Workplace health and the NHS: a rapid review and areas for exploration
C3 Collaborating for Health, October 2016

Contents

1. Executive summary 3
2. Introduction 4
3. The NHS workforce 5
4. Major issues 6
   4.1 The NHS as an organisational setting 7
   4.2 Sickness absence 9
   4.3 Musculoskeletal disorders 12
   4.4 Lifestyle 13
   4.5 Mental health 16
   4.6 Extending working lives 18
   4.7 Presenteeism 19
   4.8 Staff engagement 20
5. The current state of play 21
6. Areas for exploration 23
Annex 1: Tools and key resources 25
Annex 2: NICE Guidance 29
Annex 3: Evidence table 31
Annex 4: Case studies 41
References 42
This paper has been prepared by C3 Collaborating for Health (www.c3health.org), a London-based NGO that focuses on improving health where we ‘live, learn, work and play’ (as Sir Michael Marmot has put it). C3’s director, Christine Hancock, is on the NHS Employers Advisory Board on workplace health, established in February 2015 to help NHS England shape its healthy workplace programme and to consider how to inform the wider conversation about all employers’ responsibilities in wellbeing, including how the NHS can lead change. C3 is experienced both at report writing in workplace health, has practical experience of advising and facilitating workplace health, and has a growing C3 Workplace Health Movement (with patron, Dame Carol Black), which organises meetings and knowledge-sharing among practitioners in this space, both private and public sector.

This rapid review is part of ‘Improving the health and wellbeing of the NHS workforce’, a project funded by the Health Foundation. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the United Kingdom.
1. Executive summary

A workplace in which a ‘culture of health’ is fully embedded is one in which employees can thrive — in terms both of physical and mental health. Working people are often in their place of work for many hours a day, many days a week, for decades — and, aged between 16 and 70, they are still of an age in which working (and living) practices can make a real difference to long-term health.

The NHS is Europe’s largest employer — and one of the largest in the world — employing 1.3 million people. As a health-care organisation, it should be an exemplar for workplace wellbeing* — but this has not been the case, despite the commitment of the NHS Constitution to commit ‘to provide support and opportunities for staff to maintain their health, well-being and safety’.

The NHS presents huge challenges for wellbeing. Some affect workplaces across the board: how best to engage staff (particularly in small- and medium-sized enterprises), how to extend working lives as the workforce ages, and unhealthy lifestyles (poor diet, smoking and lack of physical activity). Others are particularly acute within the NHS, due to its structure and the need for 24-hour care: shift work, musculoskeletal disorders, and stress and other mental-health issues, leading to high rates of staff absence and presenteeism. The diversity of the NHS workforce — and variation in size of the workplaces, from small GP surgeries up to vast hospitals — mean that one size will never fit all when it comes to solutions. A further problem is that there is limited evidence on what works — partly due to the failure to gather accurate data of the impact of programmes (either in the public or private sector), and what is not measured cannot be managed.

These challenges can and must be overcome — although closing the gap between current NHS staff wellbeing (as assessed by the annual NHS Staff Survey) and the vision put forward by NICE in its Guidance on workplace health will require large-scale transformation. But change is taking place: in autumn 2015, a new, ambitious programme of measures was announced in England,† aiming to make the NHS an exemplary employer, and in April 2016, providers of NHS care will for the first time be funded to improve the support they offer to frontline health staff to stay healthy. Delivery will require careful thinking and support — and this report aims to provide insight into how C3 Collaborating for Health and its network can contribute, the first step in a process of private- and public-sector engagement.

This paper begins by setting out the size and diversity of the NHS workforce — effectively, the scale of the challenge. It then presents evidence on the major issues facing employers and employees in the NHS specifically (illustrated by mini case studies from both public and private sector‡), the current state of play following the announcement of the new programme, and sets out possible areas for further discussion and engagement. This is followed by four annexes: a select list of tools and resources that are of particular relevance to the NHS, a summary of the NICE Guidance documents on workplace health, tables of evidence (focusing on health-care settings), and a list of the case studies included in the text.

* For consistency, this report uses ‘wellbeing’ rather than ‘wellness’ (a term more common in the United States).
† See box on p. 4 for information on the other countries of the United Kingdom.
‡ More detailed information on the case studies in the text will be provided as part of the delivery of the wider project.
The United Kingdom

While much of this paper is generalisable, the focus is primarily on the NHS in England, following the recent announcements by Simon Stevens to prioritise the health of the NHS workforce in England. However, there are also ongoing programmes in the other three countries of the United Kingdom (see also examples in Annex 1: Key players), as set out below.

Wales

Working Differently, Working Together

Since 2012, NHS Wales’ Staff Health and Wellbeing Charter, ‘Working Differently, Working Together’, has supported delivery of the five-year vision for NHS Wales, Together for Health. It aims to create a culture of care for NHS staff, focusing on NHS staff being healthy and valued so that they can act as role models to the communities that they serve. Each NHS organisation will promote employee health and wellbeing by, for example, providing flexible working arrangements that support work/life balance, ensuring managers can provide support to staff both in work and those absent due to ill health, and making promotional events and information on healthy lifestyle choices available to all staff.

Scotland

Health Promoting Health Service

NHS Scotland has implemented the Health Promoting Health Service (HPHS), a settings-based approach to health promotion. HPHS aims to support a culture of effective health promotion and improvement within all hospitals in Scotland. In 2015, the Chief Medical Officer stated the commitment of HPHS to drive actions forward in the key areas of person-centred care, staff health and wellbeing and health promoting hospital environments. Prevention is key to HPHS policy.

Health Works

Health Works is the Scottish Government’s Healthy Working Lives Strategy, as part of which public-sector bodies (such as the NHS) will develop a public-sector mandate for public bodies to become examplars and champions for Health Works. Policy and practice will be adopted to promote the health and wellbeing of all staff. In 2004 the Scottish Centre for Healthy Working Lives was established within the NHS, which brought together several previous initiatives, and works to provide information and advice on workplace health and wellbeing in the NHS.

Northern Ireland

Healthcare is integrated with social care in Northern Ireland under the name Health and Social Care (HSC). HSC is sometimes referred to as the NHS, but differs from NHS England, Scotland and Wales in that it also provides social care that is provided by local councils in the other countries.

Belfast HSC Trust – B Well

The Belfast HSC Trust has a health and wellbeing scheme in place for its staff called B Well. Belfast HSC’s offer to employees include a cycle-to-work scheme and a work/life balance flexible working policy. In 2015 the trust also launched a B Well website and app to provide support and information to employees on health and wellbeing, complemented by access to training programmes, activities and events.

Smoke-free trusts

All five Northern Irish HSC trusts, Belfast HSC Trust, Northern HSC Trust, South Eastern HSC Trust, Southern HSC Trust and the Western HSC Trust now have smoke-free grounds. All except the Western HSC Trust became smoke-free in March 2016 on National No Smoking Day. The Western HSC Trust has been smoke-free since 2014: there is no smoking, e-cigarettes included, anywhere on or around trust sites, and smoking shelters are being removed.
2. Introduction

‘The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.’

So says section 3a of the NHS Constitution. Yet despite this commitment to staff health, safety and wellbeing, commentators have noted that too often staff health is seen as a nice-to-have optional extra rather than central to Board thinking in the NHS. But the tide may be changing...

Workplace-health initiatives are increasing worldwide as employers come to realise the gains to be made by addressing the wellbeing of their employees, particularly in light of the dramatic increase in non-communicable diseases that is causing rising levels of sickness absence, early retirement and early deaths. Since 2009, when Boorman published his independent review, successive policy initiatives have highlighted the need to improve the health and wellbeing of the 1.3 million members of the NHS workforce.

In autumn 2015, a new programme of measures was announced (section 5) that aim to make the NHS in England an exemplary employer, recognising that there is a proven link between healthy, engaged staff and better patient outcomes. This is an extremely ambitious programme that will present significant challenges, if it is to fulfil its aims. Making sure that workplace health and wellbeing initiatives build on, and respond to, best practice, will be critical if this investment and impetus is to realise its true potential. From April 2016, providers of NHS care will for the first time be funded to improve the support they offer to frontline health staff to stay healthy, with a share of a national incentive fund worth £450 million in 2016–17. As Simon Stevens, chief executive of NHS England, has noted: ‘If we can do this well [offering better support for staff health and wellbeing], we hope that more parts of the public and private sector will see the sense of it and also take the plunge.’ The NHS can be a leader in this space nationally and internationally.

This report aims to provide insight into ways to improve the health of the NHS workforce, based on a review of key documents, as well as bringing learning from a variety of sources, including the private sector.

3. The NHS workforce

The NHS is a challenging organisation, not least because of its size, the diversity of its operating models, and the financial pressures it constantly endures. It is a 24-hour a day, 365 days per year, multi-disciplinary, multi-professional service, providing support to approximately 1 million patients every 36 hours, across a range of settings. Each of these factors individually adds complexity to the development of effective initiatives to support workplace health improvement; understanding how they act corporately compounds this challenge.

The NHS employs 1.3 million people from a wide range of socioeconomic, ethnic and professional backgrounds (Table 1). Against the context of a dynamic and evolving multicultural society, with diverse and continuous health care needs, the NHS workforce needs to be fit for purpose – in every sense. The NHS is critically reliant on healthy, reliable staff, who are capable of responding to immediate needs and financial pressures while adapting to deliver the future care models outlined in the NHS Five Year Forward View (2014).³

A King’s Fund report, which looked at the complexity of workforce planning in the UK, highlighted the need to ensure that the existing workforce was able to meet current demand, whilst also considering whether the current composition of the workforce was able to achieve the ambitions of future care models.⁴ Arguably, there is an extra dimension to consider – it is not just the numbers of the workforce, but the health and resilience of the workforce that will be crucial to achieving NHS delivery objectives. This means ensuring that all people working for and with the NHS are adequately supported to optimise their health outcomes.
Table 1: NHS workforce statistics (2014 data)

<table>
<thead>
<tr>
<th>Professional roles:</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.6% of NHS employees are professionally qualified clinical staff (the number has risen by 12.7% since 2004). This includes:</td>
</tr>
<tr>
<td>- 150,273 doctors (annual average increase of 2.5% since 2004)</td>
</tr>
<tr>
<td>- 377,191 qualified nursing staff (annual average increase of 0.5% since 2004)</td>
</tr>
<tr>
<td>- 155,960 qualified scientific, therapeutic and technical staff</td>
</tr>
<tr>
<td>A further 26.0% provide support to clinical staff in roles such as nursing assistant practitioners, nursing assistant/auxiliaries and healthcare assistants.</td>
</tr>
<tr>
<td>2.67% of staff have management roles. The number of managers and senior managers increased slightly in 2014, having declined in each of the previous four years. There are 37,078 people in management roles (this was the second lowest total since 2004).</td>
</tr>
<tr>
<td>Infrastructure support*: 185,484 people</td>
</tr>
<tr>
<td>Support to clinical staff*: 309,164 people</td>
</tr>
<tr>
<td>Ambulance staff*: 17,832 people</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic diversity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of the 273,853 doctors registered on the GMC’s list of medical practitioners, 31.6% come from ethnic minority backgrounds. (Note 16.3% of people did not declare their ethnic background). Of these:</td>
</tr>
<tr>
<td>- 22.3% come from Asian backgrounds</td>
</tr>
<tr>
<td>- 3.1% come from black or black British backgrounds.</td>
</tr>
<tr>
<td>19.6% of qualified nursing staff, 17.4% of support staff to doctors and nurses, 2.5% of qualified ambulance staff, 8% of managers and 5.6% of senior managers come from ethnic minority backgrounds.</td>
</tr>
<tr>
<td>The most commonly occurring ethnic minority codes across all the categories were Asian/Asian British and black/black British.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td>59.2% of administrative managers were female, 40.8% male (55.1% of senior managers were female, 44.9% male)</td>
</tr>
<tr>
<td>66.2% of qualified ambulance staff were male, 37.8% female.</td>
</tr>
<tr>
<td>55.1% of doctors on the GMC’s list of medical practitioners were male, 44.9% female.</td>
</tr>
</tbody>
</table>

Source: Statistics are September 2015 data from spreadsheets at this link (unless otherwise stated): [http://www.hscic.gov.uk/article/2021/Website-Search?q=ethnicity+&sort=Relevance&size=10&page=2&area=both#top](http://www.hscic.gov.uk/article/2021/Website-Search?q=ethnicity+&sort=Relevance&size=10&page=2&area=both#top).

4. Major issues

This section lists some of the most pressing challenges in workplace health faced by the NHS.

An issue that cuts across all of these areas is a general lack of available evidence for what works in workplace health. These gaps have been highlighted by NICE, which set out proposals for research across a number of key areas including: effectiveness and cost-effectiveness of interventions and line-manager training; how effectiveness can be measured; how different leadership styles affect health and wellbeing of

* Statistics are drawn from the electronic staff record data and do not include GPs or primary care staff, dentists, two Foundation Trusts, or community service staff groups where provision is now through a non-NHS organisation.
employees; the impact of organisational culture; the contribution of occupational health, human resources and health and safety professionals in supporting line managers. NICE also stressed that all the research should aim to identify differences in effectiveness among groups, based on characteristics such as socioeconomic status, age, gender, ethnicity, size and type of employer and whether workers were paid or unpaid.

It is notable that it is not just in the United Kingdom that evidence is lacking. A 2013 report by RAND Health showed just how haphazard many of the workplace health initiatives and measurements are in practice, noting that a US study found that ‘93 percent of all employers and 70 percent of those with 500 or more employees did not measure the ROI of their health management programs, which suggests that many programs are operated without any impact assessment’ – this despite there being, in the United States, a clear line to be drawn between health and (insurance) costs to the business.

Short examples of case studies in many of the focus areas are included (these are listed in Annex 4).

4.1 The NHS as an organisational setting

4.1.1 The challenges

The NHS has a highly diverse organisational format (Table 2), covering a range of organisational forms and worksites, from small GP surgeries to large hospitals. It has the potential to provide longitudinal access to a large number of people, with multi-level ‘ecological’ interventions directed at individual, organisational and environmental determinants of health behaviours. The evidence suggests that a well-implemented multi-component health-promotion programme not only can improve the health status of participants but can also improve work-related outcomes such as productivity and sickness-absence rates. However, each hospital, trust, practice and building has its own unique challenges to address. Access to basic amenities, rest facilities and food retailers is variable, and the level of control the employer has over basic amenities is inconsistent.

Table 2: Commissioners and providers of NHS services

<table>
<thead>
<tr>
<th>There are currently in England:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 209 clinical commissioning groups (including 199 now authorised without conditions)</td>
</tr>
<tr>
<td>• 154 acute trusts (including 101 foundation trusts)</td>
</tr>
<tr>
<td>• 56 mental health trusts (including 43 foundation trusts)</td>
</tr>
<tr>
<td>• 37 community providers (15 NHS trusts, 3 foundation trusts and 19 social enterprises)</td>
</tr>
<tr>
<td>• 10 ambulance trusts (including 5 foundation trusts)</td>
</tr>
<tr>
<td>• 7,875 GP practices</td>
</tr>
<tr>
<td>• 853 for-profit and not-for-profit independent sector organisations, providing care to NHS patients from 7,331 locations</td>
</tr>
</tbody>
</table>


In effect, this means that NHS employers have to work on three fronts:

• workforce capability: supporting staff to make healthy choices by up-skilling staff, and increasing their personal knowledge and efficacy so that they can make healthy choices;
• organisational factors: ensuring that appropriate line-management support is in place, with robust policies to support staff rehabilitation and retention; and
• environmental and infrastructural factors: supporting staff to make healthy choices by ensuring, where possible, that healthy choices are available.
4.1.2 The evidence

The statistics presented above show the diversity of the NHS workforce. Ensuring that all members of the workforce have equal access to initiatives which are aimed at improving their health is a key challenge. There is some indication that this is not currently being achieved:

- The NHS Staff Survey 2015 asked whether immediate managers were taking a positive interest in the health and wellbeing of their staff – and here there has been progress: 70 per cent of responses said that this is the case (up from 59 per cent in 2014), and 90 per cent said their organisation takes positive action on health and wellbeing (another big rise – up from 43 per cent in 2014).  

- Although a number of studies have highlighted that shift work can have a detrimental impact on circadian rhythms, sleep patterns, stress levels and work–life balance, shift workers may struggle to access health-improvement initiatives, particularly if they work during the night.

- Lower-paid workforces may be less likely to access interventions. Although involvement of workers in planning of health-promotion activity is widely advocated, specific difficulties can be encountered in releasing low-paid and manual workers from their posts. This may also present a barrier to participation in workplace health improvement activities.

- Agency workers, outsourced and temporary staff may be less able to access support. They are in general a widely used resource within the NHS and can play a vital role in helping NHS organisations to plan and manage fluctuations in demand, as well as covering for periods of short-term workforce shortage. Yet the experience of agency and temporary staff can be very different from that of permanent employees (Table 3).

Table 3: Agency and outsourced staff

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outsourced staff sometimes have access to occupational health</td>
<td>Outsourced staff sometimes have access to occupational health</td>
</tr>
<tr>
<td>services either via a service-level agreement or on an ad hoc</td>
<td>services either via a service-level agreement or on an ad hoc</td>
</tr>
<tr>
<td>basis. But they appear generally to have less access to health-</td>
<td>basis. But they appear generally to have less access to health-</td>
</tr>
<tr>
<td>promoting interventions than employed staff.</td>
<td>promoting interventions than employed staff.</td>
</tr>
<tr>
<td>While 83% (96/116) of trusts report that fair terms and conditions</td>
<td>While 83% (96/116) of trusts report that fair terms and conditions</td>
</tr>
<tr>
<td>are included in the procurement conditions, only 68% (79/116)</td>
<td>are included in the procurement conditions, only 68% (79/116)</td>
</tr>
<tr>
<td>say that they insist on a living wage. And 34% (39/116) of</td>
<td>say that they insist on a living wage. And 34% (39/116) of</td>
</tr>
<tr>
<td>trusts report that outsourced staff do not have access to</td>
<td>trusts report that outsourced staff do not have access to</td>
</tr>
<tr>
<td>flexible working.</td>
<td>flexible working.</td>
</tr>
<tr>
<td>Outsourced staff tend to be lower paid and to work in manual</td>
<td>Outsourced staff tend to be lower paid and to work in manual</td>
</tr>
<tr>
<td>jobs with arguably more health risks, so this is an equity</td>
<td>jobs with arguably more health risks, so this is an equity</td>
</tr>
<tr>
<td>issue.</td>
<td>issue.</td>
</tr>
</tbody>
</table>

Studies surrounding the health and wellbeing of the NHS workforce vary greatly in terms of population, setting, size, design and outcomes of interest. Systematic literature reviews have identified that there is limited evidence available focusing on the workforce as the population of interest for health-promotion initiatives (see Tables at Annex C, and discussion in the sections below for specific topic areas).

There is a significant evidence base showing that staff working at different levels of the NHS, in different roles and in different organisational bodies, demonstrate substantial variations in measures of employee engagement, levels of ill health and sickness absence, and self-reported health and wellbeing (see Figure 2 for sickness absence by staff level). The Royal College of Physicians, quoting NHS Staff Survey 2014 data, notes that ambulance staff, for instance, report significantly lower levels of job satisfaction, higher levels of work-related stress and less support from line managers than those working in hospitals, mental health, community care or (in England) CCGs. Perhaps unsurprisingly given the complexity of the NHS, where evidence is available it tends to focus on describing the health risks or health behaviours associated with specific staff groupings, rather than looking holistically at the workforce as a whole, or focusing on what constitutes an effective intervention, and for whom it may be applicable.

Even where examples can be found, the impact of interventions on health and wellbeing outcomes is often poorly recorded:
• an evaluation of interventions targeted at lower-paid workers in Glasgow City Council and NHS Greater Glasgow & Clyde\textsuperscript{15} identified health checks as the most popular activity amongst workers in this group; however, the impact on health and health behaviours was often not recorded in the studies reviewed; and

• a systematic review conducted in 2010\textsuperscript{16} suggests that assessment can be an effective way of engaging with workers and helping them understand the relationships between their behaviour and health. However, the review findings could not support the use of assessment of health risks alone in enabling behaviour change.

The role of managers is acknowledged to be key to good workplace health, and NICE has published Guidance on ‘Workplace health: management practices’.\textsuperscript{17} This advises that health and wellbeing is fully incorporated across management practices, and that it is an organisational commitment from the top down.

Small and medium-sized organisations are particularly hard to engage in workplace health (see case study), as they lack the economies of scale or the substantial infrastructures that enable major organisations to establish wellbeing initiatives.\textsuperscript{18}

4.2 Sickness absence

4.2.1 The challenge

Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4 billion a year – around £1 in every £40 of the total budget. This figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment.\textsuperscript{19} Sickness absence rates for the NHS have consistently been higher than the UK public-sector average (Figure 1).

**Figure 1: UK sickness absence rates (%) in larger public-sector organisations and the private sector (2003, 2008, 2013)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Public-sector organisations</th>
<th>Private sector</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Central government</td>
<td>Local government</td>
</tr>
<tr>
<td>2003</td>
<td>3.7</td>
<td>3.9</td>
</tr>
<tr>
<td>2008</td>
<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td>2013</td>
<td>3.0</td>
<td>2.7</td>
</tr>
</tbody>
</table>

*Source: Labour Force Survey person datasets.\textsuperscript{20}*

Notes:

• The sickness absence rate is the percentage of working hours that are lost due to sickness absences by workers in the public and private sectors

• Sickness absence rates in larger public sector organisations and in the private sector are calculated for all people in employment aged 16 and over

• Quarterly datasets were used to generate annual averages

Annual figures published by the Health and Social Care Information Centre (HSCIC) in 2015 show that on average, NHS workers had 14.82 days a year of sickness absence in 2013–14.\textsuperscript{21} This is a decrease in the number of days off sick from 2012–13, when the sickness absence rate was 4.24 per cent (15.52 days per
HSCIC aggregated sickness-absence rates for July–September 2015* show that ambulance staff (5.48%) and health-care assistants and support staff (6.13%) have the highest rates of sickness absence, followed by nursing staff (4.66%), with nursing, midwifery and health visiting students† (1.17%) and medical and dentist staff (1.14%) having the lowest rates of absence on aggregate‡ (Figure 2). Sickness absence rates are highest among the lowest paid, in line with the general population.§

Figure 2: Rates by staff group, September 2013–September 2015


4.2.2 The evidence

NICE recommendations stress the importance of early identification and continuing close contact with employees who suffer recurrent short-term or long-term sickness absences, with systematic planning for return to work that takes account of individual need and circumstance. The audit‡ of NHS Trusts noted above, funded by NHS Employers, found that all the trusts that responded to the audit† had an organisational policy in place for long-term sickness absence. However, as Figure 3 shows, there were significant differences in the length of time managers waited before initiating management support, with some 10 per cent of trusts reporting that their policy did not give a trigger date for managerial support to commence.

This is despite strong evidence that early intervention from line managers from the first day of sickness absence reduces the overall time spent off work and can even prevent the recurrence of long-term sickness absence for common conditions such as lower back pain. The impacts of managers versus familial/friend support has been explored in the literature. A UK-based study, for instance, found that if nurses turned to family and friends for support, sickness and absence levels increased.‡ Conversely, if they turned to line managers, absence levels noticeably decreased.

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* HSCIC data does not at present show the reason for absence, although it is reported that this is being explored.
† This group is comprised students who do not spend all their time rostered onto shifts, and who have markedly different working conditions.
‡ 73 per cent of all NHS trusts were reported to have responded to the audit. Round 1 took place in 2010, round 2 in 2013.
Figure 3: Sickness absence triggers for management support

Does the policy give a trigger for when this should be done?

<table>
<thead>
<tr>
<th></th>
<th>National (n=163)</th>
<th>National (n=167)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Round one</td>
<td>Round two</td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Yes at 2 weeks (or less)</td>
<td>75 (46)</td>
<td>98 (59)</td>
</tr>
<tr>
<td>Yes by 3 weeks</td>
<td>9 (6)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Yes by 4 weeks</td>
<td>64 (39)</td>
<td>50 (30)</td>
</tr>
<tr>
<td>Yes by 5 weeks</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Yes by 6 weeks</td>
<td>0 (0)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Yes, later than 6 weeks</td>
<td>1 (1)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>No</td>
<td>14 (9)</td>
<td>16 (10)</td>
</tr>
</tbody>
</table>

Source: Sloan et al., Implementing NICE Public Health Guidance

Health inequalities characteristics were, according to the audit, considered in most trusts. However, monitoring of trends by health inequalities characteristics was not routinely undertaken, with only 31% of responding trusts reporting that they monitored trends by age, 28 per cent by ethnicity, and 24 per cent by shift pattern (Figure 4).

Figure 4: Health inequalities data reflected in sickness absence policies

Round two only

<table>
<thead>
<tr>
<th></th>
<th>5.1.3 Does the sickness absence policy address the diverse needs of staff groups by taking account of:</th>
<th>5.5 Does the trust monitor trust trends in long-term sickness absence by considering the following?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National (n=134)</td>
<td>National (n=178)</td>
</tr>
<tr>
<td>Age</td>
<td>138 (78)</td>
<td>55 (31)</td>
</tr>
<tr>
<td>Gender</td>
<td>140 (79)</td>
<td>56 (31)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>137 (77)</td>
<td>50 (28)</td>
</tr>
<tr>
<td>Staff grade</td>
<td>126 (71)</td>
<td>81 (46)</td>
</tr>
<tr>
<td>Occupational group</td>
<td>129 (72)</td>
<td>105 (60)</td>
</tr>
<tr>
<td>Shift pattern</td>
<td>129 (72)</td>
<td>42 (24)</td>
</tr>
<tr>
<td>Disability</td>
<td>162 (91)</td>
<td>60 (34)</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>126 (71)</td>
<td>35 (20)</td>
</tr>
</tbody>
</table>

Source: Sloan et al., Implementing NICE Public Health Guidance

As part of its suite of guidance on workplace health, based on evidence reviews, NICE has produced guidance on best practice for long-term sickness absence (see also Annex 2).

Case study: sickness absence

National Grid launched its staff wellbeing strategy in 2008, to decrease sickness absence and increase staff engagement. The strategy focused on education around health, addressed business issues, and also used staff health information to target and manage health and wellbeing more effectively. Workshops with senior managers were held to ensure high-level commitment, and employees at all levels engaged through programmes such as dedicated Wellbeing Champions and mobile vehicles to deliver health screening checks to remote workers. Employees have access to Health Kiosks to check and track their health, a health and wellbeing intranet was established, and cardiovascular risk assessments offered to identify and support ‘at risk’ population. The number of absence days dropped by 35,000 between 2008 and 2011, leading to a saving of £8.9 million.
4.3 Musculoskeletal disorders

4.3.1 The challenge

Musculoskeletal disorders (MSD) can affect muscles, joints and tendons in all parts of the body. Most work-related MSD develop over time, with sufferers experiencing episodic or chronic pain, and symptoms existing on a continuum from mild to severe. These disorders are seldom life threatening but they impair the quality of life of a large proportion of the adult population. Musculoskeletal disorders account for nearly half of all sickness absence in the NHS.30

An article in Occupational Health and Wellbeing (January 2016),31 suggests that approximately 6,000 NHS staff in England miss work every day because of musculoskeletal problems. Quoting conclusions based on data gathered through an FOI request* by PhysioMed, the article notes that MSD sickness absence costs the NHS £200 million a year, based on an average daily staff rate of £91.56, and an average 13,842 days lost across all 156 NHS trusts in England.† These figures resonate with findings from a 2013 FOI-based study, carried out by the Chartered Society of Physiotherapy,32 which suggested that 40 per cent of staff sickness absence in the NHS was due to musculoskeletal conditions,33 with more than 19.3 million sick days taken across the NHS over the three years covered by the FOI.34 Although neither report breaks down the sickness absence reports to show the occupational levels, gradings, or professional backgrounds of the people experiencing sickness absence due to musculoskeletal disorders, data on absence levels from the general population show that absence rates have always been higher among manual workers due to the nature of their work.

A 2011 systematic review suggested that nurses were at greater risk of musculoskeletal injuries than other health-care workers,35 and this is held up by the results of a 2013 survey of nurses, which found that ‘moving or handling’ of patients caused 11.5 per cent of all cases in which nurses had injured themselves or become ill during the previous 12 months.36

When viewed in isolation, absence levels from MSDs are far too high – when considered in combination with other factors, such as an ageing workforce and the consequences of lifestyle choices, the challenge is compounded.

Case study: MSD

After realising that musculoskeletal disorders were one of the top two reasons that staff were absent from work, Britvic decided to implement a service to prevent, address and treat employees’ musculoskeletal problems. The service is delivered in collaboration with Britvic’s occupational health partners and the administrators of Britvic’s existing Healthcare Plan. It fast-tracks employees’ concerns via a telephone physiotherapist assessment and takes them through a stepped care programme. Advice on lifestyle and prevention is also available to staff. The feedback has been positive and Britvic has also seen positive impact on staff sickness-absence rates, falling from 11 days per employee per year in 2006–7 to 5.6 days in 2008–9.

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* The FOI request was reportedly answered by 59 acute trusts, covering the three years from 2011 to 2014. Copies of some of the individual FOIs can be found by Google search, e.g. http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Websites/Internet/OurOrganisation/FreedomOfInformation/DisclosureLog/2015/201507/FOIRef904SicknessAbsenceAndMusculoskeletalDisordersIn2014To15.pdf

† HSCIC data does not at present show the reason for absence, although it is reported that this is being explored.
4.4 Lifestyle

4.4.1 The challenge

Lifestyle and chronic disease management is a ticking time bomb for the NHS. The consequences of lifestyle choices people make affects their health in the short, medium and long term, creating a double whammy for the NHS: increasing the potential future patient demand associated with managing chronic conditions associated with obesity, while also managing the impact on staff (current and future), who may also be suffering the effects of their own lifestyle choices (Table 4). The NHS cannot dictate employees’ personal choices, but it can be influential – both within and outside the workplace.

Progress has been made. Comparisons between audits carried out in 2010 and 2013 show that the percentage of staff restaurants offering and encouraging healthy options rose from 74 to 84 per cent over the three years. Yet there is still considerable progress to be made. One challenge that remains to be addressed relates to the very nature of the NHS: the 2013 audit suggested there was poor 24-hour provision, with only 67 per cent of trusts offering healthy options to evening workers and only 27 per cent overnight – for a 24-hour-a-day, 365-day-a-year service, this is an obvious area to target.

Table 4: Lifestyle and chronic disease challenges in the NHS workforce

- All trusts have a sickness absence policy and three-quarters have one for smoking cessation, but only 57% have one for mental wellbeing, 44% for physical activity and only 28% have an obesity plan.
- 38% of trusts do not allow staff to attend smoking-cessation services during working hours without loss of pay.
- 8% trusts say they do not provide access to smoking-cessation support (either on site or through arrangements with another local service).
- Around 700,000 staff are currently overweight, yet only 28% of NHS trusts in England said they have a plan or policy in place to help reduce obesity.
- Access and inequality is still an issue, with only 37% of outsourced staff having access to the same support services as directly employed staff.
- A study in the UK with pre-registered nurses showed that 28–32% of the sample population followed UK government recommendations on fruit and vegetable intake (5 a day), suggesting that in this study pre-registered nurses were not applying their learning on healthy eating to their personal nutrition behaviours. Many of the individuals surveyed believed they were following a healthy diet, despite their poor dietary practices.
- Surveys of qualified nurses in the UK have shown that nurses are exceeding alcohol guidelines when they drink.

4.4.2 The evidence

One of the key tensions apparent throughout the evidence is the need to address both the individual barriers to addressing lifestyle challenges and organisational barriers. Searching for research into management of lifestyle issues in the workplace shows that there have been limited published studies focusing on the health workforce. However, there is evidence to show that workplace interventions can be effective in smoking, physical activity and nutrition – providing that both individual and organisational factors are considered.
For example, individual factors include personal beliefs, understanding of the evidence, and access to timely resources:

- a study in the UK with pre-registered nurses showed that just 28–32 per cent of the sample population followed UK government recommendations on fruit and vegetable intake (5-a-day), suggesting that in this study pre-registered nurses were not applying their learning on healthy eating to their personal eating behaviour. Many of the individuals surveyed believed they were following a healthy diet, despite their poor dietary practices45;
- a US study that evaluated a ‘nursing live fit’ programme suggested that obesity levels could be reduced by providing evidence based programmes which combine exercise and nutritional education46;
- as one study on physical activity shows, there may be benefit to be achieved from targeting the recruitment strategies to optimise uptake and sustainability of benefit within particular workforce subsections, e.g. by considering how the intervention relates to self-image.47 The effectiveness of interventions on sedentary behaviour is more equivocal48; and
- the specific needs of different staff groups may also not be routinely reflected in the development and monitoring of plans and programmes. Audit data suggests that inequalities characteristics are often not used to monitor the effectiveness of programmes (Figure 5).

Figure 5: Use of inequalities characteristics to address staff needs and measure uptake of programmes

<table>
<thead>
<tr>
<th>2.1.3 Does the obesity policy address the diverse needs of staff groups by taking account of:</th>
<th>2.1.4.1 Does the trust measure uptake of any programmes by different staff groups?</th>
</tr>
</thead>
<tbody>
<tr>
<td>National (n=50) n (%)</td>
<td>National (n=36) n (%)</td>
</tr>
<tr>
<td>Age</td>
<td>30 (60)</td>
</tr>
<tr>
<td>Gender</td>
<td>31 (62)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>30 (60)</td>
</tr>
<tr>
<td>Staff grade</td>
<td>28 (56)</td>
</tr>
<tr>
<td>Occupational group</td>
<td>29 (58)</td>
</tr>
<tr>
<td>Shift pattern</td>
<td>24 (48)</td>
</tr>
<tr>
<td>Disability</td>
<td>30 (60)</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>29 (58)</td>
</tr>
</tbody>
</table>

53% (19/36) of trusts who monitor programmes adjust them where there are clear differentials in uptake.

Source: Sloan et al., Implementing NICE Public Health Guidance49

The quality of the evidence remains a challenge. The outcomes that are being measured are not always behavioural, and there is limited evidence that studies purporting a positive outcome have considered behaviours outside the workplace, or indeed considered whether there may be specific staff needs associated with inequalities characteristics, such as age, ethnicity or shift pattern. These are gaps that need to be considered in future study design. The robustness of data collection and analysis remains a key challenge - two systematic reviews looking at general workplace initiatives suggested that Interventions that had less rigorous research designs were more likely to report being effective than those without these characteristics50.

Case study: physical and mental health in a large organisation

PepsiCo has implemented a Health and Wellness Programme entitled ‘One Life, Your Choice’. It focuses on mental as well as physical health, and ties in with PepsiCo’s senior management’s belief that ensuring that staff are healthy makes good business sense. As part of the mental-wellbeing initiative, PepsiCo has recently implemented a cognitive behavioural therapy (CBT) programme. Employees also organised a health and wellness day where participants could find out their cholesterol levels and attend workshops on making small healthy-lifestyle changes.
The audit of NHS trusts suggests that NHS trust engagement in managing lifestyle issues has been variable (Figure 6).

**Figure 6: Organisational policies on lifestyle issues**

(Participating trusts n=172 in round one and n=178 in round two)

<table>
<thead>
<tr>
<th>Does the trust have an organisation-wide plan or policy on?</th>
<th>National Round one n (%)</th>
<th>National Round two n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall health and wellbeing</td>
<td>70 (41)</td>
<td>115 (65)</td>
</tr>
<tr>
<td>Obesity</td>
<td>23 (13)</td>
<td>50 (28)</td>
</tr>
<tr>
<td>Smoking</td>
<td>129 (75)</td>
<td>134 (75)</td>
</tr>
<tr>
<td>Physical activity</td>
<td>41 (24)</td>
<td>79 (44)</td>
</tr>
<tr>
<td>Long-term sickness absence</td>
<td>172 (100)</td>
<td>178 (100)</td>
</tr>
<tr>
<td>Mental wellbeing</td>
<td>83 (48)</td>
<td>101 (57)</td>
</tr>
</tbody>
</table>

Source: Sloan et al., *Implementing NICE Public Health Guidance* 51

In round 2 (2013), of those that said they had an organisational policy:

- for obesity: 35/50 (70 per cent) said they had board-level engagement, and 41/50 (82 per cent) said they had involved staff in the planning and development of their policy;
- for smoking: 117/134 (87 per cent) said they had board-level engagement, and 116/134 (87 per cent) said they had involved staff in the planning and development of their policy; and
- for physical activity: 50/79 (63 per cent) said they had board-level engagement, and 66/79 (84 per cent) said they had involved staff in the planning and development of their policy.

NICE has produced sets of guidance with overlapping messages on obesity, physical activity in the workplace, and environmental and building design to promote physical activity. Key recommendations include active policies to prevent and manage obesity, promotion of healthy diets through having healthy choices at food outlets, and promotion of physical activity. In addition, NICE Guidance is available on helping employees to stop smoking. (See Annex 2.)

Systematic-review evidence shows that workplace interventions aimed at the nursing workforce have been successful in reducing cigarette consumption, supporting weight loss, and promoting physical activity. 52 But a further 2013 systematic review of nurses’ health only identified 18 studies that met the inclusion criteria. Interventions included on-site wellbeing, ergonomic and exercise programs; holistic practices, including Tai Chi and massage; the use of clinical supervision; mental-health programmes; and the use of minimal, no lift and lift-team programmes. 53

**Case study: smoking cessation**

The Sandwell and West Birmingham Hospitals NHS Trust implemented a nicotine-replacement programme to help staff quit smoking. The programme ran from January to June 2014 and worked with local smoking-cessation providers. It was funded for 100 staff members: 51 joined, 11 dropped out and 29 per cent quit smoking after six months, similar to national quit rates with the use of nicotine-replacement treatment.

**Case study: health checks**

As part of its health and wellbeing strategy, Nestlé is offering free health checks to all of its 8,000 employees over three years. The checks, which take the form of a 45-minute, one-to-one health assessment with a clinician from Nuffield Health, are held on site. The assessment is drawn up as a coaching session, it focuses on the individual, lifestyle factors and behaviours which takes into account the employee’s family history, current health and aims for the future. The checks encourage individual behaviour change and the anonymous health data collected is used to create targeted interventions. The programme is being independently evaluated by the Royal Society of Public Health.
However, approaching staff to talk about their personal health challenges can be particularly difficult. One trust, which had undertaken a comprehensive evaluation of some brief intervention training,\(^4\) noted that when asked whether the training made staff consider changing their own lifestyle, 302 (75 per cent) of respondents said it did. The 164 respondents who were asked which aspects they would like to change specified the following (in order or priority): exercise, weight, diet, alcohol, mental wellbeing, and smoking. Respondents often considered that more than one aspect of their lifestyle needed some attention. The most common multiple responses were for diet, weight and exercise. The report concluded that the training could be seen as a non-confrontational way of opening discussions about staff health, and that relying on wider awareness campaigns may not make staff see the relevance to their own health. Seeking their cooperation in helping others to achieve a healthy lifestyle may be a novel approach to highlighting how their own lifestyle choices can improve their own health.

**Example: Student nurses ‘making every contact count’**

Nurses are one of the primary sources of patient education, with the responsibility of informing patients about health promotion and disease prevention. Despite their professional role, nurses are often poor models of the lifestyle behaviours they are expected to endorse, and may be viewed as less ‘credible’ by patients if they appear hypocritical, and promote health behaviours that they have clearly not chosen to engage with themselves. C3 Collaborating for Health and London South Bank University are conducting an intervention study with nursing students to encourage them to (a) engage in healthier lifestyle behaviours related to diet, physical activity, tobacco and alcohol use (b) change their attitudes towards health promotion as nurses, and (c) report engaging effectively with patients to ‘make every contact count’ (MECC) during their clinical placements.

*Source: C3 Collaborating for Health: [http://www.c3health.org/c3activities/health-professionals/nursing/healthier-nursing-students/](http://www.c3health.org/c3activities/health-professionals/nursing/healthier-nursing-students/)*

### 4.5 Mental health

#### 4.5.1 The challenge

Mental-health problems are a major cause of unemployment and sickness absence. Mental ill-health costs the UK economy £70 billion a year equivalent to 4.5% of GDP – through lost productivity, social benefits and healthcare payments.\(^5\) In the NHS, stress is believed to account for over 30 per cent of sickness absence,\(^6\) costing the service £300–400 million per year.\(^7\) The importance of mental wellbeing cannot be ignored (Table 5).

**Table 5: Mental-health challenges for the NHS**

- 57% (101/178) of trusts had an organisation-wide mental wellbeing plan in 2013. This is a modest increase on the 48% (83/172) recorded in 2010.\(^8\)
- In the 2015 staff survey,\(^9\) 36% of NHS staff reported that during the last 12 months they have felt unwell as a result of work-related stress, down from 39% in 2014.\(^9\)

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\(^1\) Roles of staff were not recorded on the evaluation forms, but booking records suggest that nurses were the largest staff group who booked a place.

\(^2\) This is the 13\(^{th}\) such Staff Survey, published on 23 February 2016 and completed across 297 NHS organisations by 299,000 staff – the highest-ever number of respondents, and approximately a quarter of the total workforce. The higher response rate in the 2015 survey, and structural changes to the NHS, means that comparisons between 2014 and 2015 figures should be treated with caution.
A report by NHS Employers, published in 2008, which aimed to provide support for people working in the NHS experiencing mental-health challenges, identified a series of features that it believed would support people to gain and retain employment:

- time-unlimited support and workplace interventions, including reasonable adjustments under the Disability Discrimination Act, to enable people to retain employment;
- helping the employee and the employer to understand whether particular behaviour observed in the workplace is related to mental-health problems (the occupational health physician may wish at this stage to enlist the help and advice of a mental-health practitioner);
- assisting the employee to access appropriate support through their GP, local mental-health services or elsewhere, if more appropriate (for example if they work in the local mental-health service and have concerns about confidentiality); and
- working with the employee and clinicians to facilitate a return to work through job modification and rehabilitation in the workplace, paying attention to user preferences and choices rather than providers’ judgements about the sort of job that is appropriate.

Alongside efforts to manage existing conditions, and promote mental health and wellbeing, there is also a need to address some of the factors that may exacerbate stress. As Table 6 shows, violence, harassment, bullying and abuse is one factor that needs to be considered.

### Table 6: Violence, harassment, bullying and abuse in the NHS

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13%</td>
<td>Staff reported experiencing physical violence from patients, their relatives or other members of the public in the previous 12 months, down from 14% in 2014. This figure is higher among staff in ambulance trusts and mental-health trusts.</td>
</tr>
<tr>
<td>25%</td>
<td>Staff reported that they experienced bullying, harassment and abuse from patients, their relatives or other members of the public in the previous 12 months – a decrease from 28% in 2013. Again, the figures are higher among staff in ambulance trusts and mental-health trusts.</td>
</tr>
<tr>
<td>64%</td>
<td>Incidents of physical violence were reported compared to 66% in 2014 and 41% of staff reported bullying, harassment and abuse cases (44% in 2014).</td>
</tr>
<tr>
<td>2%</td>
<td>Around 2% of staff said they had experienced physical violence from other staff. One in eight staff reported they had been bullied or harassed by their manager.</td>
</tr>
</tbody>
</table>

Sources: NHS Staff Survey 2015 and NHS Employers, press release (23 February 2016).

### 4.5.2 The evidence

NHS organisations that have more favourable indicators of staff mental wellbeing (for example, in relation to bullying, harassment and stress) have better attendance, lower staff turnover, less agency spend, higher patient satisfaction and better outcome measures. The literature suggests that managers may not be able to change the mental health of their staff but they can make a huge impact on how supported staff feel by communicating, listening and being open to adjustments where required and by providing support and signposting as necessary. Audit data suggests that 65 per cent of NHS trusts in England had a plan for the health and wellbeing of their workforce in 2013, up from 41 per cent in 2010. The NHS Staff Survey also suggests that progress is being made, with 70 per cent of staff in 2015 (up from 59 per cent the previous year) believing that their immediate manager took a positive interest in their health and wellbeing.

Multiple sources within both NHS and wider literature identify the management of conflict and time management as areas where action could be taken to improve mental health and wellbeing of the workforce. This resonates well with the overall impetus of the proposed NHS workforce health programme.

Examples of specific initiatives in the literature that have demonstrated efficacy in reducing workplace stress include:
• staff massage sessions; 
• manipulation of shift length; 
• job-stress awareness and assertiveness training; 
• solutions-focused supervisory sessions; 
• mindfulness programmes; 
• physical-activity programmes; and 
• positive action on workplace bullying.

One area, identified in only one study, was related to changing requirements of nurse roles. The emergence of telephone health advice services means many nurses now work in call-centres, doing work that differs markedly from traditional nursing roles. Stress associated with these roles could have implications for nurses, patients, and service provision. A cross-sectional study, undertaken in Scotland, determined that work–life conflict was significantly related to sickness absence. Minimising the impact of nurses’ work on their home lives might reduce turnover and sickness absence.

Guidance from NICE has been produced on ‘Promoting mental wellbeing through productive and healthy working conditions’, which includes recommendations on the integration of mental wellbeing into all policies and practices concerned with managing people, adopting appropriate systems for assessing and monitoring employees’ mental health, adopting a company culture that supports flexible working and addresses employees’ concerns and line managers should be supported and trained in promoting the mental wellbeing of employees.

4.6 Extending working lives

4.6.1 The challenge

People are living longer. Improvements in life expectancy brings with it the willingness, and sometimes the financial need, for older adults to work beyond the traditional retirement age, prolonging their careers and employment, resulting in an increase in older workers in the workplace. The rising number of older people in the workplace, together with the increasing policy focus on active ageing, combating ageism in the workforce and reversing the trend towards early retirement, has led to a growing interest in the role of older people in work.

Staff recruitment and retention is an ongoing challenge. A 2013 review, jointly published by the NHS Staff Council and the University of Bath, suggested that the average age of NHS staff was rising year on year, (the average age at the time of publication was 43 years of age), with a high proportion of staff retiring in their 50s for various reasons. Retaining existing staff, and supporting flexible work options would appear to make good business sense. Yet supporting an older NHS workforce may itself raise additional challenges – notably that the physical toll of working is likely to be greater for older people, the prevalence of health problems associated with ageing will increase, and age discrimination and a failure to value experience may result in increasing levels of stress.

Previous reports by The Work Foundation have highlighted the need to encourage older people to stay in the workforce, with The Work Foundation’s Health at Work Policy Unit identifying a series of recommendations to address the issue of making work more attractive for an ageing population, including special occupational health services, early intervention, workplace adjustments, education and training, flexible work and an AGE Confident campaign to persuade employers of the benefits of taking on older...

Case study: mental health

BT has dedicated a specific campaign to mental health, entitled ‘Work Fit – Positive Mentality’, fitting into the company’s greater aim of creating an ‘interdependence’ attitude towards wellbeing among BT staff, where everyone is responsible for their own, as well as others’, wellbeing. The campaign includes initiatives such as accessible information, practical guidance on improving mental health and preventing mental ill health, access to Cognitive Behavioural Therapy (CBT) and training for managers. Achievements of the campaign include thousands of BT managers trained over four years and an increase in the speed at which employees return to work as well as access services.
workers and to challenge negative stereotypes. These initiatives are equally applicable within an NHS setting.

### 4.6.2 The evidence

Programmes directed towards improving, maintaining and sustaining the health of older people, to be ultimately effective, will need to work collaboratively and facilitate the efforts of those seeking to improve the lifestyles, environmental risk exposures and opportunities for health promotion and health protection at earlier ages. This is especially true for the prevention of those disorders that, at least in part, have their origins in lifestyle choices or life experience in earlier life, for example as a consequence of obesity, smoking, or alcohol consumption.

Much of the available literature focuses on the need to manage retirement, adapt job design, and provide robust training – or picks up the health risks associated with older workforce. Yet maintaining good health and the ability to work for as long as they want or need to is fundamental to giving people a better life in old age. Many already common health problems become more prevalent with age as part of the normal and inevitable ageing process.

There has been limited research focusing specifically on the health workforce as a population of interest. An RCN report that focused on supporting older nurses in the workplace noted that there were a number of issues which needed to be addressed, including: valuing expertise, achieving career goals throughout working life, being supported to work into and beyond retirement, healthy relationships at work (including sharing knowledge across generations), provision of appropriate health and wellbeing support to take account of physical capability, meaningful activity, feeling able and equipped to do the job, continuing development (many older workers welcome new skills and working practices), and having a degree of autonomy/choice over how one works.

Research is currently being conducted by the University of Leicester, as part of the Extending Working Lives in the NHS project, to look at:

- whether there is a link between people working longer and the level of their performance at work;
- what changes to employment policy and practice may be required where people are working longer; and
- what factors affect the retirement decisions of NHS staff.

According to a press release by NHS Employers, research interviews for this study commenced in 2015 in six trusts across England, will be repeated in 2016, with the findings of the research due to be published in 2017.

Note also that NICE is shortly to publish Guidance on ‘Workplace health – older employees’ (due March 2016) and on ‘Workplace health: support for employees with disabilities and long-term conditions’ (due April 2017).

### 4.7 Presenteeism

#### 4.7.1 The challenge

The concept of ‘presenteeism’ can be used in a number of different ways:

- lost productivity that occurs when employees come to work when they are ill and therefore perform below standard. This can also be termed ‘sickness presence’ or ‘lost health-related work productivity’ (defined by NICE as ‘being at work when you should be at home because you are ill’).
- to encompass healthy employees who are just non-productive (no employee is 100% productive all of the time but examples of this type of behaviour might include surfing the web for extended periods, making lots of personal phone calls or popping out to the shops on an overly frequent basis); and
- to refer to those that are overly present (i.e. they consistently put in long hours and will not take their full holiday entitlement).
Presenteeism can be counterproductive due to lost productivity and, in the case of infectious illnesses, because employees risk infecting others when they come to work ill. It is particularly worrying in an NHS setting, where staff and patient health could be put at risk. In addition, it can result in what looks like a fall in absenteeism, distorting the overall picture of staff health and wellbeing. NICE, in its guidance on workplace health, says that presenteeism may be caused by the culture of the workplace or the nature of the work itself with many staff reporting that they go to work when they are ill because they don’t want to let their team down.

4.7.2 The evidence

Presenteeism is a particular problem in the NHS with 60 per cent of staff in England saying they had attended work recently without feeling well enough to do their jobs (a drop from 65 per cent in 2014). Of those who had attended work while unwell, 92 per cent (up from 91 per cent in 2014) stated that they had put themselves under pressure to attend; 25 per cent felt under pressure from their manager and 19 per cent from other colleagues to attend.

These findings resonate with the findings from a 2009 review highlighting the loyalty of NHS workforces to their colleagues, reporting that regular absenteeism and presenteeism (going to work despite being ill) are prevalent within health-care workforces in the UK, with staff reportedly applying personal pressure to themselves to return to work earlier than they should because of team loyalty. These findings were reiterated in the staff survey.

4.8 Staff engagement

4.8.1 The challenge

Engagement at work is about promoting connection with our work and with others – including enthusiasm, involvement in decision-making, a positive state of mind and proactivity. While there are many models of engagement, NHS Employers define engagement as: ‘a positive attitude held by the employee towards the organisation and its values. An engaged employee is aware of business context and works with colleagues to improve performance within the job for the benefit of the organisation. The organisation must work to develop and nurture engagement which requires a two-way relationship between employer and employee.’

There is consensus that no effective workplace-based health initiative will succeed long term without the true engagement of staff – and that line managers’ attitudes and skills are essential to delivering change, as leaders play a key role in supporting and shaping a culture of health and engagement in workplaces. In recognition of this challenge, the King’s Fund is working with NHS Improvement on a two-year programme to support culture change trusts through collective leadership, and the Royal Society of Public Health runs a course on ‘understanding health improvement’ for line managers.

4.8.2 The evidence

The link between employee engagement and NHS performance has been strongly made, and engagement forms a core part of the annual NHS Staff Survey. It is calculated from responses to questions covering the areas of involvement in decision-making, how positive staff feel about recommending their organisation to others, and job motivation. This is a significant issue as higher levels of staff engagement go with lower turnover, better patient satisfaction scores and reduced sickness absence.

The NHS Staff Survey 2015 gives a mixed view of engagement – it has increased from the previous year but, for example, only 42 per cent feel their work is valued by their organisation and 27 per cent do not have the opportunity to show initiative.
Setting out his plan to improve NHS staff health and wellbeing, Simon Stevens pledged to ensure that all organisations will have an identified board member to take the lead as well as a senior clinician to champion the work, while providing training to all line managers to help them support their staff. These measures are in line with the latest National Institute for Health and Care Excellence guidance, published in June 2015, which makes recommendations on improving the health and wellbeing of employees, with a particular focus on organisational culture and context, and the role of line managers.88

One way forward – which has been investigated by the Mutuals in Health Pathfinder programme (launched in 2014, following the King’s Fund report into staff engagement in the NHS89) – could be to support interested organisations in exploring how a mutual model could increase staff engagement (a model with parallels to that of the John Lewis Partnership).90 This has benefits such as greater freedom to innovate and increased engagement (and productivity) through providing staff with influence over the management of their organisation – but barriers to change included additional tax costs incurred by a mutual that is no longer part of the NHS, and losing access to public-sector sources of finance. The use of ‘health champions’ (see case study) is a way to engage staff in health and wellbeing through peer support and encouragement, in recognition of which the Royal Society of Public Health offers a course in ‘understanding health improvement’ for health champions.91

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**Case study: engagement**

After results from a staff survey showed very low levels of engagement among employees at Birmingham City Council, the public-sector organisation decided to implement a new employee-engagement strategy based on its core values of Belief, Excellence, Success and Trust (BEST). The programme used employee-led workshops to engage with staff, installing in them a sense of empowerment to change things, as well as responsibility and accountability for their work. After three years of the BEST programme, major improvements in staff engagement levels could be seen across the organisation, and the percentage of staff who said they felt motivated in their job rose from 56 per cent to 83 per cent.

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**Case study: Health Champions**

In 2013 Serco Health implemented a staff health and wellbeing initiative, the ‘Health & Wellbeing Champions Programme’. It focused on the three major risk factors for non-communicable diseases – poor diet (including the harmful use of alcohol), physical inactivity and tobacco use – and was delivered in partnership with the Community Health Learning Foundation and C3 Collaborating for Health. Health Champions were recruited from Serco Health employees to spearhead the programme through developing a variety of health activities and initiatives. Impact includes reported health benefits to both Champions and staff, empowerment of Champions to make a difference in the workplace, and new relationships built within the company.
5. The current state of play

The 2014 *Five Year Forward View* for the NHS committed to ensuring that the NHS as an employer is an exemplar in the support offered to staff to stay healthy. In September 2015, Simon Stevens announced plans to support this commitment. The new initiative has three pillars:

- to act as a driver to improve NHS staff health;
- a new national occupational health service for GPs under stress; and
- action by the NHS and Public Health England to raise catering standards.

In October 2015, a pilot in 12 local NHS organisations and NHS England itself was announced, covering around 55,000 staff, are spearheading implementation.92 This commits the pilots to six key actions:

- providing the NHS health check at work for NHS staff aged 40 and above;
- access to physiotherapy and mental health talking therapies, as well as smoking-cessation and weight-management services;
- ensuring patients and staff are always offered healthy options in restaurants, cafes and vending machines on site, and actively promoting healthier options through targeted promotions;
- establishing and promoting a local physical activity ‘offer’ to staff, such as running yoga classes, Zumba classes, or competitive sports teams, and promoting healthy travel to work by offering the Cycle to Work scheme;
- fully implementing Public Health England’s Workplace Wellbeing Charter assessment and accreditation process, fully implementing the NICE guidelines on workplace health; and
- identifying a board-level director lead and senior clinician to champion this work, while providing training to all line managers to help them support their staff’s health and wellbeing.

Evaluation will be undertaken by NHS Employers and NHS England.

The programme will be extended to all NHS employers over the next five years – and as a major step in this process, from April 2016, hospitals and other providers of NHS care will, for the first time, be funded to improve the support they offer to frontline health staff to stay healthy.93 A national incentive fund (worth £450 million in 2016–17) has been established, and providers will be able to earn a share in this if they (for example) offer frontline nurses, therapists, doctors, care assistants and other staff access to workplace physio, mental-health support and healthy workplace options, or take ‘action on junk food and obesity by ensuring that healthy food options are available for their staff and visitors, including those working night shifts’.94

A 2011 review identified five high-impact actions to improve overall nurse health and wellbeing – these resonate well with the proposed direction of the new NHS workplace health initiative.

- ensure health and wellbeing initiatives are backed with strong leadership and visible support at board level (producing an annual report of the organisation’s wellbeing will help to communicate commitment and progress);
- develop and implement an evidence-based staff health and wellbeing improvement plan to meet your organisation’s needs. This should be prepared and agreed in partnership between management, staff and unions with progress monitored regularly;
- build the capacity and capability of management at all levels to improve the health and wellbeing of staff. This will include recognising and managing presenteeism, conducting return-to-work interviews and supporting staff with long-term conditions;
- engage all staff with improving their own health through education, encouragement and support;
- use an occupational health service that offers a targeted, proactive and accredited support system for staff and organisations.95
6. Areas for exploration

The available literature on what works in terms of workplace-wellbeing programmes includes numerous success stories from individual companies who highlight improvements based on a variety of indicators (see case studies throughout). However, there are relatively few scientific, peer-reviewed studies of effectiveness, and even fewer studies that focus particularly on the NHS as a target audience.

Table 7: Possible areas for exploration

| Tailoring health and wellbeing support | Health and wellbeing support is not always tailored to reflect the diverse needs of different demographic groups (such as different age groups, shift patterns, seniority, ethnicity or gender), and few NHS providers monitor uptake across different groups or adapt services accordingly. Audit data shows that only 51 per cent (34/66) of responding organisations monitor uptake by gender and only 29 per cent (19/66) by shift pattern. Among trusts that say they measured uptake, only 50 per cent (33/66) say that they adjust their plan or programmes in response to identified differentials in uptake. |
| Equal access to interventions | Unequal access to health and wellbeing interventions in the NHS is an equity issue, and one that may exacerbate existing inequalities in health and wellbeing across the workforce. The NHS Constitution commits support to all NHS staff and, as the RCP report concisely summarises, services must be accessible to all parts of the NHS workforce, regardless of occupation or working pattern – yet it appears that this ideal is not being achieved. Staff health and wellbeing should be integrated as core components of service planning, contracts and tenders so that all NHS staff – including those who are employed by third-party contractors – have access to high-quality occupational-health services, evidence-based health-promotion initiatives (such as smoking-cessation support and healthy-eating options), and fair terms and conditions, so that, at the very least, the NHS workplace does not exacerbate existing inequalities in health in its own workforce. |
| Increasing staff engagement | The role of managers in engagement and health of the workforce is key. Reductions in sickness absence were reported across two case studies, attributable to active staff and management engagement in monitoring and managing stress in the workplace environment. Use of indicator lights at the end of a shift and active managerial roles in providing support to staff both contributed to a reduction in sickness absence. The ‘mutuals’ model could increase staff engagement (and, hence, productivity and wellbeing). |
| Access to workplace wellbeing in all NHS workplaces | Small and medium-sized organisations are challenging to involve in workplace health. Smaller NHS organisations (e.g. GP surgeries) must not be left out of efforts to improve the health of the workforce. |
| NHS staff access to health information for themselves | There has been little research into health-information-seeking preferences of NHS staff – how they themselves access health information. |
| Maximising the NHS’s own resources | The NHS can use its own resources as a first resort – for example, using a primary-care nurse in an organisation to lead on workplace health of employees, using the NHS’s own smoking-cessation programme, or identifying in-house health champions. |
| Researching the NHS as a discrete target audience | There is only limited research to date on health and wellbeing with the NHS as a discrete target audience, i.e. focusing on NHS workforces as population of interest for health-promotion activity. While this is being addressed to some extent, there is a need for more research to understand the needs of the NHS workforce and to develop effective interventions. |
extent by the new programme established in 2015/16, evaluating the impact on different demographics will be extremely valuable.

| Evaluation, evaluation, evaluation... | A final, and crucial, challenge is that of measuring the impact and effectiveness of workplace-health programmes – because what is not measured cannot be managed, and (particularly in a time of squeezed budgets) it is essential that successful programmes are scaled up, and unsuccessful initiatives are not replicated. There are indications that the 12 pilot initiatives will be ‘robustly evaluated’106 – but sharing good practice in this important, but often undervalued, area will be key. |

Clear examples of practical, evaluated workplace-health initiatives are thin on the ground – and there is a real opportunity here for the NHS, as one of the world’s largest employers, to take a lead in assessing what works, where and for whom.
Annex 1: Tools and key resources

There is a wide variety of ways in which employers can access support to improve their employees’ health and wellbeing, ranging from toolkits that are condition specific to accreditation schemes and awards. The resources listed below are selected from the large number available.

Business in the Community: Workwell Campaign

The charity provides a set of free downloadable toolkits on its website, covering specific topics: emotional resilience; healthy eating; physical activity; skills, health and wellbeing; working joints and muscles. In addition, Healthy People = Healthy Profits provides case studies highlighting successful workplace-wellbeing schemes covering companies of all sizes, from British Gas, the Metropolitan Police and Nationwide Building Society to Oaklands Care Home in Llangynidr, Wales, which employs only 20 staff. BITC also provides a public reporting guideline on employee wellbeing and engagement. http://www.bitc.org.uk/better-physical-psychological-health

C3 Workplace Health Network

The C3 WPH Movement is a networking and knowledge-sharing forum for workplace-health professionals. Its goal is to share knowledge and experience across all areas of health at work, identifying ways to make it easier for organisations to develop and maintain healthy, resilient and productive workforces. Founded by health professionals for workplace-health professionals – from policymakers, government, health experts, academics to HR and benefit practitioners – membership is open to anyone involved in health at work. http://www.c3health.org/c3activities/workplacehealth/c3-workplace-health-movement/

Fit for Work service

The Fit for Work (and Fit for Work Scotland) service is a scheme launched in May 2015 to help to reduce sickness absence and promote health and wellbeing in workplaces country-wide. It is a free service (a free referral for all employees who have been off work for four weeks or more), filling a gap in current occupational health services provided by employers (particularly those with limited in-house OH services). It also provides impartial health and work advice to employees, employers and GPs. In England/Wales http://fitforwork.org/ and in Scotland http://fitforworkscotland.scot/

Global Corporate Challenge

The Global Corporate Challenge was founded in Melbourne, Australia, in 2003 in response to concerns about increasingly sedentary lifestyles. Each year hundreds of thousands of employees worldwide compete in a 100-day challenge to improve their health. The teams of seven track their daily activity, aiming to reach at least 10,000 steps daily as they make their way on a virtual tour of the globe. Individual employees are supported via the GCC website and smartphone apps. Beyond the 100 days, there is 12-month access to GCC resources. Success stories told online include Kent Community Health NHS Trust. https://www.gettheworldmoving.com/

The Health and Europe Centre

The Health and Europe Centre works with local NHS and local government stakeholders to bring European learning, practice and policy to the local health community. It provides training and learning opportunities through collaborations with colleagues from other countries, enables stakeholders to stay up-to-date with developments in health and social care worldwide, and helps people and organisations reach health networks, institutions and other relevant bodies outside the United Kingdom. http://www.healthandeuropecentre.nhs.uk/who-we-are/

Health and Work Unit

The Health and Work Unit was established in the Autumn Spending Review 2015, with £115 million pledged for delivery of its work, piloting ways to join up thinking and action across the health and employment sectors (the Department for Work and Pensions and Department of Health, with people seconded from
local government, NHS England and the Department for Business Innovation and Skills). Its priorities have been stated by the head of delivery as being improving productivity and growth in the economy, including working to reduce health inequalities. The programme is still in development.

**Health Promoting Health Service**

NHS Scotland has implemented the Health Promoting Health Service (HPHS), a settings-based approach to health promotion. HPHS aims to support a culture of effective health promotion and improvement within all acute, mental health, maternity, paediatric and community hospitals in Scotland. In 2015, the Chief Medical Officer stated the commitment of HPHS to drive actions forward in the key areas of person-centred care, staff health and wellbeing and health-promoting hospital environments. Prevention is key to the HPHS policy, which means ‘promoting healthier behaviours and discouraging detrimental ones by ensuring that healthier choices are the easier ones that appropriate support systems are in place to encourage and reinforce these choices’.

One example is NHS Ayrshire and Arran, where a pilot health check service was delivered to help tackle health inequalities among employees and a smoke free grounds policy implemented. Another example is the NHS Tayside Drinks4Health initiative that saw sugary drinks removed from all NHS Tayside sites and a campaign launched that promoted benefits of consuming healthier drinks. [http://www.knowledge.scot.nhs.uk/home/portals-and-topics/health-improvement/hphs.aspx](http://www.knowledge.scot.nhs.uk/home/portals-and-topics/health-improvement/hphs.aspx)

**Scottish Centre for Healthy Working Lives**

The Scottish Centre for Health Working Lives was established in 2004 within the NHS, bringing together several previous initiatives, and works to provide information and advice on workplace health and wellbeing in the NHS. Its principal focus is to work with employers (enabling them to understand, protect and improve the health of their employees, and to support people with health problems who have re-entered work to remain in work), and also to support those who are not currently employed but are keen to get back into work. [http://www.healthyworkinglives.com/](http://www.healthyworkinglives.com/)

**Health Works (Scotland)**

The Health Works strategy was launched in November 2009, the Scottish Government’s Healthy Working Lives Strategy, as part of which public-sector bodies (such as the NHS) will develop a public-sector mandate for public bodies to become exemplars and champions for Health Works. Policy and practice will be adopted to promote the health and wellbeing of all staff. The ‘Scottish Offer’ defines the role of the NHS is providing services to working-age people with a health barrier preventing them from working, and Health Works tools have been developed to help delivery of the Strategy. [http://www.gov.scot/Topics/Health/Healthy-Living/Health-Work](http://www.gov.scot/Topics/Health/Healthy-Living/Health-Work)

**London Healthy Workplace Charter**

This is a self-assessment framework that recognises and rewards employers for investing in workplace health and wellbeing, providing a series of standards for workplaces to meet. So far, 60 organisations have been accredited, including Homerton University Hospital NHS Trust. It borrows its framework from the PHE Workplace Wellbeing Charter (below), developed by Liverpool as part of its World Health Organization (WHO) Healthy Cities Status. [https://www.london.gov.uk/priorities/health/focus-issues/london-healthy-workplace-charter](https://www.london.gov.uk/priorities/health/focus-issues/london-healthy-workplace-charter)

**NHS Employers: Creating Healthy NHS Workplaces – A Toolkit for the NHS**

This toolkit was launched in September 2015 by NHS Employers as a step-by-step guide to implementing several pieces of NICE workplace guidance. It covers: long term conditions, mental wellbeing, obesity, smoking and physical activity. There are also sections on leadership, staff engagement, behaviour change and evaluation. The toolkit provides case studies, guidance and web resources. [http://www.nhsemployers.org/case-studies-and-resources/2015/09/implementing-nice-guidance-toolkit](http://www.nhsemployers.org/case-studies-and-resources/2015/09/implementing-nice-guidance-toolkit)
NHS Employers network of health and wellbeing leads

Many health and wellbeing leads are members of a network established by NHS Employers. It is ‘an opportunity for health and wellbeing leads across the country to connect with one another, share good practice, and learn what’s happening in wellbeing across the NHS’. It holds regular meetings in Leeds and London, and also holds online events (for example, and runs a virtual group that uses LinkedIn and regular email updates.
To be part of the network, email healthandwellbeing@nhsemployers.org.

NICE Guidance on workplace health

The National Institute of Health and Clinical Excellence has produced a series of Guidance documents on a variety of aspects of workplace health. These are listed in Annex 2. https://www.nice.org.uk/guidance/settings/workplaces

Public Health England: Workplace Wellbeing Charter

NHS Chief Executive Simon Stevens has, stated that the NHS will fully implement Public Health England’s Workplace Wellbeing Charter assessment and accreditation process. The Charter is a statement of intent, open to organisations of all sizes and offering employers the ability to audit and benchmark against a set of standards, identifying gaps in their current provision. It provides a framework in which health, safety and wellbeing strategies can be developed, with a robust award process. The Charter has made awards to over 1,000 organisations in England. Focusing on leadership, culture and communication, there are three levels of commitment that employers can choose from depending on their size and direction. Once registered, a variety of toolkits and other support materials are made available.
http://www.wellbeingcharter.org.uk/index.php

RAND: Five Steps to a Successful Workplace Wellness Program

This toolkit is made freely available online by the RAND Corporation, a not-for-profit institution that helps improve policymaking through research and analysis. All RAND’s toolkits are quality checked via peer review. At every stage, from project design to evaluation, this programme provides current evidence to explain the importance of each step, specific lessons and examples, tools and resources.
http://www.rand.org/content/dam/rand/pubs/tools/TL100/TL141/RAND_TL141.pdf

Royal College of Nursing: Healthy Workplace campaign

The Healthy Workplace project supports health-care employers and RCN workplace representatives to create good working environments with high-quality employment practices. The website has tips for RCN reps and employers, including a pledge to support workplace health, a feedback form to share good practice, and a Healthy Workplace Toolkit (best used in partnership between employers and RCN trade union representatives), covering work–life balance, dignity at work, health and safety, job design and learning/development.
http://www2.rcn.org.uk/newsevents/campaigns/healthy-workplace

Royal Society for Public Health: Investing in the Wider Workforce – Workplace Wellbeing

The RSPH runs programmes for leadership teams (to begin to change culture, and develop strategy and implementation plans), line managers (to provide consistent skills and knowledge needed to support wellbeing of their teams) and workplace-wellbeing champions (to bring about sustainable change through engaging with peers). The programmes for line managers and champions lead to a Level 2 Ofqual-accredited qualification.

What Works Centre for Wellbeing

The What Works Centre for Wellbeing was launched in 2014, an independent collaborative organisation funded by over 17 partners including government, the Economic and Social Research Council and Public
Health England. It aims ‘to improve the wellbeing of the people in the UK by bringing together the best evidence, making it easy to use and easier to make’, by increasing understanding of what national and local governments, along with voluntary and business partners, can do to increase wellbeing. Initial areas for investigation are employment/learning, community wellbeing, and culture/sport, and work will be undertaken on measurement and analysis of data, and identifying further areas of research, so that organisations can use available evidence to best effect.

http://whatworkswellbeing.org/

The Work Foundation

The Work Foundation is a Lancaster University-based not-for-profit that addresses what ‘Good Work’ means - a concept covering the importance of productivity and skills needs, the consequences of technological innovation, and of good working practices. It does this through rigorous research programmes, and provides analysis, evaluation, policy advice and knowledge in and beyond the United Kingdom. Its Health at Work Policy Unit (launched in 2014) provides evidence-based policy recommendations and commentary on contemporary issues around health, wellbeing and work, through ‘white papers’ that provide practical policy recommendations, influencing political debate, and as a repository for good practice and evidence-based solutions.

http://www.theworkfoundation.com/

Working Differently, Working Together (Wales)

Since 2012, NHS Wales has had a Staff Health and Wellbeing Charter, ‘Working Differently, Working Together’, which aims to create a culture of care for NHS staff, acknowledging the importance of NHS staff being healthy and valued so that they can act as role models to the community that they serve. As part of the Charter, each NHS organisation will promote employee health and wellbeing by, for example, providing flexible working arrangements that support work/life balance, ensure managers can provide support to staff both in work and those absent due to ill health, and make promotional and preventative events and information on healthy lifestyle choices available to all staff.

http://www.wales.nhs.uk/sitesplus/955/page/80991
Annex 2: NICE Guidance

The following guidance documents from the National Institute for Health and Care Excellence are aimed at employers and professionals in small, medium and large organisations, who have a direct or indirect role in, and responsibility for, improving health in the workplace. It is also useful for employees, trade-union representatives and members of the public. By improving people’s health, the recommendations made in this guidance aim to help prevent the diseases associated with lack of physical activity, poor mental health, managing sickness absence and smoking.

All guidance documents on promoting better health at the workplace were developed based on reviews of the evidence, economic analyses, expert advice, stakeholder comments and fieldwork, while also considering the evidence of effectiveness.

Note: All the guidance documents complement and support each other, and it is advised that all of them be used to improve the health of employees. They are available at https://www.nice.org.uk/guidance/settings/workplaces.

Workplace health promotion: how to encourage employees to be physically active
Date published: May 2008
Original summary: http://guidance.nice.org.uk/PH13

Employers are advised to introduce, monitor and develop organisation-wide plans and/or policies to encourage and support employees to be physically active by including ways in which there should be numerous options for different parties to affect positive change. Examples of types of action include policies that encourage employees to use modes of transport that involve physical activity, flexible working policies and incentive schemes to improve health and providing guidance and links to local resources on the employers’ premises.

Promoting mental wellbeing through productive and healthy working conditions: guidance for employers
Date published: November 2009
Original summary: http://guidance.nice.org.uk/PH22
Review decision: No update required. Next review date: tbc.

NICE believes that promoting the mental wellbeing of employees is important as it can be advantageous in yielding economic benefits for the organisation - by increasing job commitment and job satisfaction, staff retention, improving productivity and performance, and reducing staff absenteeism. Recommendations include integrating promoting mental wellbeing into all policies and practices concerned with managing people, adopting appropriate systems for assessing and monitoring employees’ mental health, adopting a company culture that supports flexible working and addresses employees’ concerns and line managers should be supported and trained in promoting the mental wellbeing of employees.

Managing long-term sickness absence and incapacity for work
Date published: March 2009
Original summary: http://guidance.nice.org.uk/PH19
Review decision: No update required. Next review date: tbc.

Employers are advised to identify a well-trained case-worker, with the skills and training to act as an impartial intermediary, to undertake initial enquiries with employees who are on long-term sickness absence or recurring short- or long-term sickness absence to identify the reason for sickness. Where action is required, the guidance recommends that a detailed assessment be made by the individual to determine what interventions and services are required and to develop a return-to-work plan.
Workplace health promotion: how to help employees to stop smoking

Date published: April 2007

Original summary: http://guidance.nice.org.uk/PH5

Review decision: This guidance has been placed on the static list. This means no major ongoing studies/research was identified as due to be published in the next 3–5 years at the time when this guidance was given ‘no update required’ status.

NICE advises that employers take steps to help employees stop smoking to improve the health of people in England and reduce health inequalities, as well as taking advantage of the opportunity to offer to improve people’s health. Recommendations include employers publicising interventions and making information on local smoking-cessation support easily available at work, allowing employees time off to attend smoking cessation services during work hours without loss of pay and employees and their representatives should in turn encourage employers to provide advice, guidance and support to employees who want to stop smoking.

Workplace health: management practices

Date published: June 2015

Original summary: https://www.nice.org.uk/guidance/ng13

NICE advises that health and wellbeing is fully incorporated across management practices and that it is an organisational commitment from the top down. Employers, senior leadership and managers, and human resource teams should ensure that the physical work environment enables good health and that mental wellbeing at work is promoted. Senior leadership should ensure that the organisation actively supports employee health and wellbeing with appropriate practices and policies in place, line managers should be given adequate time, training and resources to balance aims of the organisation with concern for their employees’ health and wellbeing and their leadership style should encourage creativity, engagement, give a sense of meaning as well as offer support.

https://www.nice.org.uk/guidance/ng13/chapter/1-Recommendations

Also relevant

Other guidance from NICE, such as that on obesity (e.g. ‘Preventing excess weight gain’ (2015: https://www.nice.org.uk/guidance/ng7) and on environmental and building design to promote physical activity (2008: https://www.nice.org.uk/guidance/ph8), is also of relevance, with recommendations including active policies to prevent and manage obesity, promotion of healthy diets through providing healthy choices at food outlets, and encouraging physical activity.

NICE’s quality standard on ‘Obesity in adults: prevention and lifestyle weight management programmes’ (January 2016) includes a quality standard on vending machines, specifically suggesting that ‘local authorities and NHS organisations can set an example by providing healthy food and drink choices at their venues. They can influence venues in the community (such as leisure centres) and services provided by commercial organisations to have a positive impact on the diet of adults using them.’:
http://www.nice.org.uk/guidance/qs111/chapter/Quality-statement-1-Vending-machines

Forthcoming

- ‘Workplace health: support for employees with disabilities and long-term conditions’

  Anticipated publication date: April 2017
Annex 3: Evidence table

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Overview</th>
<th>Reference</th>
<th>Conclusions</th>
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</thead>
<tbody>
<tr>
<td>Improving staff health and wellbeing generally</td>
<td>Three case studies</td>
<td>L. Ward et al., ‘The high impact actions for nursing and midwifery 2: fit and well to care’ (2010) <em>Nursing Times</em> 106(28): 12.</td>
<td>Reductions in sickness absence were reported across two case studies, attributable to active staff and management engagement in monitoring and managing stress in the workplace environment. Use of indicator lights at the end of a shift (Case C), and active managerial roles in providing support to staff in case B, both contributed to a reduction in sickness absence. Credible external championship of physical activity, supported by organisational workshops, promoted health outcomes and reduced sickness absence in Case A.</td>
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<tr>
<td>Interventions to promote nurses’ health</td>
<td>Whittemore and Knafli’s integrative review methodology was chosen to guide the synthesis. Eighteen studies, all conducted in clinical settings, were identified.</td>
<td>S. Letvak, ‘We cannot ignore nurses’ health anymore: a synthesis of the literature on evidence-based strategies to improve nurse health’ (2013) <em>Nursing Administration Quarterly</em> 37(4): 295–308</td>
<td>Interventions included onsite wellness, ergonomic and exercise programmes, holistic practices (including Tai Chi and massage), the use of clinical supervision, mental-health programmes, and the use of minimal, no lift and lift-team programs. No information about comparative effectiveness or long-term behavioural outcomes available</td>
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<tr>
<td>Promotion of health and wellbeing of nurses</td>
<td>Systematic review of seven electronic databases</td>
<td>C.W. Chan and L. Perry, ‘Lifestyle health promotion interventions for the nursing workforce: a systematic review’ (2012) <em>Journal of Clinical Nursing</em> 21(15/16): 2247–61.</td>
<td>With design inclusion criteria relaxed to include an uncontrolled trial, only three intervention studies were retrieved, from the United States, Canada and Taiwan. All had limitations and high risk of bias, but benefits were reported. Outcomes included fewer cigarettes smoked during the intervention period, significantly reduced fat, and significant gains across a battery of fitness assessments. The paucity of work focused on nurses’ health behaviours was the important finding.</td>
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<td>Intervention</td>
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<td>Impact of staff training on health and wellbeing of staff</td>
<td>Evaluation of a training course rolled out within one trust.</td>
<td>G. Bickerstaffe and D. Williams, ‘Advising on lifestyle can improve nurses’ health’ (2014) <em>Nursing Times</em> 110(51): 17–19</td>
<td>Staff evaluations of health-promotion training provided at Bolton Foundation Trust showed how it may prompt nurses to evaluate their own lifestyles. It could benefit healthcare organisations, as it may mean staff are supported to be healthier, happier and more productive.</td>
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<tr>
<td>Vulnerability to work related health risks</td>
<td>Uses international data from the European Working Conditions Survey for 2005 to test whether older workers (aged 55–65 years) differ significantly from younger workers across a range of self-reported job-related indicators including health risk perception, mental and physical health, sickness absence, injury and fatigue.</td>
<td>M.K. Jones et al., ‘Work-related health risks in Europe: Are older workers more vulnerable?’ (2013) <em>Social Science &amp; Medicine</em> 88(18-29): 02779536</td>
<td>Results show that failure to account for both endogeneity and the ‘healthy worker effect’ (sample selection) can lead to misleading inferences.</td>
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| The aim of this review was to identify the efficacy of lifestyle health-promotion interventions intended to improve behavioural health risk factors and/or behavioural or clinical outcomes of working-age nurses. | Systematic review, included all behavioural interventions, either singly or in combination, intended to improve health risk factors and/or related clinical health outcomes in relation to:  
- overweight or obesity  
- diet (i.e. improving intake of fruit, vegetables and fibre, reduction in saturated fats and sodium) | C.W. Chan and L. Perry, ‘Lifestyle health promotion interventions for the nursing workforce: a systematic review’ (2012) *Journal of Clinical Nursing* 21(15/16): 2247–61. | The paucity of work uncovered by this review flags an important gap in occupational health and human resource management in health care. Service providers probably have the necessary skills and resources, as these are daily delivered for patients. Studies with nurses are long overdue, to test whether lifestyle interventions for nurses can positively influence individual welfare and wellbeing, and collectively impact organisational recruitment, retention and sickness absence.  
Little can be inferred from the findings of the three studies retrieved for this review because of their methodological limitations. |
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<tr>
<td>Supporting nurses to remain in academic settings</td>
<td>Nine academic nurse leaders from BSN programs nationwide were interviewed in this grounded theory study. Data were analysed using constant comparative analysis.</td>
<td>N.L. Falk, ‘Retaining the wisdom: academic nurse leaders’ reflections on extending the working life of aging nurse faculty’ (2014) Journal of Professional Nursing 30(1): 34–42.</td>
<td>However, despite this, they indicate that workplace-based health promotion interventions may be feasible and beneficial for nurses.</td>
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<tr>
<td>Nurse retention</td>
<td>A qualitative study of 15 participants who explored perceived opportunities for and barriers to implementing flexible strategies to engage older nurses in the Australian New Territories workforce after they resign from full-time work.</td>
<td>K. Voit and D.B. Carson, ‘Retaining older experienced nurses in the Northern Territory of Australia: a qualitative study exploring opportunities for post-retirement contributions’ (2012) Rural &amp; Remote Health 12(2): 1–10.</td>
<td>Aging nurse faculty members are highly valued by academic nurse leaders, bringing wisdom, experience, and institutional, historical, and cultural awareness to their many roles. Yet, some aging nurse faculty fail to keep knowledge, skills, and teaching modes current, which is problematic given the multiple environmental challenges that academic nurse leaders face.</td>
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<tr>
<td>Learning from the literature on employing older workers</td>
<td>Audit of research – extensive literature base, but most of the literature reviewed is not health-service specific.</td>
<td>University of Bath/NHS Staff Council, Extending Working Life Audit of Research relating to Impacts on NHS Employees 2013 Report</td>
<td>A knowledge and change-management approach is required to change employers’ views of the value of older nurses.</td>
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Work organisations tend to be data poor, or unsighted on a range of fronts in the later working life domain. Beyond headline outcome data on accidents, absence, staff turnover and exit, they need to gather evidence on: employee preferences / intentions; the impact of current policies and practice on employee behaviour; impacts of job design on health / capacity to work, including demographic differences. There are grounds for concluding that employers would benefit from adopting an epidemiological perspective to add to organisational learning in this area, notably to underpin a more informed, strategic approach to intervention; with effective performance measures. In particular, there are arguments for adopting a risk-based approach to identify vulnerable groups by job-
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<tr>
<td>Retaining older nurses in the workplace</td>
<td>Literature review, commentary and case study.</td>
<td>C. Long and E. Griffiths, ‘Britain's ageing NHS workforce’ (2013) Occupational Health 65(7): 18–20</td>
<td>OH needs to be proactive in considering the health requirements of the older nurse to reduce the risk of ill health and disability. Early intervention and the promotion of public health issues can reduce the risks associated with ageing. The importance of health promotion both for individuals and the organisation might include training, easy access to care, health checks and screening. The HSE recommends workplace assessments to enable early detection of health problems.</td>
</tr>
<tr>
<td>Understanding stressors at different workforce levels</td>
<td>A comprehensive survey combining questionnaire and medical examination was offered in one division in BASF Ludwigshafen. Among 867 voluntary participants, 653 returned complete questionnaires. The questions were directed at perception of safety at the workplace, self-rated health status, frequency of stress symptoms, unrealistic job demands, time pressure and maladjustment of work life balance. The outcome of interest was self-estimated health measured by the Work Ability Index (WAI).</td>
<td>M. Yong et al., ‘Occupational stress perception and its potential impact on work ability’ (2013) Work 46(3): 347–54.</td>
<td>While perceived occupational stress had an apparent impact on WAI, and WAI has been demonstrated to be predictive of early retirement, more intensive and employee group-specific stress management interventions beyond traditional strategies of routine occupational medical surveillance can be beneficial. Results: Occupational stressors were perceived differently across occupational status groups. Frontline operators had more health concerns due to workplace conditions, while professional and managerial staff reported higher frequencies of perceived tension, time pressure, and maladjustment of work–life balance.</td>
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<tr>
<td>Preventing burn out</td>
<td>Review of interventions</td>
<td>B.J. Henry, ‘Nursing burnout interventions: What is being done?’ (2014) Clinical Journal of Oncology Nursing 211–14.</td>
<td>Burnout interventions for oncology nurses showed positive outcomes as measured by participant comments. However, one limitation of many of the interventions was the lack of objective measurement tools and experimental design to evaluate efficacy. Burnout and job stress have increased, in part, because of technology, insurance changes and demands, and the vast amount</td>
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<td>Improving worker resilience through mindfulness meditation</td>
<td>Small-scale pilot study (40 participants)</td>
<td>M. Foureur et al., ‘Enhancing the resilience of nurses and midwives: pilot of a mindfulness-based program for increased health, sense of coherence and decreased depression, anxiety and stress’ (2013) Contemporary Nurse: A Journal for the Australian Nursing Profession 45(1): 114–25</td>
<td>Quantitative findings, gathered through the use of pre- and post-intervention GHQ12 questionnaires, SOC and DASS scores, suggested the intervention had a positive impact.</td>
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<td>Improving resilience in nurses in Australia and New Zealand</td>
<td>Small scale educational initiative (14 participants). Six resilience work-shops and a mentoring programme conducted over a six-month period. Mixed teaching methodologies.</td>
<td>G. McDonald et al., ‘Personal resilience in nurses and midwives: effects of a work-based educational intervention’ (2013) Contemporary Nurse: A Journal for the Australian Nursing Profession 45(1): 134–43.</td>
<td>Primary effects of the intervention were found to benefit the participants in personal and professional areas by enhanced confidence, self-awareness, assertiveness and self-care.</td>
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<td>Survey focused on all staff lifestyle behaviours, including smoking, drinking, physical activity, etc.</td>
<td>Survey of all employees in an acute trust (n=7,085).</td>
<td>H. Blake et al., ‘Health in the NHS: lifestyle behaviours of hospital employees’ (2012) Perspectives in Public Health 132(5): 213–15.</td>
<td>Poor health behaviours are still prevalent amongst NHS employees, and supports the notion that health behaviours ‘cluster’ together (e.g. those who are more active are also more likely to engage in other healthy behaviours, and vice versa). Barriers to physical-activity participation were identified as lack of time, limited managerial support for physical activity (e.g. through non-protected break times).</td>
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<td>Measuring levels of physical activity, smoking and alcohol behaviour,</td>
<td>A UK-based cross-sectional questionnaire survey of 325 pre-registration nurses (50% response rate), utilising a health</td>
<td>H. Blake et al. (2011). “‘Do as I say, but not as I do’: Are next generation nurses role models</td>
<td>The health profile of pre-registration nurses is relatively poor, and those who are sedentary engage in other negative lifestyle behaviours also. Despite significant education relating to health promotion and health behaviours of patients being targeted at pre-</td>
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<td>dietary practices and general health and lifestyle questionnaire, Age ranged from 19 to 53 years, and 96% of the sample was female.</td>
<td>for health? (2011) Perspectives in Public Health 131(5): 231–9.</td>
<td>registered nurses, it seems that this knowledge is not always transferred to their own behaviour. There is a need for timely intervention to establish healthy lifestyle behaviours amongst nurses early in their career.</td>
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  - ensure health and wellbeing initiatives are backed with strong leadership and visible support at board level. Producing an annual report of the organisation’s wellbeing will help to communicate commitment and progress;  
  - develop and implement an evidence-based staff health and wellbeing improvement plan to meet your organisation’s needs. This should be prepared and agreed in partnership between management, staff and unions with progress monitored regularly;  
  - build the capacity and capability of management at all levels to improve the health and wellbeing of staff. This will include recognising and managing presenteeism, conducting return-to-work interviews and supporting staff with long-term conditions;  
  - engage staff at all levels with improving their own health through education, encouragement and support;  
  - use an occupational health service that offers a targeted, proactive and accredited support system for staff and organisations.  
Conflict management and time management are identified as areas where action could be taken to improve mental health and wellbeing of the workforce. |
<p>| Stress and burnout | 22 nurses received up to six sessions of clinical supervision with the supervisor. Prior to commencing the sessions, participants were asked to | S. Wallbank and S. Hatton, ‘Reducing burnout and stress: the effectiveness of clinical supervision’ (2011) Community Practitioner 84(7): 31–5. | A restorative approach to supervision that remains solution focused is useful in reducing stress and burnout among health visitors and school nurses. The model can be cascaded easily and is therefore likely to be sustainable in organisations. This type of supervision appears to enable professionals to restore their capacity to think |</p>
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<td>Stress</td>
<td>A pre-experimental study was conducted among 30 Critical Care Unit nurses working in an acute hospital in India to assess the effect of stress-management interventions</td>
<td>C. Light Irin and R. Bincy, ‘Effect of stress management interventions on job stress among nurses working in critical care units’ (2012) <em>Nurs J India</em> 103(6): 269–71.</td>
<td>The results showed that caring for patients, general job requirements and workload were the major sources of stress for the nurses. The level of severe stress was reduced from 60% to 20% during post-test. The interventions tested were Job Stress Awareness, Assertiveness Training, Time Management, and Progressive Muscle Relaxation.</td>
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<td>Responding to shift-work impacts on health, work–life balance and job satisfaction in Denmark</td>
<td>A structured questionnaire was distributed to control and intervention groups pre-intervention and post-intervention (20 months). Nurses within the intervention group trialled an open-rota system in which nurses designed their own work-rest schedules.</td>
<td>J. Pryce et al., ‘Evaluation of an open-rota system in a Danish psychiatric hospital: a mechanism for improving job satisfaction and work–life balance’ (2006) <em>Journal of Nursing Management</em> 14(4): 282–8.</td>
<td>Nurses in the intervention group reported that they were more satisfied with their work hours, less likely to swap their shift when working within the open-rota system and reported significant increases in work–life balance, job satisfaction, social support and community spirit when compared with nurses in the control groups. Conclusions: The ownership and choice over work-rest schedules has benefits for nurses, and potentially the hospital</td>
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| Effects of length of shifts on health and wellbeing | Secondary analysis of cross sectional data. Used a sample of 22,275 registered nurses, working in 577 American hospitals from the Multi-State Nursing Care and Patient Safety Study. The four states included in the study represented approximately 25% of the US population and | A.W. Stimpfel et al., ‘The longer the shifts for hospital nurses, the higher the levels of burnout and patient dissatisfaction’ (2012) *Health Affairs* 31(11): 2501–9 | Results:  
- Increases in shift length were associated with significant increases in the odds of burnout, job dissatisfaction, and intention to leave the job. The odds of burnout and job dissatisfaction were up to two and a half times higher for nurses who worked longer shifts than for nurses who worked shifts of 8–9 hours.  
- Nurses' shift length was significantly associated with patient satisfaction, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems survey. |
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<td>Promotion of health and wellbeing of nurses</td>
<td>Systematic review of seven electronic databases.</td>
<td>C.W. Chan and L. Perry, ‘Lifestyle health promotion interventions for the nursing workforce: a systematic review’ (2012) Journal of Clinical Nursing 21(15–16): 2247–61.</td>
<td>With design inclusion criteria relaxed to include an uncontrolled trial, only three intervention studies were retrieved, from the United States, Canada and Taiwan. All had limitations and high risk of bias, but benefits were reported. Outcomes included fewer cigarettes smoked during the intervention period, significantly reduced fat and significant gains across a battery of fitness assessments. The paucity of work focused on nurses’ health behaviours was the important finding. Conclusion: The workplace is a potentially fruitful location for health promotion intervention but nurses have seldom been recognised as a target participant group. Given the international priority ascribed to nursing workforce retention, this is a missed opportunity for occupational health planning.</td>
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<tr>
<td>Promotion of physical activity</td>
<td>Qualitative evaluation of study using tailored email interventions.</td>
<td>T.L. Yap and D.M.B. James ‘Tailored e-mails in the workplace: a focus group analysis’ (2010) AAOHN Journal 58(10): 425–32.</td>
<td>Emails were well received, with personalisation improving perceived salience of message. All participants who received tailored messages reported following links within the messages, whereas non-tailored email recipients generally deleted quickly without following links. Traditional generic health-education materials did not provide the information or motivation needed to increase physical activity because the information was not generally read or remembered. Friendly competition, cross-group comparisons and tailoring suggestions to fit with home life (e.g. for people with children, activities suggested involved the children) supported subsequent action.</td>
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Conclusions:
- Policies should be adopted by nursing management within hospitals to monitor nurses’ hours worked, including hours worked in second jobs.
- Nursing leadership should also encourage a workplace culture that respects nurses’ days off and vacation time, promotes nurses’ prompt departure at the end of a scheduled shift, and allows nurses to refuse to work overtime without retribution.
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<td>Workplace stress</td>
<td>Staff massage sessions, with evaluation by questionnaire. 45% (n=140) of participants were nurses.</td>
<td>P. Gardiner, ‘P04.55. Examination of a staff massage break at a safety net hospital’ (2012) <em>BMC Complementary and Alternative Medicine</em> 12(Suppl 1): P325.</td>
<td>18% of respondents had comments related to improved work performance. 10% of staff members liked that they felt cared for during the sessions and felt by taking the time to attend the session that they were practising self-care. There was a significant difference between before and after scores with regard to anxiety, stress and pain. Conclusion: Massage can improve both the health and morale of the staff in this hospital community, especially for those delivering care to patients. More research is needed on incorporation of massage breaks into the workday for employees.</td>
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<td>To investigate health differences between nurses who report meeting the daily physical activity recommendations in or away from the workplace</td>
<td>Observation study of Australian and New Zealand nurses using longitudinal, population-based, observational e-cohort nursing survey. Data were informed and groups defined by the self-reported minutes per day of moderate physical activity collected from a large international survey of practising nurses (n=2264).</td>
<td>T. Henwood et al., ‘What makes a healthier nurse, workplace or leisure physical activity? Informed by the Australian and New Zealand e-Cohort Study’ (2012) <em>Journal of Clinical Nursing</em> 21(11/12): 1746–54.</td>
<td>Results: G2 (high workplace/low leisure) had a high BMI and were younger than G4. G4 (low workplace/high leisure) were significantly more active away from work and more likely to report cycling to work than G2. In contrast, G2 were most likely to have taken sick days because of their health, have difficulty sleeping most of the time and have a medical history of diagnosed anxiety and depression. Conclusions: This study shows that improved well-being can be achieved in nursing cohort through leisure-time physical activity. Relevance to clinical practice: This research shows that nurses should consider leisure-time physical activity necessary to maintain and prolong health and that workplace activity is not a sufficient stimulus.</td>
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<td>Workplace bullying effects on mental health</td>
<td>A cross-sectional survey was conducted across hospital and aged-care nurses working within a medium to large Australian healthcare organisation in October 2009. The sample comprised 233 (29.1%) hospital and 208 (43.8%) aged-care nurses</td>
<td>J. Rodwell and D. Demir, ‘Psychological consequences of bullying for hospital and aged care nurses’ (2012) <em>International Nursing Review</em> 59(4): 539–46.</td>
<td>This study demonstrates that bullying has detrimental consequences for the mental health of nurses in both hospital and aged-care contexts, resulting in psychological distress and depression. The results support the suggestion that nurses are an oppressed group at high risk of bullying, confirm the intrinsic nature of NA to the bullying process.</td>
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<td>Workplace bullying effects on mental health</td>
<td>The study used an internet-based survey administered six months after nurses completed a two-hour cognitive rehearsal programme.</td>
<td>S.J. Stagg et al., 'Workplace bullying: the effectiveness of a workplace program' (2013) <em>Workplace Health &amp; Safety</em> 61(8): 333–8.</td>
<td>This pilot study determined that attendance at a cognitive rehearsal program decreased workplace bullying. Half of the nurses reported witnessing bullying behaviours since attending the programme, 70% of the nurses reported changing their own behaviours following the course, and 40% of the nurses reported a decrease in bullying behaviours during the past six months. Although 70% of the nurses believed they could intervene in bullying situations, only 16% reported they responded to bullying at the time of occurrence. This study illuminates the need to continue searching for other effective methods to prevent and manage workplace bullying. The elements of the cognitive rehearsal programme provided to participants of this study included theoretical concepts of bullying, common bullying behaviours, the consequences of bullying, responses to bullying, and the cognitive rehearsal response. Cue cards, identifying the expected behaviours of professionals and providing responses to common bullying behaviours, were distributed during the programme.</td>
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<td>Stress amongst nurses working in a healthcare telephone-advice service: relationship with job satisfaction, intention to leave, sickness absence, and performance</td>
<td>Cross-sectional survey in Scotland. A total of 152 participants (33%) completed a questionnaire including General Health Questionnaire-12, Work Family Conflict Questionnaire, Job Satisfaction Scale and a measure of intention to leave the telephone-advice service and rated the perceived stress of two working shifts.</td>
<td>B. Farquharson et al., ‘Stress amongst nurses working in a healthcare telephone-advice service: relationship with job satisfaction, intention to leave, sickness absence, and performance’ (2012) <em>Journal of Advanced Nursing</em> 68(7): 1624–35.</td>
<td>Nurses report high levels of stress, as do call-centre workers. The emergence of telephone health-advice services means many nurses now work in call-centres, doing work that differs markedly from traditional nursing roles. Stress associated with these roles could have implications for nurses, patients, and service provision. In multiple regression, work–family conflict was identified as a significant predictor of job satisfaction and intention to leave, and significantly related to sickness absence. There were significant correlations between General Health Questionnaire scores and perceived stress of shifts and some performance measures. Conclusions. Work–family conflict is a significant predictor of job satisfaction, intention to leave, and sickness absence amongst telephone helpline nurses. Minimising the impact of nurses’ work on their home lives might reduce turnover and sickness absence.</td>
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Annex 4: Case studies

These 11 case studies have been drawn up in consultation with each organisation. Short versions appear throughout the text of this report, in the sections indicated. Complete versions are available on request from C3 Collaborating for Health.

- Birmingham City Council – employee engagement (section 4.8)
- Britvic – musculoskeletal disorders (section 4.3)
- BT – mental health (section 4.5)
- Forster Communications – healthy lifestyles in an SME (section 4.4)
- Guy’s and St Thomas’s NHS Foundation Trust – work–life balance (section 4.8)
- National Grid – sickness absence (section 4.2)
- Nestlé – health checks (section 4.4)
- PepsiCo – physical and mental health (section 4.4)
- Sandwell and West Birmingham Hospitals NHS Trust – smoking cessation (section 4.4)
- Serco Health – Health Champions (section 4.8)
- Various (Mars / Novo Nordisk / Unilever) – Health and Wellbeing Local Business Partnerships (HWLBP) (section 4.1)
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URLs correct as of March 2016.


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9 NHS Staff Survey 2015: http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2015-Results/


15 Ingram, Health at Work – Health Improvement Fund.


22 Ibid.


24 RCP, Work and Wellbeing in the NHS.

25 Sloan et al., Implementing NICE Public Health Guidance.


27 Sloan et al., Implementing NICE Public Health Guidance.

28 Ibid.


30 Ibid.


37 Ibid.

38 Ibid.


40 RCP, Work and Wellbeing in the NHS.


42 Ibid.

43 Sloan et al., Implementing NICE Public Health Guidance for the Workplace.


45 Blake and Harrison, ‘Health behaviours and attitudes’.


49 Sloan et al., Implementing NICE Public Health Guidance.


51 Sloan et al., Implementing NICE Public Health Guidance.


58 Sloan et al., Implementing NICE Public Health Guidance for the Workplace.

59 NHS Staff Survey 2015.


63 See, for example, CIPD, Building the Business Case for Managing Stress in the Workplace (2008): http://www.cipd.co.uk/NR/rdonlyres/F5B27E2A-1A75-4C26-9140-1C9242F7A9C6/0/4654StressmanagementWEB.pdf


80 NHS Staff Survey 2015.


84 King’s Fund, ‘A programme with NHS Improvement to support culture change through collective leadership’ (launched 20 January 2016): http://www.kingsfund.org.uk/projects/changing-culture-collective-leadership

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See C3 Collaborating for Health’s ‘Serco Health – health champions programme’: http://www.c3health.org/c3activities/workplacehealth/health-champions-programme-serco-health/

NHS Employers, ‘The health and wellbeing offer to NHS staff’.