staff health and wellbeing through a combination of human resource budget, OH income and lottery funding, or sought out cost-neutral activities only.

Many trusts evaluated the national staff survey findings to inform the health and wellbeing agenda and some used focus groups to produce improvement plans. Most other programmes and initiatives were undertaken without in-depth evaluation. It was evident in some of the improvement planning sessions that managers and staff did not realise the full extent of health and wellbeing programmes the trust had in place – a point of learning in itself in relation to effective communications.

Although improved health outcomes from health and wellbeing initiatives may only be seen over a number of years, some trusts were identifying ways of setting targets at the outset – monitoring interest, attendance and short-term health outcomes, for example from smoking cessation programmes. They also recognised that more could be done to build detailed learning about successes and failures into future action plans and tailor health and wellbeing activities to be more in line with staff health needs and priorities.
High impact change 2 – Strong, visible leadership

Board-level involvement in health and wellbeing

One of the major findings of the project has been the low-level engagement and support of board members for the health and wellbeing agenda in trusts. Anecdotally, this was accredited to financial pressures which resulted in a lack of support for investments in health and wellbeing business cases and a lack of confidence that investment would significantly impact on sickness absence rates. Many trusts had clear cost saving objectives to drive sickness absence rates down but had no associated funding available.

All trust boards received some level of reporting on sickness absence data, but few boards had regular reports on the outcomes of health and wellbeing initiatives and even fewer had examples of information which provided boards with links between health and wellbeing outcomes and sickness absence rates.

There were trusts whose board members did engage with staff health and wellbeing and who showed a personal interest with examples of:

- health and wellbeing committees reporting directly to the board
- sponsorship of focus groups
- board-level health and wellbeing strategic objectives
- a health and wellbeing section in the trust’s annual report, including the connection to quality patient outcomes.

In trusts with high-level board involvement, where board members acted as champions or became personally involved in health and wellbeing activities, this was reflected in the attendees at the improvement planning sessions. They were more motivated to support health and wellbeing, encouraged others, were more likely to attend operational and soft skills training and were more confident and proactive in their management of sickness absence requiring less support from HR and OH services.

The links between high-level board engagement and lower sickness absence rates did not always apply. One or two trusts showed little board engagement and had low sickness absence rates. It was therefore difficult to draw clear conclusions from this information.

Health and wellbeing data

Almost all trust boards received a set of sickness absence data for each meeting, with the majority of trusts also providing a periodic workforce report. Many trusts provided a set of data to line managers, some via a self-service dashboard but often through exception HR reporting, for example staff who had gone through sickness absence triggers.

Live data was available to line managers at many trusts via systems such as e-Roster, pro-Roster, and ESR manager self-service. In trusts where live access to data was not available, line managers relied on ESR data which was approximately six weeks old.

There was great variety in the quality and quantity of data used and how this was presented to provide the trust with meaningful information upon which to draw conclusions and base decisions. Few trusts triangulated sickness absence and health and wellbeing data with wider workforce or clinical data, patient outcomes and costs.

Whilst some trusts triangulated sickness absence data with staff survey results and evaluated events/initiatives, very few included OH data and public health priorities in any performance data. It was found that 62 per cent of trusts connected their sickness absence with temporary staffing data.

The vast majority of trusts recorded the reasons for sickness absence. There was, however, wide variation with several trusts with upwards of 30 per cent of sickness absence as “Unknown” or “Other Known” in ESR. This skewed their understanding of top sickness absence reasons, the cost of each reason, and where to effectively focus their resources to improve sickness absence. Trusts cited difficulties with the ESR terminology and insufficient sickness absence categories as reasons for poor data capture.
The majority of trusts did not have a data warehouse accessible to stakeholders wishing to draw down automated or bespoke data and reports. There were often many, diverse groups and committees across the trust collecting, collating and analysing health and wellbeing and making decisions in isolation of each other.

Several trusts had very good quality performance data. Some trusts used health and wellbeing data:
- in conjunction with workforce data to manage temporary staffing costs more effectively
- to focus individual training and coaching needs
- to highlight ‘hotspot’ staff groups and areas
- to combine ESR and e-rostering capability effectively.

No trusts who provided and triangulated the full range of data associated with sickness absence, workforce issues, costs and patient outcomes.

Temporary staffing

One-third of trusts involved in the project had an in-house bank service as well as agency and medical locum arrangements.

Management and monitoring of temporary staffing was often undertaken by different management groups, for example a senior nursing group might lead on nursing temporary staffing and individual divisions hired temporary clerical staff and so on. A minority of trusts reported that temporary staffing arrangements were well under control. Many trusts did not manage or audit bank listings so were unaware of the scale of their bank, whether bank listings were up-to-date, why and how many bank shifts were booked. The majority of trusts were unaware of how many substantive staff regularly took bank work, especially following sickness absence.

Many trusts left temporary staffing arrangements to divisional management and monitoring of these arrangements were often not audited regularly by HR or finance to give an overall trust picture. Trusts reported difficulties with obtaining an appropriate level of agency staff at short notice – increasing pressure on trust staff. Some trusts reported that the NHS may be losing staff to agency contracts, compounding any problems with turnover.

Forty per cent of trusts reported that they do not make any connections between sickness absence and temporary staffing and generally, the reasons for temporary spending were not correlated with establishment figures, vacancy levels and turnover or exit interview information.

Connecting temporary staffing and sickness absence

[Pie chart showing 61% Yes and 39% No]
Health and wellbeing communications and engagement

All trusts communicated with their staff about workforce issues, mostly through the intranet, team brief, newsletters and notice boards. Many trusts tried to engage staff by undertaking, for example, ‘big conversations’ or opening a direct email link to the chief executive to raise issues. Approximately half the trusts used short in-house surveys to inform what they did, but staff participation was often a problem, mainly because of distrust or survey fatigue. Most improvement planning sessions reflected that communications and engagement about health and wellbeing are inconsistent and could be more effective, with an over-reliance on electronic methods. Effectively communicating and engaging with staff in community settings was found to be a challenge.

Most health and wellbeing leads did not work closely with communications teams to ensure that health and wellbeing was included in communications strategies. OH communications were not integrated with other trust health and wellbeing communications.

Thirty two per cent of trusts had branded their health and wellbeing, often grouping all OH services, health benefits and web pages under one colourful logo and only a few trusts had utilised social media.

Equality of access may be a challenge especially for newly-merged integrated trusts – particularly where team size had increased and opportunities for face-to-face meetings had eroded. A further point was that staff and staff side representatives gathered important anecdotal health and wellbeing information and may benefit from being able to feed into trust health and wellbeing communications in a more structured, integrated manner.

Management working with staff side was variable, some partnership relationships were excellent whilst a few were problematic, with the majority somewhere in between.

Health and wellbeing in performance management

Staff appraisal systems varied greatly with regard to content. A few trusts included sickness absence but many felt that this was inappropriate during the appraisal process. Whilst a small number of trusts made a clear link between strategic and individual objectives and values, very few discussed personal responsibility as part of the process and only 20 per cent included health and wellbeing.

Some trusts had specific sickness absence reduction targets for divisions but most acknowledged that individual divisions may remain worse than trust average if they had stretch targets. Although managerial responsibilities for aspects of staff health and health and wellbeing are outlined in attendance management policies, no individual line managers had specific targets for reduction of sickness absence.

The extent to which health and wellbeing was discussed at appraisals was variable and generally low. Few trusts met their appraisal targets. Many managers at improvement planning sessions cited time pressures trying to fit large numbers of meaningful appraisals within organisational performance management time periods as additional difficulties.

NHS trusts where health and wellbeing is formally discussed at appraisal

- Yes: 20%
- No: 80%

Reducing sickness absence in the NHS using evidence-based strategies
High impact change 3 – Improved management capability

Responsibility for staff health and wellbeing
Operational sickness absence training on implementing policy and return to work meetings took place in all trusts. There was little evidence of absence training and periodic refresher operational training being compulsory. Difficulty to find time to attend training was reported by some managers. Several trusts were changing the type of HR support provided to managers – providing a coaching approach instead – while a few had appointed dedicated sickness absence leads. Whilst many of the absence management policies set out the roles and responsibilities in broad terms, some managers reported that this left them uncertain of their own responsibilities.

Most trusts did not evaluate the quality of support that managers give to staff health and wellbeing, other than through some appraisal processes; most only measured compliance with policy.

Sickness absence/health and wellbeing training – formats and content
Training formats varied from face-to-face sessions, e-learning, tips and guidelines available on intranets, individual coaching by HR business support staff within trust divisions to wider leadership development programmes, some of which were extensive and accredited.

In almost every trust, mental health issues were in the top three sickness absence reasons, but only a small number of trusts provided managers with training for early recognition of these issues.

In improvement planning sessions some managers requested help on the application of policy to real-life scenarios, support to work smarter with OH to get the most out of the service, leading case management of complex or long-term absence and resilience for themselves and their colleagues. They also suggested that the use of 360 degree feedback would be useful to embed positive behaviour, improve relationships and reduce grievance levels.

Where managers had access to live sickness absence management data, only a minority of trusts – citing that the software was user-friendly – had ensured that managers had sufficient IT skills to run ad hoc reports and manipulate data.

Learning and sharing health and wellbeing good practice
There were some examples of effective practice in sickness absence management within individual directorates or units in trusts, but this wasn’t routinely shared and disseminated in a structured way across the organisation. Staff who attended the improvement planning sessions suggested that this could be done through buddies/mentors or professional groups e.g. nursing forums or from the use of simple case studies drawn from local evidence which could be shared and included in training courses or in guidelines. Participants in the project also commented that they could network and learn more from local organisations, including from private firms, as well as learn from patient experiences to help support staff with mental health and stress issues.
High impact change 4 – Access to local, high-quality accredited occupational health services

Occupational health processes and services
The majority (86 per cent) of trusts indicated that they were either accredited or going through the SEQOHS accreditation process.

A few OH departments had sophisticated e-booking systems for appointments but many battled with Did Not Attend (DNA) levels, sometimes linked to staff fear of the ‘formal’ and punitive feel to OH attendance. There were tensions between the quality and usefulness of OH reports and the quality and detail of managers’ referral documentation. Data collected from cohort 2 trusts showed 71 per cent adopted a case management approach in complex or longer-term sickness absence management and sometimes it was unclear which department or individual was leading the case management approach and was responsible for satisfactory outcomes.

Not all trusts had service level agreements in place (particularly those with in-house services) and of those that had, few had reviewed their Key Performance Indicators (KPIs). Therefore, few OH departments collected and provided meaningful, timely data against agreed relevant KPIs to give trusts an evaluation of the services provided. This meant that trusts found it difficult to triangulate OH with other data to highlight and reinforce where resource should be targeted. This issue will no doubt be rectified as trusts progress through the SEQOHS accreditation process.

Focus on top sickness absence reasons
Many of the trusts identified that stress and mental health issues had overtaken musculo-skeletal disorders (MSDs) as the main reason for sickness absence. However, very few trusts had effective support structures in place for staff and were unclear of the pathways for staff who required professional help. Many trusts provided staff counselling services with many of them reporting waiting lists for access. Thirty one per cent of cohort 2 trusts offered employee assistance programmes (with a few extending services to family members of staff). Trusts also reported that managers at a local level were unsure of how to identify and manage stress and mental health issues amongst staff with few trusts providing training on mental health.

MSDs were also one of the key reasons for staff sickness. Some trusts had put in place bio-psycho-social programmes to help staff with both MSD and mental health issues but few trusts were undertaking regular physical competency assessments linked to job descriptions or helping managers support staff with complex health issues.
Proactive approach – prevent and promote health and wellbeing

Two thirds of trust OH departments were proactive in promoting staff health and wellbeing, with at least one trust’s OH department directly responsible for delivering its health and wellbeing strategy. Many OH departments liaised with local GPs but cited tensions when recommended adjustments and redeployment options were difficult to accommodate.

Although some OH services were offered at staff workplaces, and were open at times to suit a wider number of shifts, most OH departments did not offer equality of access to services at all trust sites. This was a particular challenge for trusts with community staff. Some OH departments sold their services successfully to external organisations, thus creating an income stream to resource extra staff and widen the services they are able to offer.

High impact change 5 – Encouragement and enablement of staff to take personal responsibility

Vacancy to pension approach to health and wellbeing

The majority of trusts listed benefits in ‘Working for us’ and in their job advertisements and some referred to health and wellbeing activities and OH services as staff benefits.

Induction was the first opportunity new recruits had to learn of the trusts’ level of commitment to health and wellbeing, and the conveying of this message varied from the involvement of the trust chairman in health and wellbeing discussions to the handing out of leaflets. Twenty six per cent of trusts said they gave a consistent, explicit message about personal responsibility at the start of the working relationship. No trusts continued this clear, explicit message throughout the whole of the employment lifecycle.

The challenges of supporting personal responsibility

Most trust data indicated an ageing workforce but few have a policy in place or were actively signposting and supporting staff regarding specific issues e.g. age or gender related issues. A few trusts were signposting health checks for specific staff groups, and ambulance services were offering step-down/horizontal moves for older staff to shelter them from overly-pressured situations.

Discussions at improvement planning sessions reflected that trusts recognised presenteeism or the pressure to attend work as a challenge. Linked to this, several trusts realised that flexible working arrangements were often put in place without setting a review date.

Some trusts were actively tackling transparency issues around, for example, whistle-blowing by trying a ‘normal not formal’ approach to the need to highlight poor action and help the trust improve services through improvement ideas.
CONCLUSIONS

From a review of the information and data gathered directly from the 102 NHS trusts, the team has developed a list of conclusions which would benefit from consideration and further development:

1. A third of the 102 trusts do not have a health and wellbeing strategy and the range of strategies seen were variable. All trusts provide some level of health and wellbeing initiative, but few of these are based on known staff health needs or reviewed for their impact and outcomes.

2. The data provided to trust boards on sickness absence varied, with 40 per cent making links between sickness absence and temporary staff, few trusts triangulating sickness absence, staff survey and health and wellbeing data. Almost no trusts connected sickness absence data to patient care data.

3. Despite clear messages from national reviews and reports on the importance of staff health and wellbeing and the impact on patient care and outcomes, the project found a number of trusts where there was a lack of board engagement on this agenda and that it is an area that requires focus and drive.

4. There is an opportunity to develop an improved understanding on the connection between local public health priorities and the health and wellbeing issues of staff recruited from that same area.

5. Managing sickness absence and staff health and wellbeing needs to be more strongly embedded into organisational culture, with a stronger understanding of the links between sickness absence and the impact on patient care.

6. One of the highest reasons for staff sickness absence across all the trusts is mental health and stress and yet this remains one of the underdeveloped health and wellbeing areas for OH and managers. Few trusts provided managers with training on identifying and managing mental health issues and few had examples of good quality.

7. Staff training in sickness absence and supporting health and wellbeing is focused primarily on providing only policy-based training and less on the range of soft skills training and the use of real-life scenarios.

8. Appraisals are rarely being used as an opportunity to discuss health and wellbeing, with 20 per cent of the trusts having a health and wellbeing question as part of the appraisal process. The majority of trusts saw appraisals as a high priority in terms of percentage achieved, and whilst many were intending to review their appraisal processes in the context of robustness for pay progression very few had considered including health and wellbeing.

9. Staff taking personal responsibility for their own health and wellbeing remains an underdeveloped area. When addressed in the improvement planning sessions, it was engaged with enthusiastically with trusts able to identify improvement ideas going forwards.
NEXT STEPS

All 102 trusts have improvement plans in place with agreed actions to drive improvements in sickness absence rates and staff health and wellbeing. The trust support team recommends that the trusts involved have some level of on-going contact to identify improvements made since the start of the project and the impacts on sickness absence rates. Several trusts have requested some level of on-going support and engagement with NHS Employers.

The contact could involve quarterly calls or surveys to identify the progress and challenges in implementing their improvement plans. The national sickness absence data would provide some indication of progress but verbal updates would provide more in-depth information on the cause of sickness absence rates going up and what has impacted on sickness absence going down. This information would provide a longer term overview of how a defined cohort of NHS trusts are managing the challenge of improving sickness absence rates.

The following information is also available on NHS Employers website:
- a summary of the key findings and outcomes of the project
- good practice examples from the 102 trusts
- a list of the top tips.

The NHS Employers health and wellbeing team will be keeping in contact to share relevant information.

And finally... a list of improvements with the 102 trusts brought about in one of the trusts after being involved in the project.

Rotherham NHS Foundation Trust

Since the improvement planning session with the trust support project team, we have developed a local strategy which incorporates the 5 high impact changes (HICs) with a detailed work plan which includes formal review and progression of ideas raised at the workshop.

The strategy was approved by the board in September, we have a new non-exec champion for health and wellbeing and the commencement of a new committee that will maximise staff engagement in initiatives. Using the information you provided in the feedback report we have developed a new performance report which is presented to the board on a routine basis.

Our health and wellbeing service will launch a programme of health improvement initiatives, which are branded and communicated via a range of media including the trust intranet.

We will be holding a follow-up workshop with the same stakeholders who attended the improvement planning session in order to present on work streams undertaken and agree processes for capturing future opportunities.

Many thanks for your support, which has added significant value in progressing the health and wellbeing agenda.

Ian Tegerdine, Director of People and Organisational Development, the Rotherham NHS Foundation Trust
APPENDIX 1. 102 TRUSTS INVOLVED IN THE PROJECT BY NAME AND TYPE

1. 5 Boroughs Partnership NHS Foundation Trust – mental health
2. Aintree University Hospitals NHS Foundation Trust – acute & community
3. Alder Hey Children’s NHS Foundation Trust – specialist
4. Avon and Wiltshire Mental Health Partnership NHS Trust – mental health
5. Barking, Havering and Redbridge Hospitals NHS Trust – acute
6. Bradford District Care NHS Trust – mental health & community
7. Bradford Teaching Hospitals NHS Foundation Trust – acute
8. Brighton and Sussex University Hospitals NHS Trust – acute
10. Burton Hospitals NHS Foundation Trust – acute
11. Camden and Islington NHS Foundation Trust – mental health & community
12. Central Manchester University Hospitals NHS Foundation Trust – acute & community
13. Cheshire and Wirral Partnership NHS Foundation Trust – mental health
14. Clatterbridge Centre for Oncology NHS Foundation Trust – specialist
15. Countess of Chester NHS Foundation Trust – acute
16. University Hospitals Coventry & Warwickshire NHS Trust – acute
17. Cumbria Partnership NHS Foundation Trust – community
18. Dartford and Gravesham NHS Trust – acute
19. Derby Hospitals NHS Foundation Trust – acute
20. Devon Partnership NHS Trust – mental health
21. Dorset County Hospital NHS Foundation Trust – acute & community
22. Dorset HealthCare University NHS Foundation Trust – community & mental health
23. Ealing Hospital NHS Trust – acute & community
24. East and North Hertfordshire NHS Trust – acute & community
25. East Kent Hospitals University NHS Foundation Trust – acute
27. East of England Ambulance and NHS Trust – ambulance
Reducing sickness absence in the NHS using evidence-based strategies

29 Epsom & St Helier NHS Trust – acute & community
30 Gloucestershire Hospitals NHS Foundation Trust – acute
31 Greater Manchester West Mental Health NHS Foundation Trust – mental health
32 Harrogate and District NHS Foundation Trust – acute
33 Heart of England NHS Foundation Trust – acute & community
34 Hertfordshire Partnership NHS Foundation Trust – mental health
35 Hillingdon Hospitals NHS Foundation Trust – acute
36 Imperial College Healthcare NHS Trust – acute
37 James Paget University Hospitals NHS Foundation Trust – acute
38 Kettering General Hospital Foundation Trust – acute
39 Lancashire Teaching Hospitals NHS Foundation Trust – acute
40 Leeds & York Partnership NHS Foundation Trust – mental health
41 Leeds Teaching Hospitals NHS Foundation Trust – acute
42 Lewisham Hospital NHS Trust – acute
43 Maidstone and Tunbridge Wells NHS Trust – acute
44 Mersey Care NHS Trust – mental health
45 Mid Cheshire Hospitals NHS Foundation Trust – acute
46 Mid Staffordshire NHS Foundation Trust – acute
47 Mid Yorkshire Hospitals NHS Trust – acute
48 Newcastle Upon Tyne Hospitals NHS Foundation Trust – acute & community
49 Norfolk & Suffolk NHS Foundation Trust – mental health
50 North Bristol NHS Trust – acute & community
51 North East London NHS Foundation Trust – mental health & community
52 North Lincolnshire and Goole Hospital NHS Trust – acute
53 North Tees and Hartlepool NHS Trust – acute & community
54 North West Ambulance Service NHS Trust – ambulance
55 Northampton General Hospital NHS Trust – acute
56 Northern Devon Healthcare NHS Trust – acute & community
57 Northumberland, Tyne and Wear NHS Foundation Trust – mental health & disability
58 Oxford University Hospitals NHS Trust – acute
59 Papworth Hospital NHS Foundation Trust – specialist
60 Pennine Acute Hospital NHS Trust – acute
61 Portsmouth Hospitals NHS Trust – acute
62 Princess Alexandra Hospital NHS Trust – acute
63 Rotherham NHS Foundation Trust – acute & community
64 Royal Bolton Hospital NHS Foundation Trust – acute & community
65 Royal Cornwall Hospitals NHS Trust – acute
66 Royal Liverpool & Broadgreen University Hospitals NHS Trust – acute
67 Royal National Hospital for Rheumatic Diseases NHS Foundation Trust – specialist
68 Royal National Orthopaedic Hospital NHS Trust – specialist
69 Royal Orthopaedic Hospital NHS Foundation Trust – specialist
70 Royal Surrey County Hospital NHS Foundation Trust – acute
71 Royal United Hospital Bath NHS Trust – acute
72 Royal Wolverhampton Hospitals NHS Trust – acute & community
73 Scarborough - York Teaching Hospital Foundation Trust – acute & community
74 Sheffield Children’s NHS Foundation Trust – specialist
75 Sheffield Teaching Hospitals NHS Foundation Trust – acute
76 Shrewsbury & Telford Hospital NHS Trust – acute
77 South Central Ambulance Service NHS Foundation Trust – ambulance
78 South East Coast Ambulance NHS Foundation Trust – ambulance
79 South Essex Partnership University NHS Foundation Trust – mental health
80 South London Healthcare NHS Trust – acute
81 South Staffordshire and Shropshire Healthcare NHS Foundation Trust – mental health
82 South Tees Hospital Foundation NHS Trust – acute & community
83 South Tyneside NHS Foundation Trust – acute & community
84 South Warwickshire NHS Foundation Trust – acute & community
85 University Hospital Southampton NHS Foundation Trust – acute
86 Southern Health NHS Foundation Trust – mental health & community
87 Southport and Ormskirk Hospital NHS Trust – acute & community
88 St Georges Hospital NHS Trust – acute & community
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APPENDIX 2. DATA COLLECTED ON THE 102 TRUSTS

The following data was gathered on each trust involved in the project to develop a consistent baseline to compare and contrast trusts.

Trust size (by staff) and type
1. Did the trust have a health and wellbeing strategy in place?
2. Did the trust carry out a health needs assessment of its staff? (Cohort 2 only)
3. Did the trust evaluate health and wellbeing initiatives? (Cohort 2 only)
4. Was there a dedicated health and wellbeing budget? (Cohort 2 only)
5. Were links made between temporary staff and sickness absence?
6. Did the trust use an internal or external temporary staffing provider (Cohort 1 only)
7. Was health and wellbeing branded?
8. Was health and wellbeing discussed in appraisals?
9. Was there partnership working with staff side? (Cohort 1 only)
10. Did the trust look at public health profiles in relation to their staff?
11. Was OH SEQOHS accredited?
12. Did OH promote health and wellbeing?
13. Did the trust take a case management approach to sickness absence management? (Cohort 2 only)
14. Did the trust have an Employee Assistance Programme? (Cohort 2 only)
15. Was personal responsibility explicit?
APPENDIX 3. EXAMPLE OF TRUST BALANCED SCORE CARD

### WORKFORCE PERFORMANCE DASHBOARD

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### Key Performance Indicators

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### Workforce Model Development

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### Workforce Model Resources

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### APPENDIX 4. DARTFORD AND GRAVESHAM NHS TRUST OCCUPATIONAL HEALTH WORK PLAN

#### Health and Wellbeing Work Plan 2013 (Occupational Health)

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#### Workplace Health – Staff Induction Talks

- **Carillion**: Health and Wellbeing: Education on a One-to-One basis at pre placement screening with regards to:
  - Occupational health function and support;
  - Infection prevention and control (including uniform policy, hand washing, skin care and use of alcohol rubs);
  - Prevention of Blood Borne Viruses transmission (Hepatitis B, Hepatitis C and HIV); practical measures and the importance of immunisation;
  - The management and prevention of inoculation injuries and reporting procedures;
  - Working safely with Display Screen Equipment, the DSE regulations and risk assessment.

- All the above supported by appropriate literature.

- **Ongoing**: Advice to anyone attending occupational health appointments regarding:
  - Smoking – its health impact and how to stop. Supported by 12 weeks cessation support.
  - Lifestyle Awareness – the impact of lifestyle on health, measures to improve lifestyle and the benefits of doing so (health gains). Supported by a 12 week Lifestyle Program.
  - The benefits of immunization. What the Department of Health recommends and why.

- Workplace health issues – Student Nurses and Doctors in training. Session includes HIV, Blood Borne Viruses, Inoculation Injuries and Health Promotion Why Bother? 
  - Pregnancy – the health impact on work performance and capability. Support in for individuals. Support for managers in carrying out risk assessments.
  - Travel vaccinations advice on what's recommended. Where to obtain them.
APPENDIX 5. EXAMPLE OF AN OCCUPATIONAL HEALTH DASHBOARD
NHS Employers

The NHS Employers organisation is the voice of employers in the NHS, supporting them to put patients first. Our vision is to be the authoritative voice of workforce leaders, experts in HR, negotiating fairly to get the best deal for patients.

We help employers make sense of current and emerging healthcare issues to ensure that their voice is front and centre of health policy and practice. We keep them up to date with the latest workforce thinking and expert opinion, providing practical advice and information, and generating opportunities to network and share knowledge and best practice.

We work with employers in the NHS to reflect their views and act on their behalf in four priority areas:

- pay and negotiations
- recruitment and planning the workforce
- healthy and productive workplaces
- employment policy and practice.

The NHS Employers organisation is part of the NHS Confederation.

Contact us

For more information on how to get involved in our work, email getinvolved@nhsemployers.org

www.nhsemployers.org

@nhsemployers
NHS Employers
www.youtube.com/nhsemployers

NHS Employers

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Kendell Street
Leeds LS10 1JR