A strategic partnership approach to improving health and wellbeing in NHS and public sector staff

A project between the Black Country and Herefordshire & Worcestershire NHS Locality Boards and The School of Health and Wellbeing, University of Wolverhampton

Report Authors:
Dr Robin Gutteridge
Consultant in Health and Wellbeing, School of Health and Wellbeing, University of Wolverhampton
Dr Ralph Leavey
Project Research Associate, School of Health and Wellbeing, University of Wolverhampton
Acknowledgements

Grateful thanks are due to:

The Black Country and Herefordshire and Worcestershire NHS Locality Boards for funding this project
All project members, participants and supporters for interest and involvement
Senior Managers who enabled time and staff from their organisations to participate
A wide network of colleagues, too numerous to mention, but who generously contributed time, expertise and support.

Particular thanks go to:
Dr Sally James, Public Health Workforce Lead, NHS Midlands and East
Professor Linda Lang, Dean of the School of Health and wellbeing
Alan Jarvis: Head of Adult Lifestyle Services, Walsall Healthcare NHS Trust
Jayne McCullough, Health Trainer Coordinator, Worcester Health and Care NHS Trust
Julian Mellor, Principal Workforce Planning Consultant, Walsall Metropolitan District Council
Chris Nash, Associate Director of HR & Workforce Transformation, Worcester Health & Care NHS Trust
Alison Pope, Workforce Deanery, NHS Midlands and East
Yvette Sheward, Director of Quality and Organisational Development, NHS Walsall
Professor Magi Sque: Professor of Clinical Practice and Innovation, UoW School of Health and wellbeing and Royal Wolverhampton Hospitals NHS Trust
Paul Vaughan, Regional Officer, Royal College of Nursing
Dr Barbara Watt, Consultant in Public Health, NHS Walsall

University of Wolverhampton colleagues and volunteers:
Lindsey Halifax: Management Accountant
Tracy Lee: Management Accountant
Emma Hall: Finance Officer
Lynsey Duncan Pitt: Head of the Multi Media Unit, School of Health and wellbeing
Gemma Witton: Web Developer, Multi Media Unit
Karl Eagles: Procurement Manager
Audrey Taylor: Procurement Officer
Steve Male: Marketing and Communications
Members of the University of Wolverhampton Morale and Wellbeing Group

Thanks also to our external providers:
Task and Finish Group 2:
IE Design: www.iedesign.co.uk
Task and Finish Group 4:
Dr Tessa and John Crilly, Crystal Blue Consulting Ltd www.crystalblueconsulting.com
Task and Finish Group 5:
Walkgrove plc: www.walkgrove.co.uk

This report will be available to download from www.healthandwellbeing.nhslocal.nhs.uk

The text in this document may be reproduced free of charge in any format or medium providing it is reproduced accurately and not used in any misleading context. The material must be acknowledged as University of Wolverhampton copyright and the title of the document specified. Where third party material has been identified, permission will need to be obtained from the parties concerned.

Contacts for other correspondence or use of the material:
Robin.Gutteridge@wlv.ac.uk or
The Centre for Health and Social Care Improvement, University of Wolverhampton: chsci@wlv.ac.uk

© University of Wolverhampton.
Executive Summary

The University of Wolverhampton led a partnership project with the Black Country and the Herefordshire & Worcestershire NHS Locality Boards, developing resources to assist organisations more speedily to implement the Boorman recommendations and the NICE guidelines on Health and wellbeing at work. The outputs from this project are intended to facilitate an integrated local and regional response to the Boorman Report and help organisations support individual employees to look after their own health and wellbeing.

Section 1 sets out the rationale and scope of the project. Health and wellbeing remain a key issue for the NHS and other public sector organisations. The Boorman Review found that NHS employees were experiencing poorer health than other public sector organisations. Sickness absence incurs substantial costs for individuals, their employers and for the social and economic health of society. Boorman suggested the annual cost to the NHS was more than £1billion per year. His review team highlighted wide variations in performance between organisations, suggesting there is considerable scope for improving standards across the sector, especially through integrated working within and between organisations. Boorman highlighted the relationship between staff health and well-being and performance; evidence shows there are clear links between staff health and well-being and the key quality indicators: patient safety, patient experience and the effectiveness of patient care.

Our focus was on the key messages from the Boorman Report: enshrined as a duty with the NHS Constitution, staff health and wellbeing needs to be recognised from Board level down as a crucial issue and a collective and shared responsibility. Improving staff health and wellbeing requires cultural and systemic change, proactive leadership, political will and practical tools and resources. This project was intended to contribute to the momentum generated by the Boorman Review.

Health and wellbeing is an enormous topic and for feasibility in a short term project some fundamental assumptions were made; i) when staff feel healthy, well, valued and supported they will also be more satisfied and engaged, leading to increased productivity, efficiency, safety and quality and increased staff and patient satisfaction; ii) that improving the health and wellbeing of the workforce will, over time, reduce sickness absence; iii) that enabling more integrated working between individuals, employers and Occupational Health Services will lead to more cost effective and efficient management of absence, liberating resources to enable a greater focus on prevention and health promotion and on staff development to support public health messages such as ‘Every Contact Counts’ which aims to equip every member of staff to offer brief interventions about healthy lifestyles and behavioural change to patients and clients.

Section 2 outlines the aims and objectives:

- to facilitate implementation of the Boorman recommendations and the NICE guidelines on Health and wellbeing at work
- to provide resources which would support both organisations and individual staff members working in the NHS and other public sector organisations to improve their health and wellbeing and reduce sickness absence
- to stimulate discussion, debate and learning about:
the notion of improving staff health and wellbeing a means of reducing sickness absence

the importance of investment in workforce health and wellbeing

the relevance to staff as well as patients of Public Health messages about wellbeing and the need to develop proactive services that are more than merely managing illness.

The project was carefully aligned with NHS West Midlands Quality Innovation, Productivity and Prevention (QIPP) objectives while working in partnership across health economies was intended to facilitated shared learning and minimise duplication of effort so that good practice ideas to improve staff health and wellbeing could speedily be disseminated. The challenges inherent in partnership working are also presented as the project group wished to evaluate the process of partnership evolution throughout the duration of the project. The University of Wolverhampton acted as a co-ordination hub to facilitate shared learning, evaluation, identification of evidence based best practice and speedy sharing of best practice.

Section 3 reviews the policy and research evidence base. Staff health and well-being is contextualised in relation to policy documents such as the Boorman Review, but also the NHS Constitution, Lord Darzi’s report High Quality Care For All, the Department of Health report A High Quality Workforce and the proposals in Dame Carol Black’s review Working for a healthier tomorrow. Key causes of staff sickness absence are identified and the evidence underpinning good practice initiatives is discussed. Evidence shows that work related mental health problems are increasing while musculoskeletal problems and planning for effective return to work after surgical intervention are all significant contributors to the cost of managing sickness absence. Managing short term acute illness was not explicitly addressed in this project as systemic health economy wide solutions for the control and management of infection and were beyond the project scope. However, integrated approaches were considered. For example, the role of health checks and a positive health and wellbeing culture can help emphasise the importance of good diet, exercise, adequate rest and psychological resilience which may all impact on the immune system.

The concept of presenteeism is discussed, as the causes and costs of health and wellbeing related under-performance are both complex and little-understood.

Section 4 explains the structure and relationships which supported the project while Section 5 describes the governance arrangements and infrastructures which were devised for efficient and cost effective project management and implementation. These, together with supporting Appendices, are presented in the hope that ensuing projects can benefit from and build on our learning so that continuous improvement and ever-slower dissemination and integration are made easier.

Section 5 also summarises the implementation plans of five mini-project Task and Finish Groups and the planned evaluations which together realised the overarching aims of this project to improve staff health and wellbeing. An extended planning period took place after the funding was awarded by the Black Country and Herefordshire & Worcestershire NHS Locality Boards. This proved pivotal in ensuring alignment with the QIPP programme and continuing relevance during the massive systemic restructure and reorganisation of health and social care following the White Paper 'Equity and Excellence, Liberating the NHS.'
Continuing support from the two Locality Boards was absolutely crucial during this period, particularly their agreement that good quality outcomes were the over-riding priority.

**Section 6 is the largest, summarising the outcomes of the project.** Outputs are all designed to help organisations implement the findings of the Boorman Report by providing resources and information in an accessible format which will assist:

1. Individual employees who want to improve their personal health and wellbeing
2. Managers more confidently to support health and wellbeing among their team
3. Organisations to support their staff with effective and integrated approaches to enhancing staff health and wellbeing

These outputs include:

i) An exemplar strategic framework, based on evidence and existing good practice

ii) A suggested client pathway for staff members wishing to change their health behaviour, supported by findings from a 6 month pilot of an intervention pathway ‘Your Health Matters’ programme. The pilot was completed in April 2012 together with the first phase of a planned three phase evaluation.

iii) A suggested set of metrics to assist Boards to monitor staff health and wellbeing and sickness absence over time

iv) A report and a simple modelling tool produced by health economists to facilitate benchmarking and help organisations predict their own potential own cost savings

v) An interactive e-learning tool to help managers have more effective health and wellbeing conversations with their team members. This will be ready to pilot in August 2012.

vi) An e-resource, hosted on NHS Local at [www.healthandwellbeing.nhslocal.nhs.uk](http://www.healthandwellbeing.nhslocal.nhs.uk)

This site is still in development but will include:

- already existing information, resources and good practice examples for both individuals and their employers, drawn together into a single site to save time and support planning and decision making
- relevant policy documents, research evidence, good practice guidance to help build business cases and to inform decisions about personal health and wellbeing
- toolkits and training tools for organisations to use and adapt for local needs
- outputs from the project working groups
- project reports and dissemination material will also be uploaded to the e-resource site

All project plans and good practice exemplar outputs were devised collaboratively, using the research evidence base, examples of good practice and following widespread consultation with project partners and networks.
Section 6 also includes evaluation summaries. As a condition of approval of their mini-project workplan, each Task and Finish group was expected to demonstrate how their mini-project would contribute to the overarching project objectives and had potential to help organisations implement the recommendations of the Boorman Report and / or the NICE guidelines on workplace health and wellbeing. More intensive evaluations were planned for a number of aspects of the project:

- Evaluation of the ‘Your Health Matters’ pilot which tested the exemplar client intervention pathway devised by the project. The pilot was conducted by Task and Finish Group 1 at a community hospital in Worcestershire.

- Task and Finish Group 3 conducted a small empirical research study to investigate whether factors in the home and personal life of an employee affect effectiveness at work and strategies for managing this balance. Although the impact of work on home life has been well researched, this effect of home on work appears to be understood less well.

- Continuous self-evaluation by the Steering Group of the experience and evolution of partnership working

Evaluation of ‘Your Health Matters’ pilot was planned for participants at three points in their programme. Data comprised a range of measures collected for the National Health Trainer evaluation database, supplemented by three additional quantitative measures. A small sample of participants were invited to participate in a more in depth semi structured interview

The six month pilot commenced relatively late in the project life and was not due for completion until the end of April 2012, so only Stage 1 of the planned three stage data collection was able to be undertaken by the end of the project funding. The evaluation plan was therefore designed so it could be continued by NHS colleagues. As it was very short, the pilot data was supplemented by a comparable service evaluation of the individualised component within the NHS Walsall Healthy Workforce Programme. Analysis of the Stage 1 data from both sites is continuing. However, early indications suggest both programme exert a positive impact on client motivation and confidence and the assessment process is perceived a helpful, informative and educational.

The ‘Your Health Matters’ pilot received excellent feedback. There was also some indication of a positive impact on sickness absence, though it must be acknowledged the winter pressures in 2011/2012 were not severe. Monthly sickness absence rates fell at the pilot site during the project, amounting to more than 2 percentage points difference between the start of the pilot in November 2011 and the end in April 2012. Further work would be needed to understand whether and by how much this reduction was due to the ‘Your Health Matters’ pilot and if so, how long the impact continued for once the pilot had ended.

Survey of factors outside work. The survey was conducted using similar but unmatched samples from an NHS site and a group of university staff. Although not generalisable to a whole workforce, this provided some interesting and useful qualitative information which confirmed the value of the training tool for managers being developed by Task and Finish Group 5 There were no major differences between NHS and university staff. The findings
suggest that where there is conflict between work and home life, the adjustment occurs at home to minimise the impact on productivity and efficiency at work. Where there is impact at work, the ‘added value aspects’ of a role, such as mentoring others, appear to be affected and in particular respondents were less likely to access continuing professional development activities. Respondents reported a number of strategies being used help maintain their work: life balance, effectiveness and wellbeing.

**Evaluation of partnership working.** This project provided an opportunity to explore the challenges and benefits of bringing together a diverse membership to share a common aim. Two methods were adopted: a monthly self-evaluation form invited anonymous feedback from Steering Group members throughout the project, and an on line end of project survey was conducted, using Survey Monkey. Responses to both forms of evaluation were low so the findings must be treated with caution. However, the formal evaluation data correlated closely with informal feedback.

Although some tensions are inevitable in a large and diverse group of individuals sharing a project as complex and ambitious as this, the data suggested that the partnership had adequately sustained the project. Respondents felt they had both shared and achieved the aims of the project, working and communicating effectively. All the respondents felt their knowledge of workforce health and wellbeing had increased, the partnership had enabled a wider exploration of the topic would otherwise have been possible and that they were better equipped to help their own organisations to develop a more integrated approach to staff health and wellbeing as a result of their membership of the group. Equally important, respondents reported that being a member of the project group was enjoyable, rewarding and interesting.

**Dissemination activity is also presented in Section 6.** The project has been reported and presented at a number of conferences locally and nationally. A range of other invited speaker invitations were accepted for meetings and conferences throughout the UK, responding to themes as diverse as Public Health, Workforce Development, Partnership, Research Methods, Modernisation and Management of individual and organisational behaviour change. Wherever possible, meetings and presentations were offered to Boards, Senior Executives, Non-Executive Directors, Union Officers and Workforce leads. Substantial efforts were made to engage with relevant SHA leads. The two Locality Board Managers utilised their own contacts and networks to promote and raise awareness of the project to invite collaboration and involvement.

A successful project dissemination conference was held on 1st February 2012. Dr Steve Boorman was the invited keynote speaker and supported the aims and outcomes of the project. Outputs from the Task and Finish Groups will be available from the e-resource website, which will be hosted for the sustainable future by NHS Local. Project partners are also able to link their local workforce health and wellbeing intranet home page directly to this web resource.

A substantial post-project dissemination activity plan is in progress, co-ordinated by the Black Country Locality Board Development Manager. Two NHS colleagues who have participated in the project have been appointed as Dissemination Consultants to undertake a planned programme of meetings and promotional activities to raise awareness, to share the project outcomes and to consider how these could be integrated with NHS, Local authority
and Higher Education organisations across the Black Country and Herefordshire & Worcestershire Localities. Activity will continue until autumn 2012. A Publicity Working Group convened from the original Steering Group membership has supported the Consultants to design a comprehensive information pack for decision makers and a range of publicity materials for raising awareness. The Consultants and the materials developed will highlight the key outcomes and resources from the project and signpost individuals to the e-resource at [www.healthandwellbeing.nhslocal.nhs.uk](http://www.healthandwellbeing.nhslocal.nhs.uk).

**Section 7 is a reflective commentary** summarising learning from the project. Aspects of planning, organisation, communication and partnership are discussed and limitations considered. A typology of partnership behaviours is proposed. Key strengths of the project are identified including: the support of the two Locality Boards to allow the project time to evolve and to focus on quality. Secondly, leadership from the Locality Boards to develop an explicit dissemination strategy using conserved project funds. This will enable several months of activity to disseminate project outputs with decision makers and to discuss with all participating organisations how the outputs and resources could be integrated into their individual staff health and wellbeing strategies and implementation plans. Third, the determined focus on locally relevant solutions which helped practical outputs to be generated. Fourth, the co-ordination and communication hub and academic rigour provided by the University. Constraints included the short term funding which limited the scope of evaluation, different perceptions of partnership and the external context, as wide ranging structural changes in health and social care accompanied the project throughout.

**Section 8 contains a summary conclusion and makes recommendations** for continuing and further work. The project outputs have created a network and set of resources which provide a sound platform for developing staff health and wellbeing and for long term impact evaluation of the project outputs. Research and health economic evaluation is also needed to understand the cost effectiveness and impact on service quality of investing in workforce health and wellbeing.

Organisations are invited to use the outputs of this project further to develop their own workforce health and wellbeing strategies and implementation plans.

Organisations are also invited to make use of the planned programme of dissemination. Dissemination Consultants will be undertaking a programme of meetings and promotional activities to raise awareness, to share the project outcomes and to consider how these could be integrated with NHS, Local Authority and Higher Education organisations across the Black Country and Herefordshire & Worcestershire Localities. Activity will continue until autumn 2012.

In summary, this project was delivered by an innovative and creative partnership group which achieved relevant and practical outcomes while also exploring the different ways of working needed to create a future proof health and social care sector. The project outputs can be utilised by organisations and by future initiatives to improve staff health and wellbeing. Appendices are contained in a separate document, providing information and templates which can be used to minimise duplication of effort in the future.
Contents

Executive Summary 3-8
Section 1. Introduction 11-12
Section 2. Project Aims and Objectives 13-14
Section 3. Context and Background 15-28
Section 4. Project Structure 29-30
Section 5. Project Organisation 31-36
Section 6. Project Outcomes 37-78
  Overview 37
  6.1 Task & Finish Group 1. Strategic Framework, client intervention pathway/pilot 38-44
  6.2 Task & Finish Group 2. E-resource one stop shop 45-49
  6.3 Task & Finish Group 3. Staff perceptions and needs 50-54
  6.5 Task & Finish Group 5. E-learning tool for Managers 63-72
  6.6 Task & Finish Groups contributions to project objectives 73
  6.7 Dissemination 74-75
  6.8 Evaluation of partnership working 75-78
Section 7. Project learning 79-82
Section 8. Conclusions and Recommendations 83-85
Section 9. Project contributors 86-88
Section 10. References 89-94

Figures

Figure 1.1 Project Aims and Objectives 13
Figure 4.1 Project Relationships 30
Figure 5.1 Project Task & Finish Groups Overview 34
Figure 6.1 Strategic framework: exemplar 39
Figure 6.2 Individual behaviour change intervention pathway 40
Figure 6.3 Integrated staff support service: sample options 42
Figure 6.4  Home screen of e-resource www.healthandwellbeing.nhs.local.nhs.uk
Figure 6.5  E-resource: Physical Health search screen
Figure 6.6  E-resource: sub category of Physical Health
Figure 6.7  Board level monthly reporting scorecard
Figure 6.8  Board Scorecard: sample control charts
Figure 6.9  Self completed individual level scorecard
Figure 6.10 Example of simple individual user feedback
Figure 6.11 E-Learning tool for Managers: rules of the Game
Figure 6.12 Selecting the virtual team
Figure 6.13 First learning task is introduced
Figure 6.14 Sample 1 of virtual personnel file
Figure 6.15 Sample 2 of virtual personnel file
Figure 6.16 Introducing managerial dilemma 1
Figure 6.17 Response options for the learner
Figure 6.18 Sample feedback to the learner after decision
Figure 6.19 Task & Finish Groups: contributions to overall project objectives
Figure 7.1  A Typology of partnership behaviours

Appendices
Appendix 1  20 recommendations derived from the Boorman Review
Appendix 2  Extract from Yorkshire and Humber NHS Social Partnership Forum
10 behaviours of successful partnership working
Appendix 3  Steering Group monthly self- evaluation template
Appendix 4  Steering Group evaluation of partnership survey
Appendix 5  Project Steering Group Terms of Reference
Appendix 6  Factors outside work survey template
Appendix 7  ‘Your Health Matters’ pilot evaluation plan
Appendix 8  Individual wellbeing survey template
Section 1. Introduction

This report details the process and outcomes of a project to develop an exemplar strategic framework and implementation tools with potential to improve health and wellbeing in NHS and other public sector staff across the West Midlands region. The outputs from this project are intended to assist organisations more speedily to implement good practice derived from the Boorman (2009b) recommendations and the NICE guidelines on Health and wellbeing at work (NICE 2007, 2008, 2009 a,b,c); also to facilitate an integrated, coherent local and regional response to the Boorman Report (2009a, b) and to support individual employees who wish to look after their own health and wellbeing.

Guided by a small but persuasive body of research evidence, the project group made two fundamental assumptions that were beyond the timescale of the project fully to investigate:

1. that improving the health and wellbeing of the workforce will, over time, reduce sickness absence

2. that enabling more integrated working between individuals, employers and Occupational Health Services will lead to more cost effective and efficient management of absence and free up resources to enable a greater focus on proactive health promotion

The main priorities for the project were helping individual staff members to feel constructively supported by employers in taking personal responsibility for their own health and wellbeing and reducing the costs of sickness absence. However, we wanted also to widen the focus of this project. Utilising knowledge from existing best practice we believed that enhancing wellbeing of the workforce would convey added value to workforce productivity and service quality as well as being an effective approach to reducing sickness absence. There is emergent research to demonstrate the cost-effectiveness of investing in workforce health and wellbeing, demonstrating a positive impact of quality. We assumed that when staff feel healthy, well, valued and supported they will also be more satisfied and engaged, leading to:

- Increased productivity, efficiency, safety and quality
- Increased staff and patient satisfaction

Working together across health economies was intended to facilitated shared learning and minimise duplication of effort so that good practice ideas to improve staff health and wellbeing could speedily be disseminated. Working with the NHS West Midlands Quality Innovation, Productivity and Prevention (QIPP) Workforce Programme, and the health and wellbeing Operational Group, this project was carefully aligned with NHS West Midlands QIPP objectives. The project was directed by a Steering Group comprising members of the Black Country and Herefordshire and Worcestershire Locality Boards and other key partners, local, regional and national. The aim of this partnership approach was to pool resources (skills, knowledge, expertise and funding) to develop an integrated approach. The University of Wolverhampton acted as a co-ordination hub to facilitate shared learning, evaluation, identification of evidence based best practice and speedy sharing of best practice.
Funding was awarded in a competitive bid to two NHS Locality Boards (LB). This enabled the project potentially to involve every organisation with membership of either the Black Country (BC) and Herefordshire and Worcestershire (H&W) Locality Boards. NHS Locality Boards are local networks, supported by the Strategic Health Authority (SHA) and led by service Chief Executive Officers. Their remit is to facilitate workforce planning and innovation that reflects the needs of the local health economy. Following structural re-organisation arising from the Health and Social Care Act (2012) Locality Boards will be replaced by Local Education and Training Committees/Boards (LETC/B).

In total, 24 organisations supported the project, comprising member organisations from the Black Country and Herefordshire & Worcestershire Locality Boards, representatives from the SHA and regional health and wellbeing champions. As the project objectives and workstreams clarified during the first six months, one organisation decided the project would not assist with their operational focus and left the Steering Group, though they remained connected via a local Workforce Partnership Forum. Although every member worked in a public sector organisation concerned with health and social care, the project contributors and participants comprised commissioners and providers; senior, middle and junior managers; researchers and educationalists; clinicians and Human Resources leads; public health and occupational health; health, social care and education; IT experts; Quality and Performance Managers; accountants and administrators.

The project was accompanied throughout by massive re-organisation of NHS and Social Care following the Government White Paper Liberating the NHS: Equity and Excellence in Health and Social Care (2010). These whole scale changes reduced the original number of 24 participants to 19 by the end of the project. Project participants are listed in Section 9 of this report.
Section 2. Project Aims and Objectives

The project aimed to provide resources which would support both organisations and individual staff members working in the NHS and other public sector organisations to improve their health and wellbeing and reduce sickness absence. The objectives are summarized in Figure 1:

Figure 1.1; Staff health and wellbeing project objectives

Objectives

- To synthesise good practice for improving staff health & wellbeing into an accessible e-resource centre
- To compile metrics to facilitate longitudinal monitoring of
  - sickness absence
  - impact evaluation of interventions to improve staff HWB
- To devise an integrated approach to staff health & wellbeing
- To share learning to minimise duplication and maximise dissemination & integration of outcomes
- To evaluate the impact of improving individual health and wellbeing on professional practice
- To facilitate implementation of NICE guidelines & Boorman recommendations on staff HWB
- To share learning to minimise duplication and maximise dissemination & integration of outcomes
- To facilitate implementation of the Boorman recommendations (Boorman 2009b) and the NICE guidelines on health and wellbeing at work (Nice 2007, 2008, 2009a,b,c). The outputs from this project are all designed to assist organisations more speedily to implement these recommendations and guidelines. Project workstreams were devised also to align with QIPP and Every Contact Counts (Mooney 2012). Every Contact Counts is a Public Health led initiative to raise awareness and skills in brief interventions so that every member of NHS staff feels equipped to engage service users in health education and promotion. Boorman (2009b) emphasises that staff, as members of a community, encounter exactly the same lifestyle issues as the rest of the population, namely, obesity, poor diet, smoking, too little exercise and overuse of alcohol. However, NHS staff who become consumers of health services exert a ‘double whammy’ impact on productivity; not only are they receiving health care, but are not fully available for work, whether this is because they are unwell enough to require sick leave, or are continuing to work but at less than full potential.
The group also wanted to stimulate discussion and debate about:

- the notion of improving staff health and wellbeing a means of reducing sickness absence
- the importance of investment in workforce health and wellbeing
- the relevance to staff as well as patients of Public Health messages about wellbeing and the need to develop proactive services that are more than merely managing illness.

Separate but interconnected workstreams were undertaken during the project, all working to produce a range of health and wellbeing-oriented resources. These resources were designed to help:

1. Individual employees who want to improve their personal health and wellbeing
   - by providing information and exemplar interventions to support individual staff members in making healthy lifestyle choices
   - by helping individual staff members to feel better supported by employers in taking personal responsibility for their own health and wellbeing,

2. Managers more confidently to support health and wellbeing among their team
   - by providing a purpose designed e-training tool

3. Organisations to support their staff with effective and integrated approaches to enhancing staff health and wellbeing
   - by provision of a good practice sample strategic framework and exemplar metrics to help Board level monitoring of staff health and wellbeing and sickness absence and more effective workforce planning over time
   - by devising evaluation tools for the project activities which would more effectively measure the impact of staff health and wellbeing initiatives.
   - by creating knowledge and interventions which could be used as a platform for longitudinal evaluation of the impact and cost effectiveness of investing in staff health and wellbeing.

4. Given the political and policy drivers towards integrated working and partnership the project group were interested in evaluating whether the project acted as a functional partnership between employer, employee and academia and of the impact of working in a collaborative project in relation to knowledge transfer, shared learning and speedy integration.
Section 3. Context and background

Although publication of the Boorman Review in 2009 was the catalyst for developing this project, health and wellbeing among the NHS workforce has been under scrutiny for some years. Previous reports include the Nuffield Trust review of research (Williams et al. 1998). This was grounded in the Green Paper ‘Our Healthier Nation’, (DoH1998) which highlighted the responsibility of the NHS, as the largest employer in Britain, to set an example by showing that it was serious about occupational health and safety (Harrison 1998). Williams et al. (1998:8) commented that in isolation each report had generated small impact, but:

“The effect of drawing them together in a single review, is, however, pretty startling.”

The DoH (1998) report found that the NHS had been experiencing high staff turnover as well as an absenteeism rate of 5.6%; higher than the British industrial national average. The emotionally stressful nature of the work performed by NHS staff was also highlighted. Recommendations focused on four key areas: management culture, style and skills; employment practices; prevention, detection and treatment of ill health; and special arrangements for on-call staff. Specifics of management culture, style and skills related to concerns with locus of control, personal worth, support, and role clarity.

In the NHS Plan (2000a) the centrality of employee well-being and organizational factors in producing high-quality patient care was recognized:

.... a modern NHS must offer employees a better deal in their working lives. Improving the working lives of employees contributes directly to better patient care through improved recruitment and retention – and because patients want to be treated by well-motivated, fairly rewarded employees. [ ... ] The way NHS employers treat employees will in future be part of the core performance measures and linked to the financial resources they receive.....

(Department of Health, 2000a:56)

The NHS Plan was followed by the Improving Working Lives Standard NHS (Department of Health, 2000b) which allocated funds to each Trust for staff to determine how it could be used to achieve objectives and targets by 2003/4. The IWL framework was reviewed in 2009 and identified as one of a range of tools available to support NHS organisations to become employers of choice (Social Partnership Forum, 2011).

3.1 The Black and Boorman reviews

Dame Carol Black's Review of the health of Britain's working age population for the cross-government working party (Black 2008) showed that people were living longer, but that this was not accompanied by a similar improvement in self-reported health status. The annual cost of ill health among the working age population including benefit costs, additional health costs and lost tax revenue was estimated to be over £60 billion. In addition, the annual economic costs of lost production through sickness absence and inability to work linked to ill-health were estimated to be over £100 billion.

The Government responded to the Black Review by commissioning a review of the health and well-being of the NHS workforce (Department for Work and Pensions and the
Department of Health, 2008). Lord Darzi’s report on High Quality Care and the Department of Health report on A High Quality Workforce (2008a,b) was also published.

The NHS has the largest workforce in the country and all the iterations of the NHS Constitution (2012a) have pledged to keep its workforce healthy and safe, acknowledging the imperative for the Department of Health to consider the health of people who work in the NHS.

The Boorman review was subsequently commissioned to review the evidence and determine priorities for whole-system improvement, recommending action to enable local delivery. The interim review (Boorman, 2009a) found that:

- NHS employees had high levels of sickness absence; at an average of 10.7 days, their sickness absence compared unfavourably with staff in government departments and was well above the average for the public sector as a whole (9.7 days), and higher than the private sector (6.4 days)

- NHS sickness rates were not reducing at the same rate as in the private sector; in the past year private sector sickness rates had fallen from 7.2 days to 6.4; public sector rates had fallen only from 9.8 days to 9.7 days

- There was a greater propensity for NHS staff to incur a work-related illness or accident than other comparative groups of workers. The probability of an NHS worker having an illness was 1.491 times greater than a non-health worker and the probability of having an accident was 1.731 times greater

- Nearly half of all NHS staff absence was accounted for by musculoskeletal disorders and more than a quarter by stress, depression and anxiety. NHS staff also reported more work-related illnesses due to infectious diseases and stress, depression and anxiety than did workers in other sectors.

The Interim Report (2009a) attracted media coverage which suggested a ‘sick note’ culture in the NHS, and some time was spent rebutting this by health professional organisations. For example, UNISON, the UK’s largest health union, condemned press reporting on the interim Boorman review, arguing that content was taken out of context and reported inaccurately to attack NHS staff.

3.2 Added value of health and wellbeing in the workforce

Evidence in the Boorman Report (2009a,b) clearly demonstrated wide variability in the performance of NHS organisations in supporting employees’ health and well-being, and argued that there was scope for improving performance by reaching the standards achieved by the best organisations in the public sector.

Boorman (2009b) highlighted the direct and indirect costs of sickness absence. In addition there is increasing evidence about the loss to the organisation in other ways due to ill health.

According to Boorman (2009b) evidence from the NHS National Staff Survey and the Acute In-patient survey suggests that a typical trust, moving from average to high levels of staff health and wellbeing was associated with and 8% drop in absenteeism, equivalent to nine
staff reporting for work per day and resulting in a saving of more than £350,000 per annum in direct salary costs. Boorman (2009b) also reports that trusts with high levels of staff health and wellbeing show greater levels of staff satisfaction, (around 11% drop in staff turnover – equivalent to 43 fewer staff leaving per year in a typical acute trust) and significant rises in patient satisfaction.

A review by Dawson et al (2009) demonstrated that staff health and wellbeing variables were significantly related to quality indicators. Patient satisfaction ratings, staff job satisfaction and turnover intentions were the most closely linked. Staff turnover intentions are accepted as a proxy measure of psychological wellbeing; these were significantly related to both actual turnover levels and the proportion of overall staff costs spent on agency staff. A Trust in the top 10 per cent of organisations in terms of health and wellbeing was likely to be in the top 20 per cent of Trusts in terms of patient satisfaction. Health and wellbeing variables were significantly associated with MRSA infection rates. The difference in infection rates between an acute trust with an average and a poor staff health and wellbeing approach was around 0.32 infections per 10,000 bed days. Reports by Dawson et al (2011) and West et al (2011) demonstrate a clear association between staff engagement, quality and patient mortality.

Health and wellbeing variables were also significantly related to staff absenteeism rates and to work-related injury. The difference in absenteeism rates between an average and a good Trust with regard to staff health and wellbeing was approximately 0.4 per cent, which equates to an estimated cost of £350,590 for an average-sized Trust. Across the whole of the NHS this is equivalent to around £137 million per year.

3.3 Boorman Recommendations

The final report (Boorman 2009b) produced a checklist of 20 recommendations that a staff health and wellbeing - aware organisation would be achieving. A list derived from these is included as Appendix 1. In summary, Boorman (2009b) recommended:

- that there should be consistent access to early and effective interventions for common musculoskeletal and mental health problems in all Trusts
- that all NHS Trusts should implement the guidance both from the National Institute for Health and Clinical Excellence (NICE) on promoting mental health and well-being at work
- that all NHS organisations provide staff health and well-being services that are centred on prevention (of both work-related and lifestyle-influenced ill-health
- that all NHS Trusts develop and implement strategies for actively improving the health and well-being of their workforce, and particularly for tackling the major health and lifestyle issues that affect their staff
- that training in health and well-being should be an integral part of management training and leadership development at local, regional and national levels
that high priority should be given to ensuring that managers have the skills and tools to support staff with mental health problems

that all NHS leaders and managers are developed and equipped to recognise the link between staff health and well-being and organisational performance

that delivery of staff health and well-being services should properly be monitored and regularly assessed and reviewed

Although recent and continuing structural reorganisation and the economic climate are all reported to be exerting a negative impact on staff morale, the Fifth Aviva Annual Workplace Report (2011) suggests that the current challenging economic situation may be having a positive effect on employer behaviours in relation to the health of their workforce:

*nearly three quarters (73%) of business leaders admit that the impact of the recession has made them recognise the importance of looking after their employees’ health and wellbeing* (Aviva 2011:24)

Although market research, rather than formal research, this annual review is carried out by an independent commercial organisation using a substantial multi-sector sample group of 2000 employers and 2000 employees. Although not specifically related to health and social care, the Aviva report supports the earlier findings of the Boorman Review (2009b):

- Employers are increasingly recognising that the health and wellbeing of their workforce directly relates to productivity, motivation and morale
- Organisations need to balance the cost of investing in employees’ health and wellbeing with the financial priorities for the business.
- Productivity remains the number one priority for the majority of businesses
- Around one in five employers plan to invest more into employee health and wellbeing over the coming year.
- Six in ten employers say that a healthy workforce is more productive than an unhealthy one.
- Employees say they work harder for an employer that invests in their health and wellbeing.
- Around a third of employers plan to improve their workforce’s work/life balance in the coming year. A similar amount want to improve motivation and morale
- One in five employers say that improving employee wellbeing is key.

(Aviva 2011:5)

**3.4 Key causes of sickness absence**

It must be acknowledged that some forms of sickness absence cannot be proven, so may be open to abuse. Proactive, but supportive and not punitive Sickness Absence Policies and procedures are all important aspects of organisational procedures which should accompany Staff health and wellbeing enhancing initiatives. Accurate recording and Return to Work interviews are important means of identifying where there are regular trends and patterns in absence, while proactive management deters abuse of the system.
Despite some data quality concerns, reports among project partners were affirmed by wider internet searches of NHS Trusts nationally and the key causes of sickness absence in the NHS were identified as:

1. stress and mental health difficulties
2. musculoskeletal problems
3. surgical intervention
4. short term acute illness such as colds and diarrhoea and vomiting

These correlate with the findings of the Boorman Review (2009b).

Any attempt to enhance health and wellbeing in employees and the employing organisation must also consider the potential impact of employees being at work while unwell or unfit. Known as presenteeism, the causes, prevalence, incidence and costs of health and wellbeing related under-performance are complex and unclear.

3.5 Presenteeism

Presenteeism, defined as being at work when ill (Johns 2010) has received attention relatively recently but there is some evidence to suggest it might cause more aggregate productivity and quality loss than absenteeism.

In 2011, The Centre for Mental Health (CMH) defined presenteeism as ‘reduced productivity when employees come to work and are not fully engaged or perform at lower levels as a result of ill health’. They estimate that presenteeism from mental ill health alone costs the UK economy £15.1 billion per annum, compared to absenteeism costs of £8.4 billion per annum. The CMH has produced a discussion paper about managing presenteeism which incorporates discussion of cultural, organisational and individual factors.¹ This paper proposes the type of integrated approaches advocated by Boorman and that this project sought to address.

Presenteeism appears to have been researched from two main perspectives: a focus on the precursors of, and the resultant productivity loss.

However, Johns (2010) argues that a definition should not ascribe motives, nor consequences to. In particular, he suggests that labelling working while ill as presenteeism is unhelpful because it implies a negative connotation, and conflates cause (present while unfit to work) with effect (productivity loss). He suggests the issue is complex and needs careful exploration of all the inter-related individual, cultural and organizational factors, without conflating value judgments or assumptions about potentially fallacious causal links:

\[\text{We need to increase our understanding of how absence episodes start and how decisions to return to work are effected, and to probe the loosely coupled but important connections among having a medical condition, defining oneself as ill, and engaging in work behaviors associated with assuming a sick role......}\]

¹ the discussion paper can be downloaded from http://www.centreformentalhealth.org.uk/pdfs/managing_presenteeism.pdf
Such knowledge could contribute to more accurate estimates of employee health costs, and is required if organisations are to take informed decisions about how to manage presenteeism. (Johns 2010:522)

3.6 Narrowing the project focus

Enhancing staff health and wellbeing is an enormous topic needing integrated systemic solutions and substantial work was already under way at national and regional level. The project team was most anxious to minimise duplication, to avoid repetition and to focus on locally relevant deliverables that would support existing good practice.

A significant number of staff are absent from work for surgical intervention. This aspect of health and wellbeing may best be addressed by an integrated approach, including health checks to plan the return to work and to identify any further health intervention needed to support the return to work. Short term acute illness arising from viral infection require both local policies for the control and management of infection and systemic health economy wide solutions that were beyond the scope of this project, but health checks and a positive health and wellbeing culture can help emphasise the importance of good diet, exercise, adequate rest and psychological resilience which may all impact on the immune system.

Early plans among the project group to explore ways to support a cultural shift in Occupational Health Services towards a health promotion service and more integrated working with managers were rendered redundant by a DoH announcement of a complete review of Occupational Health Standards.

Musculoskeletal problems, stress and psychological wellbeing were therefore identified as the issues most aligned to the type of integrated solutions and interventions this project sought to devise.

The remainder of this section presents summary overviews of the research literature, national policy reviews, narrative reviews and best practice initiatives relating to musculoskeletal and mental health issues and to integrated approaches to support healthy lifestyle choices in the workforce.

3.7 Evidence of Effective Interventions

3.7.1. Interventions for common musculoskeletal problems

Musculoskeletal condition is a major contributor to overall absence. Low back pain is overwhelmingly the most common issue, closely followed by neck and upper limb problems.

Common best practice approaches include:

- Automatic Ergonomic assessment (or reassessment) for staff with identified musculoskeletal conditions with the support of a dedicated Back Care/ Repetitive Strain (RSI) team. This should be triggered from the Return to Work interview and monitored through regular monthly reporting and input from the Back Care (RSI) team with targeted support, training and advice relevant to both workplace and personal life.
- Fast –Track access to Physiotherapy
- Speedier referral (either self-referral or by Managers) to Occupational Health Services to trigger early support and rehabilitation.
- Regular Health and wellbeing checks for all staff.
- Proactive monitoring and exception reporting to monitor trends within staff groups and departments
- A personalised programme of mandatory and essential skills training

However, the evidence base for the optimal type of treatment is mixed, as summarised in the next section

i) Sub-acute low back pain.

A systematic review by Karjalainen et al (2003) aimed to determine the effectiveness of multidisciplinary rehabilitation for sub-acute low back pain (LBP) among working age adults. 1808 abstracts and the references of 65 reviews were included. Only two relevant studies were found and both were considered to be methodologically of low quality Randomised Controlled Trials. Despite the limited studies, they concluded that multidisciplinary biopsychosocial rehabilitation programs (including workplace visits) seemed to offer some benefit for adults with sub-acute low back pain.

In another review Hayden (2005) evaluated the effectiveness of exercise therapy for low-back pain compared to no treatment and other conservative treatments. Exercise therapy appeared to be effective at decreasing pain and improving function in adults with chronic low-back pain. Graded activity programmes also reduced absenteeism. Heymans (2004) found that back schools (integrated biopsychosocial interventions) for patients with chronic LBP, in an occupational setting, reduced pain and improved function and return-to-work status, in the short and intermediate-term, when compared to exercises, manipulation, placebo or waiting list controls.

Henschke (2010) looked at three kinds of behavioural therapy for low back pain: i) operant (which acknowledges that external factors associated with pain can reinforce it), ii) cognitive (dealing with thoughts, feelings, beliefs, or a combination of the three, that trigger the pain), (iii) respondent (interrupts muscle tension with progressive relaxation techniques or biofeedback of muscle activity). There was little or no difference between operant therapy, cognitive therapy or a combination of behavioural therapies in the short- or intermediate-term. Behavioural treatment was more effective than usual care (which usually consists of physical therapy, back school and/or medical treatments) in the short-term. Over a longer term, there was little or no difference between behavioural treatment and group exercise for pain relief or reduced depressive symptoms. Schaafsma (2010) compared the effectiveness of physical conditioning programs in reducing time lost from work for workers with back pain. The review found that physical conditioning programs probably had a small effect on return-to-work for workers with chronic back pain. No difference in effect was found between a light or an intense physical conditioning program and the review also found that cognitive behavioural therapy probably had no value as an alternative therapy, or as an addition to physical conditioning programs.

Martimo (2007) looked at the effectiveness of Manual Material Handling (MMH) advice and training and the provision of assistive devices in preventing and treating back pain. Their review found no significant difference in reports of back pain, back-related disability or
absence from work between groups who received training on proper lifting techniques and assistive devices and those who received exercise training, back belts or no training. It also reported no difference between those who received intensive training and those who received shorter instruction.

In relation to upper body pain, Rempel (2006) evaluated the effects of a wide forearm support surface and a trackball on upper body pain severity and incident musculoskeletal disorders. Rempel (2006) and concluded that providing a large forearm support combined with ergonomic training was an effective intervention in preventing upper body musculoskeletal disorders and reducing upper body pain associated with computer work.

Despite conflicting and inconclusive research evidence and some lack of methodological rigour in existing studies, NICE guidelines (2009c) proposed that manual therapy, exercise and acupuncture individually were cost-effective management options compared with usual care for persistent non-specific low back pain. NICE (2009c) also concluded that the cost implications of treating people who did not respond to initial therapy and so received multiple back care interventions were substantial.

ii). Promoting physical activity at the workplace

The effectiveness of promoting more physical activity among the workforce at the workplace was appraised in a systematic review by Hillsdon (2005). Forty nine quasi-experimental and experimental studies were reported, though only two studies were from the UK.

Eight studies examined the effectiveness of a workplace physical activity programme on self-reported levels of physical activity and five studies reported a positive effect on physical activity. The two UK studies, targeting ambulance workers and factory workers respectively, showed no significant effects on physical activity.

3.7.2. Interventions for improving psychological health in the workforce

i) Stress and Anxiety

Stress and anxiety is identified as a significant issue in the Staff Survey (West et al 2011) and is highlighted by both Boorman (2009b) and the DoH (2000b).

Common good practice solutions include mandatory stress risk assessment during Return to Work interviews and line manager responsibility to follow up the action plan. Occupational Health support for stress risk assessment can be targeted at areas identified from the monthly sickness absence report. Consultation and engagement with staff and ideally, embedding health and wellbeing discussion within appraisal systems and personal development planning (PDP) are also recommended by some Trusts. Regular health checks are also a way of early identification of stress and burnout. Once more, the evidence underpinning the best type of treatment is inconsistent, though the quality of leadership is clearly implicated.

ii) Reducing mental ill health in the workforce

Van der Klink (2001) conducted a meta-analysis of studies exploring individual and organisational-level interventions aimed at helping employees with high and low levels of baseline stress. The results showed that individually targeted interventions were successful
in reducing psychological ill-health in employees, improved their coping skills and improved their work-life quality. However, the impact of these interventions on levels of absenteeism was not significant.

Michie et al (2003) conducted a systematic review of studies into reducing work related psychological ill health and sickness absence. Key work factors associated with psychological ill health and sickness absence in staff were long hours worked, work overload and pressure, and the effects of these on personal lives; lack of control over work; lack of participation in decision making; poor social support; and unclear management and work role. There was some evidence that sickness absence was associated with poor management style. They found that interventions which improved psychological health and levels of sickness absence used training and organisational approaches to increase participation in decision making and problem solving, to increase support and feedback, and improve communication.

Several studies have looked at interventions from outside the workplace trying to reduce the length of sick leave taken due to emotional stress. Brouwers (2006) reports on a Randomised Control Trial (RCT) focused on understanding causes, developing and implementing problem solving strategies and promoting early work resumption which was delivered by social workers in primary care, with General Practitioners (GP’s) offering care as usual. The study sample comprised employed patients on sick leave with emotional or mental health problems for less than three months. The treatment group reported higher satisfaction but overall the results showed no significant difference in outcomes such as sick leave duration or mental and physical health between the study groups.

Bakker et al (2007) compared effects of intervention by primary care physicians who had received training to deliver a minimal intervention for stress-related disorders, compared to care as usual. Results showed no effect on return to work and over the course of the study, symptoms reduced in both intervention and control groups.

Blonk et al (2006) reported on a brief intervention based on Cognitive Behavioural Therapy (CBT) principles which was combined with graded activity and a phased return to work. Effect was assessed using an RCT on samples of self-employed Dutch people who had been off work for 2-3 weeks with disorders such as burnout and stress. It was reported that the trial group returned to either full- or part-time work within a shorter period of time than those in the group who only received CBT or the control group who received two brief sessions with their GP. A study comparing outpatient psychiatric treatment plus occupational therapy, versus treatment as usual found that those in the intervention group started work three months earlier than controls, even while remaining symptomatic (Schene et al 2007).

Evidence about workplace interventions for people with common mental health problems was reviewed by Seymour and Grove (2005). The review indicated that interventions focusing on individuals were most effective in producing positive health outcomes. The most effective programmes offered support and training to build individual coping skills. Brief forms of individual therapy, such as cognitive behavioural therapy, that lasted less than two months were the most successful form of intervention. CBT was effective whether delivered face-to-face or through computer-aided software. There was support for using cognitive behavioural therapy (CBT) in brief therapy sessions of up to eight weeks with people already
presenting with common mental health problems. CBT was most effective for jobs that already involved a high degree of autonomy. Seymour and Grove (2005) suggested that increasing their control potential should be prioritised for employees with a low degree of authority to make decisions; this systemic change should then be followed by CBT interventions. The 2005 (Seymour and Grove) review was later updated with papers published from 2004 until the end of 2008 (Seymour 2010). Only six provided high quality evidence in the area of interest. All were from North America or non-UK Europe. The main overall finding was that poorly targeted interventions had little effect on rehabilitation, retention in work or prevention. Cognitive behavioural approaches seemed to be the most promising. Individually targeted interventions that used several complementary methods were more effective than those that used only one.

Hill et al (2007) mainly confirmed previous findings: CBT was effective in reducing not only psychological ill-health but also absenteeism. The review was cautious: there was only a limited amount of good quality evaluation evidence, mostly about individual-level intervention types. Results for organisational-level interventions were contradictory.

iii) Preventing mental ill health in the workforce

Ways of preventing occupational stress in healthcare workers were examined in a review by Marine (2006). The review found evidence that organisational-level interventions including communication or changes in work organisations had a positive effect on stress levels as well as reducing the possibility of burnout and general symptoms. Positive effects lasted on average from six months to two years.

Enabling greater resilience has been seen as one way of helping people cope with stress. Millear (2008) reported on a pilot resilience-building programme (Promoting Adult Resilience PAR). The PAR program integrated interpersonal and cognitive–behaviour therapy (CBT) perspectives and was conducted in the workplace over 11 weekly sessions. Pre-intervention, post-intervention and follow-up measures on 20 PAR participants were compared with a non-intervention-matched comparison group. At follow-up, the PAR group had maintained significant post-test improvements in coping self-efficacy and lower levels of stress and depression, and reported greater work-life fit than the comparison group. A qualitative evaluation of the PAR program showed that skills were rated highly and were widely used in everyday life at both post and follow-up measurement times.

3.3. Promoting health and wellbeing in the workforce

Promoting health and wellbeing in the workforce requires a holistic approach, integrating best practice for both physical and psychological balance within a culture that both recognises and mediates the health and wellbeing challenges and works in partnership with staff. This is a significant leadership challenge, but many of the solutions are not expensive. For example, Boorman (2009b) reported that staff who feel unheard by their manager are significantly more likely to take sick leave over the following twelve months. But simple management behaviours and practices made a big difference to the chance of being off sick. Staff who felt respected, supported by appraisal processes, well managed during and after sickness absence all contributed to the predictive risk of future sickness. But a personal enquiry about individual wellbeing and being thanked reduced the risk.
Michie and West (2004) examined evidence about management and psychological approaches and their respective contribution to the output of an organization, with a particular focus on the National Health Service (NHS) in the UK. They found that work demands (long hours, workload and pressure), lack of control over work and poor support from managers were the most common work factors associated with psychological ill-health and that social support and control at work protected mental health, whereas high job demands and effort–reward imbalance were risk factors for psychological ill-health. Large scale survey research reported by Nadeem and Metcalf (2007) found that management attitudes to work-life balance also mattered. There was a clear link between employee perceptions that managers understood their responsibilities outside work and employee commitment to the organisation, their job satisfaction and work-stress.

Giga’s (2007) review identified the types of interventions that were in use and the effectiveness of the interventions. It reported on 16 UK-based studies which had assessed the impact of stress reduction strategies. The vast majority of interventions were targeted at the individual employee. All intervention levels were found to have some human and/or organisational benefits but strategies aimed at the individual level were less likely to result in longer-term benefits. However, there was a tendency for researchers to evaluate interventions over a relatively short time-frame so there is a need for more longitudinal impact evaluation.

Baxter et al (2009) carried out the review on which the NICE (2009a) Promoting Mental Well Being at Work guidelines were based. Baxter et al (2009) argued that research relevance and rigour was adversely affected by the number of complex inter-subjective concepts and lack of agreed definitions, a lack of valid and reliable measurement instruments, a tendency for cross-sectional study designs, and limited evidence on interventions. In addition, they noted a tendency for interventions and research to approach well-being from a perspective of crisis management rather than preventative health promotion. Employees wanted strategies to reduce adverse responses such as strain; organisations wanted effective ways to train employees in how to modify their responses to stress. The review team argued that these post hoc approaches were at the expense of emphasising the positive psychological aspects of promoting well-being.

In a later report from this work, Baxter et al (2010) argued that ‘wellbeing’ should be considered a mediating factor in behavioural and attitudinal outcomes, which in turn would have a mediating effect on any business outcomes. A ‘tiered’ set of relationships was proposed as a way of understanding the processes involved. These distinguished the context of work from work ‘content’ factors. Key context factors influencing wellbeing were: management style, organisational justice, work-place support, employee participation and communication systems. Key content factors were: work demands, level of control, effort and reward, role, working schedules, sense of fulfilment and job stability.

Voss (2009) reported a case study where hospital management change towards more openness produced positive results. The hospital was characterised by an open culture of dialogue, which allowed individualised contact with any staff member by phone at any time in order to arrange a meeting as soon as possible. In addition, there were numerous practices of social dialogue based on a decentralised way of organisation with an emphasis on transparency.
A review by Macleod and Clarke (2009) concluded that there is a clear positive correlation between feeling connected to the organisation delivering high quality service.

To summarise this review of the health and wellbeing literature, it is clear that workface health and wellbeing and sickness absence have been an increasing focus of attention. There is evidence of good practice initiatives and some emergent evidence of positive impact. However, there is considerable variation in awareness, leadership support and investment between Trusts. More work is needed to establish the optimal balance between investment and return, to identify the most cost effective set of interventions and to evaluate the added value aspects of service quality which are most likely to be associated with enhancing workforce health and wellbeing.

Nevertheless, despite progress, it is also clear that challenges remain, as illustrated by the recommendations of the Futures Forum (Field 2012):

A very strong message from our engagement is that if we expect healthcare professionals to improve the health and wellbeing of the people they meet in the course of work, the NHS must first ‘put its own house in order’

We also heard the NHS has a long way to go before this is standard across the system

3.4. Partnership working

The newly approved Health and Social Care Act (2012) places emphasis on partnership working as a means to ensure resource management and service quality in the sustainable future. This builds on experience and knowledge arising from the transformation of community services (DoH 2011) and World Class Commissioning (DoH 2007) which catalysed systemic change in the NHS; both espoused the principles of partnership. This project provided a real-time opportunity to model and explore partnership behaviours members represented considerable cultural diversity, with many perceptions of the constituents of effective partnership, yet every stakeholder shared a common interest in workforce wellbeing. Project members included Service Human Resource and Occupational Health leads, educationalists, academics and researchers from Higher Education, individual employees, staff side representatives and representatives of the SHA.

However there is no single definition of partnership, which is a dynamic enterprise evolving over time, rather than a fixed position. The behavioural changes needed to support effective partnership are still being worked out, especially in the current climate. The Audit Commission (2005) defines partnership as:

an agreement between two or more independent bodies to work collectively to achieve an objective.
Audit Commission (2005)

A new agreement between the DOH, Employers and the Trades Unions (DoH 2012) sets out their agreed Principles for Effective Joint Working:
1. To deliver partnership working successfully it is important to develop good formal and informal working relations that build trust and share responsibility, whilst respecting difference.

2. These principles are underpinned by the NHS Constitution.

3. To facilitate this, all parties commit to adopt the following principles in their dealings with each other:
   - build trust and a mutual respect for each other's roles and responsibilities
   - openness, honesty and transparency in communications
   - top level commitment
   - a positive and constructive approach
   - commitment to work with and learn from each other
   - early discussion of emerging issues and maintaining dialogue on policy and priorities
   - commitment to ensuring high quality outcomes
   - where appropriate, confidentiality and agreed external positions
   - make the best use of resources
   - ensure a no surprises culture.

(DoH 2012:4)

These high level strategic principles imply a need for an underpinning integrated set of partnership oriented behaviours and if tokenism is to be avoided, the differences between partnership intention and partnership behaviour need to be understood. There are different types and levels of partnership working and the behaviours needed to support the evolution of meaningful partnership may need to be flexible. It cannot be assumed that effective partnerships are automatic outcomes of commitment, goodwill and shared or common objectives.

In 2008, a Yorkshire and Humber Social Partnership summit devised a model of ten essential and inter-related behaviours. Their ten identified behaviours include:

- Having mutual respect
- Actively listening to each other
- Working from shared values
- Walking in each other's shoes (Empathy)
- Being honest with each other
- Being Solution Focused
- Acknowledging the views of others
- Being inclusive
- Open communication and information sharing
- Trusting each other
Trust in each other is identified as the most important factor:

At the heart of partnership working is trust. Building and maintaining trusts requires us to practice each of the behaviours above consistently over time.

Building trust takes time, but it only takes an instance to damage or even destroy it.

Partnership working plays a crucial role in delivering highly motivated and committed staff who can continuously improve the quality of the care they provide to patients and their families, and who can be proud of the NHS.

(Yorkshire and Humber Social Partnership Forum 2008:1)

The Yorkshire and Humberside model is reproduced in Appendix 2

An audit tool\(^2\) based on the Yorkshire and Humber NHS model, to help organisations evaluate the effectiveness of their partnership behaviours was adapted by the UoW project management team for use as one of two methods for the project Steering Group to self-evaluate the extent to which partnership behaviours were perceived and altered during the life of the project. The self-evaluation design is described in Section 5 of this report, the findings in Section 6 and the survey templates are included in Appendices 3 and 4.

In summary therefore, the project group agreed to integrate a reflexive exploration of their own partnership while devising a range of outputs which would address some of the identified pinch points of workforce health and wellbeing. These included developing: an integrated strategic framework; an intervention pathway to support employee health and wellbeing; resources to help organisations and individuals improve musculoskeletal health, stress and psychological wellbeing; tools to support monitoring and effective leadership of a positive health and wellbeing culture.

\(^2\) The audit tool can be downloaded from http://www.socialpartnershipforum.org/SiteCollectionDocuments/YH%20Partnership%20Behaviours%20Toolkit%20for%20Download.pdf.
Section 4. Project Structure

The project was funded through a competitive bid for innovation funding to two Locality Boards. To the best of our knowledge, this was the first time two Locality Boards have collaborated to achieve a shared aim. Development work began on the proposal in October 2009, shortly after the interim Boorman review (2009a) was published. Funding was approved in May 2010.

The relationships between the project group and the SHA are described in Figure 4.1. This diagram also shows that the project was aligned to the QIPP workforce groups that were in operation under the SHA during 2009-2010. In particular this project was closely aligned to the Metrics QIPP group and to the Workforce Health and wellbeing Group and we ensured the project was represented on these groups and they were similarly linked to the project Steering Group. In addition, the SHA Public Health Workforce Lead ensured there was close contact and liaison between our project and her workstream. This was a most valuable and valued link and it was very helpful to highlighting the relevance of public health agendas and ‘Every Contact Counts to this project.

This project also linked with the West Midlands Workforce Health and wellbeing Forum. Intended as an information sharing network, this group was instigated by the Director of Workforce and Organisational Development (OD) at West Midlands Ambulance Service. Membership of this group was open to all NHS organisations in the West Midlands. It included NHS organisations from a wider geographical area than the Black Country and Herefordshire & Worcestershire Locality Boards (LB) membership but excluded the universities and local councils who were part of the LB structures. Liaison with the Workforce health and wellbeing Forum was extremely helpful as it enabled consultation about the project design and the opportunity to benefit from good practice ideas and examples from NHS organisations not directly involved in this project. As well as knowledge exchange, this helped maintain a focus on locally relevant solutions.

Following the general election in 2010, the White Paper (DoH 2010) signalling a complete structural and functional re-organisation of health and social care was published. This received Royal Assent in March 2012, becoming the Health and Social Care Act 2012 as this report was being drafted. Uncertainties and decreasing workforce morale therefore accompanied this entire project, arising from this wide ranging and wholescale legislative restructure, together with stringent cost saving programmes and increasing media attention to concerns about the quality of care in the NHS. Inevitably, it became an increasing challenge to maintain close alignment between the project objectives. More importantly, there was an impact on engagement, involvement and continuity of the alliances and networks underpinning the project partnership. Nevertheless, despite a wry acknowledgement that this might not have been the optimum to embark on a collaborative enterprise to improve physical and psychological health and wellbeing, the renewed focus on workforce as a critical and expensive resource created a real opportunity for any learning outcomes to be heard.
The Staff Health and wellbeing Project group worked together for 18 months, from June 2010 until February 2012. The project reported to the two Locality Boards and governance systems were set up early in the project life to facilitate transparency and efficient monitoring and reporting. Funding for the project management team expired at the end of February 2012 and a planned handover of incomplete and continuing workstreams and remaining funds occurred.

The next section describes how the project was organised to support achievement of the identified objectives.
Section 5. Project Organisation

5.1 Governance and management

Members of the West Midlands Workforce Health and wellbeing Forum had supported the proposal submitted for the funding application. Once funding was agreed, members from this group who represented the two Locality Board areas nominated representatives for membership of the project Steering Group. A general invitation was extended to any other NHS and public sector organisation linked with the BC or H&W Locality Boards. In addition the SHA Workforce team was asked to nominate representative members and to put the project group in touch with local, regional and national workforce health and wellbeing champions. We were keen to ensure the Steering Group was as representative and inclusive as possible, and also has clear lines of communication with decision makers in individual organisations and with the SHA. The Chair and Vice Chair of the West Midlands Social Partnership Forum agreed to join the Steering Group and to act as a conduit for information sharing and consultation with staff side representatives. It was felt important to achieve support and engagement by Union representatives.

The Managers of the two Locality Boards also decided to join the Steering Group. None of the members representing NHS or Social Care partners had sufficient capacity to Chair the Steering Group, so the PM was selected as the most viable solution. In hindsight, these two decisions probably helped generate some confusion about lines of decision making and authority, making it more difficult to manage equity and equality within the partnership.

5.1.1 Ethical Approval

The project received ethical approval from the University of Wolverhampton School of Health and wellbeing Ethics Committee on 20th December 2010. As more detailed workstreams evolved, the need for further ethical review was determined by consultation with the Integrated Research Application System (IRAS). The project and all subsequent workstreams fell within the IRAS criteria of a service evaluation, so were deemed to be exempt from IRAS scrutiny. All organisations involved in the project delivery were asked to seek approval from their local Research Governance Manager and where consultation with staff was undertaken, all documentation was submitted for local scrutiny to the relevant Research Governance lead.

5.1.2 Role of the Project Management Team

In parallel, the School of Health and wellbeing convened an internal project management team. This team administered the Steering Group, which was chaired by the Project Manager. The project management team was accountable for the governance, finance and reporting processes, for maintaining project direction and progress and for networking and outreach to prepare for dissemination, integration and plan for a smooth handover at the end of the funded project. All project workstreams were supported by the project management team who assisted with mini-project design and evaluation planning, provided the evidence base for planned work and provided administrative and organisational support where necessary. The project management team also acted as a hub for co-ordination and communication to ensure the work of each project group maintained a focus on the overarching objectives and that wherever possible, resources and learning were shared to minimise duplication. Although intended for efficiency, this was also necessary to ensure
sufficient overlap to ensure a coherent, integrated set of mini-projects. This became especially important as not all project groups ultimately included representative members from both Locality Boards, so this function was important to help manage the inevitable tensions which occasionally occurred between local priorities and the shared objectives of the partnership project. As the project progressed the project manager also submitted proposals to apply for further research funding, and worked with the Black Country Locality Board Development Manger to plan for continuity and support dissemination planning.

To fit within a tight budget, the project management team was kept very small, comprising a 0.4wte project manager and a 0.2 wte administrator. The project manager, an academic, psychologist, practising counsellor and ex-physiotherapist had written the funding proposal, was experienced in design, delivery, evaluation and leadership of collaborative and partnership projects and had a strong profile in applied research for quality enhancement. The project manager also serves as a Non –Executive Director within the NHS, so was well acquainted with the on-going challenges and changes in progress. A 1.0wte Research Associate with an academic public health background was purposefully recruited to a one year contract and joined the team in February 2011. This member was late joining the project partly because of the timescales imposed by an external recruitment process, but also because it was not possible to determine the research skills and competencies needed to support the project until the workstreams became clearer. A small amount of project management budget was allocated to buy in Consultancy from two Exercise Psychologist colleagues in the School of Sports Performing Arts and Leisure who were actively involved in a large and ground breaking European Social Research Council (ESRC) project exploring how individuals can learn effectively to self-regulate emotional responses such as stress. This knowledge was invaluable in helping consider creative ways of supporting and measuring behaviour change for enhanced health. In addition, a final year undergraduate student from the School of Sports Performing Arts and Leisure undertook his work placement with the project management team between September 2011 and February 2012. As a student in the BSc Hons Physical Health and Exercise programme, with an interest in supporting behaviour change, this student contributed valuable time and skills to the evaluation aspects of the project without any cost to the budget.

The project management team was also able to draw on expertise within the wider university, including Finance, Procurement, School of Health and wellbeing Multi-Media Unit, Marketing and Communications, Events Management and HR. The project was also supported by the University of Wolverhampton Morale and Wellbeing Group, a strategic group tasked with developing the University Staff Health and wellbeing approach. Several members of this group joined the project to help devise, deliver and lead the workstreams. These additional contributions by the university were invested on a goodwill basis to demonstrate their commitment and participation as a project partner as well as the co-ordination hub. Support from these internal university colleagues was pivotal as the project management team was exceedingly small for such a large and complex project. At times this was problematic, particularly in the planning and development phase of the project, when processes and networks were not yet functional, the vision was evolving and partnership support needs were at their highest. Tensions arose between the requirement to demonstrate value for money and the need for an effective, efficient team with sufficient capacity not merely to administer but also to drive project momentum and development.
Terms of Reference were agreed for the Steering Group (see Appendix 5). A schedule of monthly meetings was agreed, with supplementary meetings to be arranged as needed. The group intended to conduct as much interim business as possible by email; this had the advantage of efficiency and an audit trail. Early difficulties occurred with email transmission of large documents and variations between firewalls and in-box capacity in different organisations. Therefore a purpose designed project website was constructed. As well as uploading and sharing documents and progress among the various workstreams, this included a blog facility to facilitate sharing of ideas, learning and problem solving and was also designed to maintain confidentiality so that evolving but not fully formed ideas could be discussed without risk of being circulated to a wider audience where they might be taken out of context. However although initially welcomed by members of the Steering Group, this website was never used, except by the University of Wolverhampton project management team. NHS colleagues explained they were too busy to log in to another source of information and so never developed the habit of using the project website.

Simple systems and schedules to facilitate transparent and efficient governance, reporting and communication were agreed and initial but key decisions about project focus were made. As identified in Section 3, the project aimed to generate locally applicable outputs relevant to both employee and employers, including: an integrated strategic framework; an intervention pathway to support employee health and wellbeing, resources to help organisations and individuals improve musculoskeletal health, stress and psychological wellbeing; tools to support monitoring and effective leadership of a positive health and wellbeing culture. In addition, the Steering Group would utilise the opportunity of working together to appraise the benefits and challenges of partnership.

5.2 Project implementation

The project was delivered in three integrated phases:

5.2.1 Phase 1: Planning and Development

The first six months, until September 2010 were spent:

- ensuring alignment with the QIPP and Public Health agenda
- consulting to minimise duplication of relevant work in progress at SHA and DoH levels.
- convening the Steering Group and agreeing terms of reference (Appendix 5).
- establishing wider liaison and networking links
- developing the communication and governance systems and processes.
- recruiting the project management
- evolving five time limited Task and Finish Groups to take forward specific mini – projects all contributing to the overall project objectives
- reviewing the research and policy literature to provide an evidence base for the emerging workstreams

Once the five Task and Finish Groups (T&FG) had identified their focus within the overall objectives of the project, and Leads had been identified, the next six months until early 2011 were spent working up more detailed work plans. The agreed Task and Finish Groups topic areas are shown in Figure 5.1 and their outputs described in Section 6.
Two project groups were led by members of the Herefordshire & Worcestershire Locality Board from Worcestershire Health and Care NHS Trust; two were led by the University of Wolverhampton and the remaining group was led by Walsall Healthcare NHS Trust; both latter organisations are members of the Black Country Locality Board. Each working group was intended to include a representative cross section of all project partners.

This planning and development phase took considerably more time than anticipated; partly due to the re-organisations which resulted in constant movement of staff between organisations or roles, disrupting membership continuity; partly due to overwhelming workloads arising from the changes which diverted attention; partly as a result of a continuing need to re-align the project objectives with changing DoH and SHA priorities and policy directives. These uncertainties meant it was not until September 2011 that the Steering Group felt confident enough that QIPP, local Cost Improvement Programmes, staff changes and the structure of emergent organisations began to settle sufficiently for some of the project groups to get under way. The support of the two Locality Boards was absolutely crucial during this period, particularly their agreement that good quality outcomes were more important than deadlines. This support enabled the project to continue for more than the year normally funded by the Locality Boards.
5.2.2. Phase 2: Implementation

Once the focus for each T&FG had been agreed, indicative budgets were allocated and every group then worked up a detailed mini-project plan with costings, including outcome indicators and timescales. These were formally approved at a Steering Group meeting.

Two T&FG needed to undertake full procurement processes: T&FG2 and T&FG5 so work began as soon as indicative budget allocations were agreed.

Work plans and budget allocations were approved by the Steering Group by June 2011. Funds were then devolved to the employing organisations of each T&FG Lead to expedite local operational control and efficiency. Each T&FG submitted a progress report to the Steering Group at alternate monthly intervals using a standard RAG report and financial report template (Appendices ? and ?). These reporting arrangements were devised to align efficiently with the reporting schedules of the two Locality Boards.

The outcomes of each Task and Finish Group are reported in Section 6 of this report. A summary of learning from undertaking this project is presented in Section 7 and recommendations for future work are summarised in Section 8.

5.2.3 Phase 3: Dissemination

Learning and emergent good practice suggestions were shared continuously throughout the project, both formally and informally. Formal dissemination occurred through conference presentations and attendance at seminars. Informal dissemination occurred through networks and routine meetings. In addition, unallocated and conserved project funding was used to fund a planned dissemination programme following the formal end of the project on 29 February 2012. This dissemination activity is described in more detail in Section 6.

All project partners are also able to link their local workforce health and wellbeing intranet home page directly to a specific output of the project, a web resource developed by Task and Finish Group 2 at www.healthandwellbeing.nhslocal.nhs.uk.

5.2.4 Planned Evaluations

All the T&FG workstreams were expected to incorporate a relevant evaluation plan. Methodological and practical support was offered by the PM team where needed. Evaluations of each Task and Finish Group work are described in the relevant project outcomes in Section 6.

In addition, two specific supplementary evaluations were planned and undertaken by the project management team.

i) Factors outside work survey

The initial literature review identified policy and practice based debate as well as empirical research about the work life balance. However, the focus was primarily about how work impacts on home and private life. Although presenteeism is a clearly identified issue, there appeared to be very little consideration of how issues at home or in the personal life of an individual affected their performance and effectiveness at work. Accordingly, Survey Monkey was used to construct an on line anonymous response survey of how factors
outside work affect personal productivity, focus and interpersonal relationships. With appropriate research governance permissions and consent processes, this survey was sent to all NHS employees based at the community hospital where some Task and Finish Group activity was taking place and to a control group of all staff employed in the School of Health and Wellbeing at the University of Wolverhampton. The survey template is included in Appendix 6 and the results are discussed in Sections 6 and 7.

ii) Evaluation of Partnership Working

Evaluation of partnership working among the Steering Group was undertaken by two methods. First, continuous feedback was invited, using a monthly self-evaluation sheet which was returned anonymously. Although the monthly return rate was low, it was sufficient to identify trends and in particular, enabled respondents to feedback about any issues of concern that they might have felt inhibited otherwise to disclose.

Second, the Yorkshire and Humberside audit tool was adapted\(^3\) for use as an end of project survey of all Steering Group members. Survey Monkey was used to invite participation. This is an electronic survey tool enabling anonymous response. The online survey was sent to all Steering Group members after the final Steering Group meeting, with a follow up reminder two weeks later.

This section has explained how the project was organised; the next section will present the outputs of the Task and Finish Groups work.

\(^3\) The audit tool can be downloaded from http://www.socialpartnershipforum.org/SiteCollectionDocuments/YH%20Partnership%20Behaviours%20Toolkit%20for%20Download.pdf.
6. Project Outcomes

A brief overview followed by more detailed descriptions of the outputs of each Task and Finish Group are presented in this section. The project outputs are all designed to help organisations implement the findings of the Boorman Report by providing resources and information in an accessible format which will assist:

1. Individual employees who want to improve their personal health and wellbeing
2. Managers more confidently to support health and wellbeing among their team
3. Organisations to support their staff with effective and integrated approaches to enhancing staff health and wellbeing

These outputs include:

i) An exemplar strategic framework, based on evidence and existing good practice

ii) A suggested client pathway for staff members wishing to change their health behaviour, supported by findings from a 6 month pilot of an intervention pathway ‘Your Health Matter’s’ programme. The pilot was completed in April 2012 together with the first phase of a planned three phase evaluation.

iii) A suggested set of metrics to assist Boards to monitor staff health and wellbeing and sickness absence over time

iv) A report and a simple modelling tool produced by health economists to facilitate benchmarking and help organisations predict their own potential own cost savings

v) An interactive e-learning tool to help managers have more effective health and wellbeing conversations with their team members. This will be ready to pilot in August 2012.

vi) An e-resource, hosted on NHS Local at www.healthandwellbeing.nhslocal.nhs.uk

This site is still in development but will include:

- already existing information, resources and good practice examples for both individuals and their employers, drawn together into a single site to save time and support planning and decision making
- relevant policy documents, research evidence, good practice guidance to help build business cases and to inform decisions about personal health and wellbeing
- toolkits and training tools for organisations to use and adapt for local needs
- outputs from the project working groups
- project reports and dissemination material will also be uploaded to the e-resource site

The remainder of this section describes project outputs in more detail, from the perspective of each Task and Finish Group.
6.1 Task and Finish Group 1: Strategic framework and pilot employee wellbeing programme

This working group generated a good practice example of a strategic framework, grounded in the research evidence, together with wide consultation and utilising good practice examples provided by West Midlands Ambulance Service and Dudley Walsall Mental Health NHS Trust. Although many organisations already have proactive staff health and wellbeing strategies in place, it was felt important to identify the type of incremental, stepped interventions that would most effectively provide an integrated approach to from induction onwards, however complex or simple health and wellbeing needs might be for a particular individual. As well as providing an example to stimulate consistent good practice, this strategic framework also provided the foundation for the remaining T&FG mini-projects.

T&FG1 also devised an intervention pathway for supporting behaviour change in individual staff and piloted a segment of this pathway in a local organisation.

The strategic framework is shown in Figure 6.1 and the client intervention pathway in Figure 6.2.
Figure 6.1: Strategic framework for a proactive integrated health and wellbeing strategy

Strategic levels of intervention

Level 4
Long term sickness and high risk
• OH assessment and ongoing review
• Individual, Manager and OH agree management plan
• Planned return to work
• Reasonable adjustments to workload or contract

Level 3
Continuing problem, new risk identified or sickness absence trigger
• Motivational support for behaviour change
• Fast Track referral to expert services (e.g., Physio, OT, Counselling, GP, diagnostics, specialist service)
• Referral to OH wellbeing service

Level 2
Behaviour change wanted
Self referral [or agreed with manager]
• Triage/health trainer assessment inc. external factors
• Individual action plan
• Signposting and referral inc. training and development
• Support through brief intervention programme (6/12 weeks)

Level 1
For everyone
• HWB culture
• HWB at induction & regular discussion with Manager
• NHS Health Checks & Ergonomic assessment
• Health promotion information, signposting and resources

Enter pathway at any level, may progress up or down in flexible cycle
Elements from other levels can be incorporated cumulatively or individually

Level 1 interventions exemplify the type of knowledge and information needed by the entire workforce in order to promote a positive health and wellbeing culture.

Level 2 suggests the basic components to support behaviour change in individuals who wish to improve their health behaviours or make lifestyle changes. Level 3 identifies some aspects of support needed to maintain and improve health and wellbeing in employees identified at risk, whether or not they have been on sick leave. Level 4 suggests the type of integrated approaches which are most likely to support an individual who has been identified...
as high risk, perhaps because of a previous injury, medium to long term absence, health related performance concerns or lifestyle and behavioural habits and individual socio-economic circumstance. Individuals can enter the pathway at any Level of intervention, and may proceed up and down between the suggested levels, according to need.

It is fundamental and crucial that integrated health and wellbeing strategies and interventions are promoted and perceived by staff as supportive, not punitive.

Once the strategic framework had been amended in the light of consultation feedback, T&FG1 members turned attention to devising a client pathway which would enable commissioning and evaluation criteria to be drafted and a sample intervention programme to be designed. The client pathway is intended to support any employee wishing or needing health and wellbeing intervention above Level 1, which is the level of information and support needed by every employee. The pathway is shown in Figure 6.2

Figure 6.2: individual staff member health and wellbeing enhancement pathway

Pathway flow above Level 1

A six month pilot project followed, led and managed by Worcester Health and Care Trust and based at Princess of Wales Community Hospital in Bromsgrove. This is a small in-patient unit with a range of primary and community services working from this base, so provided access to a diverse range of clinical, support and administrative staff. The aim of the pilot was to test the effectiveness and feasibility of the client pathway. The Health Trainer Service acted as the assessment and delivery hub for up to six weeks personalised
intervention; the key priorities identified by Boorman (2009a,b) underpinned the programme of interventions available through the Health Trainer Service:

1. Improving mental health and wellbeing
2. Increasing participation in physical activity
3. Smoking reduction and cessation
4. Reducing alcohol consumption
5. Reducing obesity

Other services and signposting or referral information available during the pilot are shown in Figure 6.3. Fast track referral to Physiotherapy was already available to NHS staff in Worcester Health and Care Trust and was utilised. Other popular and well received services included Thai Chi and exercise classes, massage, particularly for relaxation of the neck and back, blood pressure and cholesterol checks and a Moodmasters programme. Moodmasters is a commercial education package, delivered over twelve weeks. It is grounded in Cognitive Behavioural Therapy approaches and intends to improve stress management and resilience. It is devised in accordance with research evidence.

Awareness raising and advance briefings to managers and good publicity to staff were felt to be important success factors. Staff were also allowed time within working hours to attend, but it was notable that many staff chose not to take advantage of this offer and instead attended in lunch hours or off duty time. The area dedicated for the pilot was also made bright and welcoming and was near the staff canteen. It also seemed important to have a dedicated administrator available at specific times (initially two days per week) to handle appointments and enquiries. A summary of the evaluation is included below.
Types of intervention: altering behaviour, mood, function

- **Signposting**: eg Social Services, GP, education & training
- **Access**: Level 1, 2, 3 and 4 interventions in planned, individualised programme of support.
- **Referral**: Fast track to Primary and Secondary care, specialist services, IAPT, Counselling, Life Coach
- **Occupational Health Services**: Planned return to work. Reasonable adjustments

**Levels 3 & 4**

**Level 2**

- 5 a Day
- The Eatwell Plate
- Change for Life
- Alcohol unit calculator
- NHS Health Checks
- Stop smoking

Self Assessment on-line. Well-being Promotion – eg roadshows, health and wellbeing events, e.g. Regional Touch Rugby

Local options and discounts (eg Gym Membership, swimming vouchers)

- Expert Patient Programme
- Carers Support programme

**Level 1**

- Get Walking
- Hobbies
- Relationships
- Domestic violence
- Advice
- Mental Health First Aid
- Stress
**Task and Finish Group 1 Evaluation**

The strategic framework was devised collaboratively, using the research evidence base, contributed examples of good practice and following widespread consultation with Organisational Development leads, Heads of Human Resources and health and wellbeing leads among the participating organisations. The draft framework was circulated for comment to all project partners, Public Health contacts and regional and national health and wellbeing champions before the framework was finalised.

The ‘Your Health Matters’ pilot was designed with an integral evaluation plan. This is included in Appendix 7. Evaluation was planned for participants at three points in their programme: Stage 1: at assessment, Stage 2: on completion of their individualised programme and Stage 3: follow up at 3-6 weeks after the end of their personalised programme, to appraise continuing behavioural change. Data comprised a range of measures collected for the National Health Trainer evaluation database, supplemented by three additional quantitative measures:

i) the WHO-5 (English) Wellbeing Index, 1998 Version;

ii) the new General Self-efficacy Scale (Chen Gully and Eden 2001);

iii) a visual analogue scale of self-perceived current state of general health.

All participants in the programme were asked to complete these measures. In addition, a small (n=8) sample of participants were invited to participate in a more in depth interview:

iv) a purpose designed semi-structured interview. This explored the factors relating to motivation and perceived self-efficacy that promoted participation and the changes arising as a result of participation in the programme. As we predicted that effort invested may be related to participant belief in the programme, the assessment point interview also assessed the extent which each participant believed the intervention would be successful.

The six month pilot commenced relatively late in the project life and was not due for completion until the end of April 2012, so it was possible to complete only Stage 1 of the planned three stage data collection by the end of the project funding. Knowing they would be disbanding at the end of February 2012, the project management team therefore designed the plan so it could be continued by NHS colleagues if wished.

In an attempt to compensate for the limited evaluation possible from the Worcester ‘Your Health Matter’s pilot, the Steering Group also agreed to a proposal to supplement the dataset through a comparable service evaluation of the individualised component within the NHS Walsall Healthy Workforce Programme. The NHS Walsall Healthy Workforce Programme came to the attention of the project manager in November 2011. Already in operation for the previous five years, this is a comprehensive Public Health led programme focused towards local organisations, particularly small and medium enterprises (SME’s). It

---

comprises three components: a Bronze, Silver and Gold Membership scheme for organisations who commit to a criterion based programme to improve workforce health and wellbeing; awareness raising and links to NHS Health Checks, commissioned through a Local Enhanced Service Agreement with GP’s and available to anyone registered with GP in Walsall who is over the age of 45 years; an individualised programme of up to sixteen weeks, provided by the local Health Trainer Service. A three stage evaluation was planned, comparable to the ‘Your Health Matter’s evaluation design, but also incorporating a retrospective survey sent to every NHS employee who had accessed the individualised programme within the previous twelve months. This was expected to yield information about whether such staff support schemes lead to sustainable improvements in health behaviours or self-rated health and wellbeing. As highest return on investment is also an important factor when designing staff health and wellbeing programmes , it was also hoped tentatively to begin to explore differences between a six week intervention (Worcester) and a fifteen week programme (Walsall). Similarly to the Worcester pilot, by the end of May 2012, it was possible only to complete Stage 1 of the data collection at Walsall.

As data collection continued well beyond the formal end of the project, the detailed analysis of the Stage 1 data from both sites is still continuing as this report is drafted. However, early indications suggest both programme exert a positive impact on client motivation and confidence and the assessment process is perceived a helpful, informative and educational.

The ‘Your Health Matters’ pilot was deemed a considerable success, receiving excellent feedback from managers and staff. There was also some indication of a positive impact on sickness absence. Monthly sickness absence rates fell at the pilot site during the project, amounting to more than two percentage points difference between the start of the pilot in November 2011 and the end in April 2012. Further work would be needed to understand whether and by how much this reduction was due to the ‘Your Health Matters’ pilot and if so, how long the impact continued for once the pilot had ended. It must be acknowledged the winter pressures in 2011/2012 were not severe and rates of seasonal ‘flu were relatively low.
6.2 Task and Finish Group 2; A One Stop Shop: Hub of information, tools and resources

T&FG2 led the procurement, design, development and testing activity for a new web based resource containing information, toolkits, resources and existing good practice. This would be relevant for both organisations and for individual employees and would draw a range of useful information into a single source. Exploration during the planning phase of the project led to the realisation that a wealth of good practice already exists, though much had not been evaluated. Nevertheless, this information provided useful learning and information, so making it more efficient to search for this information would assist planning for both individuals and organisations. Locating a substantial amount of useful and relevant information in a single web based e-resource was intended to increase efficiency and ease of comparison of different and frequently conflicting information.

A full procurement exercise was undertaken and IE Design were awarded the contract to develop the web architecture, populate the site with material provided by the project partners and pilot the website. It was agreed that the website would be hosted on NHS Local; Maverick, the commercial company developing NHS Local were in the process of working with the SHA to develop the workforce element of NHS Local. IE Design with T&FG2 worked closely with the e-learning lead at the SHA, who also joined the Steering Group. It is expected that hosting by NHS Local will facilitate currency and relevance of the website for the sustainable future.

The website went live in February 2012, though it is still being populated; the domain is accessible at www.healthandwellbeing.nhslocal.nhs.uk. Figures 6.4 –6.6 convey an impression of the interactive website and some of the content.
Five top level categories are accessed via search Tabs which allow individual users to search for topics related to physical health emotional wellbeing. Two tabs are provided for organisations and, managers and wellbeing leads to search for relevant policies, guidelines, standards and policy documents and for exemplars of training materials, syllabi and toolkits. A further tab allows users to link to the health and wellbeing information on the intranet of their own employer. The last tab ‘About’ tells users the function of the website and invites contributions and feedback. Figure 6.5 shows examples of the type of information which is
accessible through the ‘Physical Health’ tab. Users can search though a high level menu on the left hand side of the page, and download information or resources from the material displayed in the centre of the page. Many cross links were built within the web architecture so the right hand segment of the page suggests other information that might be of interest or useful. Contributions of additional content are invited throughout the website. This was particularly important as despite considerable effort and time invested and populating the site with many hundreds of individual documents, the team were aware that much remained unidentified; this website is intended to be a work in progress and success will depend on continuing relevance.

Figure 6.6 exemplifies content at the next level down; as if the user had clicked from Physical Health to the information about Healthy Ageing.
Figure 6.5: Physical health search screen

Screen 2
T&FG2 evaluation

A tracking log was built into the web architecture to enable usage to be monitored over time. The website will therefore have capacity to be evaluated in the long term by the web host NHS Local. A tab on all pages invites user feedback and fault reporting.
6.3 Task and Finish Group 3: Staff health and wellbeing; perceptions and needs

This group planned to lead on staff engagement and consultation. As discussed in Section 5, the original intended workplan proved unfeasible, primarily due to the amount of consultation and the climate of anxiety arising from the reorganisation of health and social care following the White Paper (DoH 2010). Membership of this group comprised UoW staff but no NHS or social care partners, so for efficiency, this workgroup was subsumed into the PM workplan. Budget conserved from the amended workplan for Task and Finish Group 3 was reallocated to fund the continuing dissemination work, described in Section 6.7.

Tasks that would otherwise have been conducted by Task and Finish Group 3 included:

1. Outreach, networking, relationship building and awareness raising with local and regional workforce health and wellbeing activists, leads and decision makers. Organisations representing staff side were a particular focus and substantial efforts were made to link and liaise with NHS Employers, RCN and Unison.

2. Helping the other Task and Finish Group leads to consult and obtain feedback on their emerging work, so that this was continually shaped by employees and workforce wellbeing experts.

3. Design and implementation of the Worcester ‘Your Health Matters’ and NHS Walsall evaluations of the health workforce programmes. These are described within Task and Finish group 1 outputs.

4. In addition Task and Finish Group 3 also conducted the survey, outlined in Section 5 to investigate factors outside work that impact on health and wellbeing at work.

6.3.1. Summary of findings: Survey of factors outside work

As discussed in Section 5, there appeared to be very little research investigating how issues at home or in the personal life of an individual affected their performance and effectiveness at work. A Survey Monkey semi-structured questionnaire was sent to all NHS employees based at the community hospital where the Task and Finish Group 1 pilot ‘Your Health Matters’ was taking place; the survey was also sent to a comparison group of all staff employed in the School of Health and Wellbeing (SHaW) at the University of Wolverhampton. The survey template is included in Appendix 6.

Response rates were low; 36 staff members completed the survey in SHaW and 34 from the NHS, giving a response rate of approximately 17%. However, the survey used a qualitative design, which is appropriate to explore phenomena that are not well understood (ref needed) so there was no intention to generalise. The aim of the survey was to understand this under-researched area a little better.

The two sample groups were not matched but were comparable in size and demographic mix so can be considered as a combined sample of 70 respondents.

62% of respondents in the NHS sample were in clinical roles, 24% were in non-clinical roles and 6% were managing dual or multiple roles. 24% were working part time. In SHaW, 73% of respondents were in academic or research roles, 20% were administrative or support staff, 14% were managing multiple or dual roles and 3% were working part time.
The most interesting finding, similar in both groups, is that where there is a conflict between home and work responsibilities, the adjustment occurs in the home domain so that work obligations continue to be fulfilled:

5 work impacts on home life more than the opposite

home life suffers whilst remaining productive and professional at work

Despite home demands you owe it to your colleagues and [customers] to make them high priority. There are few reasons home life should interfere with work.... work is a commitment I made therefore I owe it respect and try not to cause problems with covering the work

Respondents at both sites indicated that they rarely felt too tired or preoccupied to be effective at work because of home factors. Very few said working time or behaviour was affected by personal responsibilities:

On the occasions when work and home life interfere do with one another, this appeared to impact more on ability to concentrate and quality rather than productivity in around half of NHS staff, while quality and the amount of work that gets done is more affected in the same proportion of SHaW staff. However, the impact on these factors is reported as minimal to moderate. Similarly, around half of respondents in both groups reported a minimal to moderate impact on creativity and willingness to take on additional work, undertake quality enhancing activity or ‘go the extra mile’.

Impact of home life on interpersonal relationships at work was also predominantly reported to be minimal or moderate. Taking advantage of professional development training or opportunities was the aspect of work most likely to be affected negatively by home issues. Around 8% of NHS respondents and 15% of SHaW respondents said this was severely or very severely affected.

These findings suggest that while everyday work continues to be completed to a satisfactory standard, the extra qualitative aspects that raise performance from good to excellent, or moderate to good may be less evident. However, work can also act as a useful distraction:

If I have a personal matter going on, I find work can help. Keeps my mind busy...

problems in my home life that I cannot resolve do affect my work. Being with my colleagues normally lifts my mood

Around half in both groups said it was moderately easy to balance work and personal lives in their workplace though 4% of NHS respondents said it was not at all easy, compared to 30% of SHaW respondents. This may perhaps reflect the greater predominance of flexible working patterns in Higher Education which may more easily support a less structured start and end to the working day.

Some respondents mentioned the additional stresses imposed by commuting or tight deadlines:

deadlines mean working extra hours

5 where necessary to preserve anonymity detail has been omitted from quotes
with travel time I’m out of the house 12 hours a day, so have little time for myself

Travel time is long so cannot easily get home and come back quickly if I need to sort out any crises

When struggling to cope with a problem outside work, 59% of SHAW respondents would feel very confident or reasonably confident to tell their Manager. 49% of NHS respondents would feel very or reasonably confident. Although there were a few negative comments, these seemed linked to beliefs that a manager might not understand pressures arising from the respondent’s individual home context. Respondents were predominantly positive and valuing of support from their Manager:

My manager is approachable and supportive and seems concerned for my wellbeing

... previous experience suggests [manager] would understand

Where respondents perceived their manager to lack empathy or sensitivity, this seemed linked to a particular experience which had a disproportionate impact:

my [family member] was in an accident and I asked for the next day off. The first question to me was whether I would make up the hours or take it as leave. Not how is your [family member] or how are you. I was extremely upset and incapable of work anyway

Some respondents do not seek support because they do not find it easy to disclose, suggesting that managers may need to be very perceptive and intuitive at times:

I find it difficult to talk about things outside work, especially if I’m struggling

I don’t like to seem not to cope so I struggle on

A number of respondents mentioned that managing to maintain a healthy work; life balance was increasingly difficult as public sector funding cuts exerted their influence:

Due to many changes..... the work increases but there are less people to do it

The survey also enquired about sources of support when struggling to juggle personal and work life. Family and friends were the most likely sources. Around half would consider confiding in a work colleague. The least likely sources of support in both groups were Trade union, GP and Occupational Health or other staff support service. Very few would seek support from an independent, voluntary or charitable sector organisation, eg Citizens Advice or debt advice while only around 10% would consider searching the internet for self-help. These findings suggest there may be benefit in raising awareness and signposting to sources of support and self-help, or promoting the health improvement role of Occupational Health Services.

The final question in the survey invited respondents to share their best tip for managing the dual demands of work and personal life. This question elicited the highest number of qualitative responses: 37 in total. Tips fell into five main themes:
a) Time management

Be as organised as possible and keep calm

Time management and prioritise

Compartmentalise and concentrate on the task in hand

Don’t check mobile phone until lunch break

Have an organised calendar and pre-plan

Try not to work in non- work time

b) Look after self

Try not to feel guilty; it’s impossible to keep everyone happy

Try to keep hold of a sense of humour

Take time out to relax, meet friends, and talk to others in similarly stressful situations

Get a good night’s sleep

c) Be realistic

Be flexible let standards at home drop

Expect to struggle; you can’t have everything no matter what people say

Decide where I want to excel and be satisfied with good enough in other things

Keep it in perspective. Worrying can make it worse

d) Seek support

Have at least one truly discreet confidante outside work and let your frustrations out there, knowing they won’t be repeated

Be open and honest if struggling

Get a supportive partner

Get a cleaner / ironing service

Join a Trade Union and agitate for better terms and conditions of service.

e) Be assertive

Get a job that allows you to contain it within reasonable hours

Negotiate at work and at home

Periodically evaluate own expectations; be honest and firm with self

Say no and mean no
In summary, the survey of factors outside work was not generalisable to a whole workforce but provided some interesting and useful qualitative information which confirmed the value of the training tool for managers being developed by T&FG5. There were no major differences between NHS and SHaW staff and the findings suggest that where there is conflict between work and home life, the adjustment occurs at home minimising the impact on productivity and efficiency at work. Where there is impact at work, the added value aspects of a role, eg mentoring others, appear to be affected and in particular respondents were less likely to access continuing professional development activities. Respondents reported a number of strategies being used help maintain their work: life balance, effectiveness and wellbeing.
6.4 Task and Finish Group 4: Measuring health and wellbeing

After consultation about local needs and with Occupational Health leads, this working group decided to devise a set of metrics that would assist Boards and Quality teams to monitor changes in staff health and wellbeing over time. A number of organisations were already beginning to devise such scorecards, in particular WMAS and NHS Walsall with its main providers, Dudley Walsall Mental Health NHS Trust and Walsall Healthcare NHS Trust. Their knowledge was generously shared to help the exemplar eventually devised accurately to reflect good practice. Such a scorecard is a necessary baseline to help organisations achieve control of sickness absence, facilitate benchmarking within and between organisations and also to prepare for impact evaluation of any health and wellbeing interventions for the long term future. This planned work was expected to supplement a project already under way with Aston University Business School for the SHA QIPP workforce group. The SHA Metrics work was primarily focused on the costs of sickness absence, so the focus of T&FG4 on key measures to monitor absence and costs but also wider indicators of health and wellbeing was complementary. It was also intended to complement the SHA Workforce Modelling Tool. A lengthy delay before publication of the Aston Report generated concern in case there was more overlap than anticipated, but these fears proved unfounded. To supplement the Board level scorecard, T&FG4 also proposed an individual employee scorecard which has potential not only to help individual employees to monitor their own health and wellbeing over time, but also to enrich Board level understanding of workforce status. Finally, T&FG4 also commissioned specific health economist modelling work to help organisations predict savings from reductions in absence and likely returns on investment from health and wellbeing enhancement initiatives. Trust partners had indicated this was needed to help build their business cases for such investment.

6.4.1 Board Level Scorecard to monitor staff health and wellbeing over time

After considerable discussion and review of the available literature, the exemplar monthly scorecard contains suggested indicators of staff health and wellbeing and sickness absence to enable a Board, Quality or Performance Committee to gain a rounded picture and to monitor changes over time. Thirteen key measures were identified:

- Staff in Post (Whole time equivalents, WTE)
- Staff Turnover
- Sickness Absence, sub-categorised into short, medium and long term
- Work Related Injury absence
- Work Related Stress absence
- Retirement due to ill health
- Occupational Health Contacts
- [Individual Well-being Surveys completed]
- Appraisals Completed
• Mandatory Training completion rates
• Vacancies
• Cost of Sickness absence
• Cost of Agency Staff

Screenshots of a dummy scorecard and associated control charts are shown in Figures 6.7 and 6.8

The scorecard was designed to be compatible with the electronic staff record system (ESR) used by NHS organisations and is easily adaptable for other Public Sector IT systems. When linked to ESR it will generate control charts to monitor trends and support exception reporting. To minimise duplication and additional work, it uses data already collected for reporting requirements, or which exists and could be linked to ESR.

The scorecard was piloted across the staff health and wellbeing project partnership, receiving positive feedback about relevance, ease of use and potential contribution to Board intelligence.

This scorecard could be used or adapted by individual organisations, or useful at cluster/regional level for benchmarking. If supplemented by individual level data from the self-completed scorecard provided later in this section, a more rounded picture of organisational health and wellbeing could be generated.
Figure 6.7. Board Level monthly scorecard format

The layout

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Indicator</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff in post (WTE)</td>
<td></td>
<td>120</td>
<td>120</td>
<td>80</td>
<td>115</td>
<td>114</td>
<td>114</td>
<td>114</td>
<td>114</td>
<td>113</td>
<td>110</td>
<td>90</td>
<td>80</td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td>107.8</td>
<td>107.8</td>
<td>107.8</td>
<td>107.8</td>
<td>107.8</td>
<td>107.8</td>
<td>107.8</td>
<td>107.8</td>
<td>107.8</td>
<td>107.8</td>
<td>107.8</td>
<td>107.8</td>
</tr>
<tr>
<td>Staff turnover</td>
<td></td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td>46.3</td>
<td>46.3</td>
<td>46.3</td>
<td>46.3</td>
<td>46.3</td>
<td>46.3</td>
<td>46.3</td>
<td>46.3</td>
<td>46.3</td>
<td>46.3</td>
<td>46.3</td>
<td>46.3</td>
</tr>
<tr>
<td>STD</td>
<td></td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
</tr>
</tbody>
</table>

Sickness absence

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Indicator</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short term</td>
<td></td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>STD</td>
<td></td>
<td>0.16205</td>
<td>0.16205</td>
<td>0.16205</td>
<td>0.16205</td>
<td>0.16205</td>
<td>0.16205</td>
<td>0.16205</td>
<td>0.16205</td>
<td>0.16205</td>
<td>0.16205</td>
<td>0.16205</td>
<td>0.16205</td>
</tr>
</tbody>
</table>

Figure 6.8. Board level scorecard; control charts
6.4.2. Individual employee self-completed health and wellbeing scorecard

Partner organisations indicated that they would find it valuable to understand how employees are feeling. Measures of resilience and motivation can be complex and there are ethical concerns about asking sensitive or personal questions. However, there are relatively simple ways and effective ways of enquiring as shown by the exemplar shown in Figure 6.9 and reproduced in full in Appendix 8.

Using an electronic survey, staff can be asked consciously to reflect upon their health, well-being and associated regulatory behaviours to identify and evaluate their practice. The exemplar in Figure 6.9 is a short self-completed questionnaire that can be used to help individuals reflect on their health and wellbeing during the previous month (or daily, as preferred). It could be available through the staff intranet and set up at relatively low cost so that the completed questionnaire generates a personalised report and a confidential personal record over time. A simple bar chart feedback is shown in Figure 6.10 but responses can also be organised into a more personalised report. Depending on the responses, the personalised report could be designed to generate simple suggestions for improving health and wellbeing and signpost the user to other support services or resources. Research indicates that interventions based on the modification of existing behaviours tend to be effective (eg Cropley et al 2007).

Health and well-being are part of natural self-regulation; people want to feel happy and healthy more often than miserable or ill. Moreover they are prepared to feel tired or anxious if the task is worth doing. Most people also have the ability to manage their emotions (both positive and negative) if reassured that their feelings are appropriate for their current situation. Organisations would benefit from having a workforce who are more aware about self-regulating their health and well-being. In practical terms, people do this anyway by signing themselves off sick when their coping resources are overwhelmed.

Self-assessment offers a way to gain insight into personal health and well-being and to reflect on personal strategies used to manage or change well-being and self-esteem, to informing future behaviour. Increasing self-awareness may motivate staff towards change, helping signpost them towards appropriately signposted staff development courses or staff health and wellbeing programmes such as the ‘Your Health Matters’ pilot undertaken by Task and Finish Group 1 (see Sections 5 and 6.1).

6.4.3. Enriching the Board Level scorecard with individual level data

The suggested self-completed individual level data could also be anonymised and collated in ESR at team, department and whole organisational level to supplement the Board level Scorecard also available in this section. In this way, individual scorecards have potential to provide an indication of the collective health and well-being of staff at Board level.

The exemplar provided was devised using research evidence and adapted from a large Research Council funded project being undertaken by colleagues from the UoW School of Sports, Performing Arts and Leisure (SSPAL). It was piloted across the Staff health and wellbeing project partnership. Highly positive feedback was received about relevance, ease of use and potential contribution to Board intelligence. This scorecard could be used or adapted by individual organisations, or useful at cluster/ regional level for benchmarking.
Data can be interrogated by different variables of interest, for example ethnicity, job role, gender or age.

6.4.4 Encouraging staff engagement in monitoring health and wellbeing

To integrate such an individual level questionnaire within the culture of an organisation, it must be acknowledged that a co-ordinated campaign by Organisational Development, Human Resources and Communications teams would be necessary to motivate and engage staff, and to reassure them about anonymity and confidentiality.

However, health and well-being of people are collaborative goals for both employer and employee so monitoring and self-assessment should be a win-win situation, increasing self-awareness for the individual that all is not well, and signalling to the organisation that individuals and/or groups of individuals are not coping. Such awareness increases the likelihood of signposting or referral to appropriate support.

To encourage staff engagement, it is recommended that any approach to self-assessment should incorporate the following good practice points:

- Is quick to complete
- Online
- Provides immediate, personalised feedback
- Highlights emotional well-being
- Data is collected centrally to develop norms for the individual and the organisation
Figure 6.9. Self-completed Individual level scorecard

A full individual questionnaire is contained in Appendix 8
6.4.5 Health economics modelling

The third component of the workplan for T&FG4 was to commission two pieces of work from health economists, with the specific intention of complementing and extending QIPP related workforce Metrics projects under way at the SHA.

Dr Tessa and John Crilly, from Crystalblue Consulting were asked to produce a benchmarking report that would:

- Compare sickness absence rate per staff group to the national average
- Compare sickness absence rates by organisation type against the national average
- Help organisations understand estimated cash cost of their current rate and evaluate the impact of change
- Model the cost impact of 1% reductions in sickness absence costs
- They were also asked to design a very simple speedy and user friendly interactive modelling tool that would enable Performance and Finance teams to model the actual costs and savings from percentage point changes in staff sickness absence, incorporating variable factors such as organisation type and staff group.

The interactive modeller has been designed as a very simple Excel file, with drop down menus. Figures for a particular organisation can be inserted resulting in a numeric figure that equates to the actual cash saving from reductions in sickness absence. The
modeller can be downloaded from the Training and Toolkits section of the e-resource www.healthandwellbeing.nhslocal.nhs.uk

The outputs from T&FG4 were piloted and reviewed across the health economy. A semi-structured Survey Monkey questionnaire invited anonymous feedback, which was positive.

Valid criticism of the Benchmarking report referred to the baseline figures dating from 2010. Although the health economists had previously undertaken related work for the DoH, as outsiders to the NHS they and the Project Management Team (UoW staff) were refused access to more current data, despite receiving assurances from SHA colleagues that the project was being undertaken with and on behalf of the NHS.

75% of organisations who responded said they would be highly likely to adopt or amend the Board level scorecard. 66% of respondents expressed considerable interest in developing an individual level self-completed return and could conceive how this could be integrated into ESR if staff engagement challenges could be overcome. The interactive modeller received highly positive feedback about ease of use, relevance and potential contribution to effective business cases arguing for investment in staff health and wellbeing.
6.5 Task and Finish Group 5: Interactive E-learning tool for Managers

This group was interested in developing a training and confidence building curriculum to help managers have more sensitive and proactive conversations with their staff about personal health and wellbeing. The literature review had identified the key role played by good leadership and effective management; also that managers report feeling unconfident about the boundaries between active management and unintentional harassment, or interest and intrusiveness. Members of T&FG5 also wanted to generate a training tool that would be fun, interactive, enabling and would not require release from the workplace to participate. For these reasons, the group decided to initiate the development of an interactive e-learning tool with purpose designed scenarios to prompt decision making and reflection about the type of performance, inter-personal, equality and diversity and similar Human Resource dilemmas managers face on a day to day basis.

This aim was fully aligned to the overarching project objectives of devising ways to enable managers and individuals to generate a shift towards a positive health and well-being culture and to facilitate more integrated working between Occupational Health services, managers and staff. It also addressed the recommendation by Boorman (2009b) to develop training for managers which to build understanding of the link between staff health and well-being and organisational performance. In developing an integrated health and wellbeing approach, it seems to be vital that managers understand the pivotal nature of their actions and behaviour in terms of contributing to or undermining health and wellbeing in their teams.

After consultation and literature review, the key topics to be covered were identified:

- Role of the Manager
- Mental Health
- Musculo-skeletal health
- Infection Control and impact on sickness level
- Role of Occupational Health
- Equality and Diversity (all nine social variables defined in the Equalities Act (2010) have potential to impact on health and wellbeing but a particular emphasis on disability discrimination was felt appropriate
- Disability and anti- discriminatory practice
- Lifestyle and health behaviours
- Proactive and sensitive management of performance and sickness absence

In the design on the training tool, a number of principles were adopted. In terms of learning, the training tool would be high support/ high challenge. Therefore it would need to be:

- Interactive and enjoyable
- Inspiring and engaging
- Practical, helpful and supportive
- Thought provoking
- Reflexive, with a focus on continuous self- assessment rather than a ‘test’ at the end
- Flexible to some degree, to enhance relevance to the individual learner

A full procurement exercise was undertaken, through Walsall Healthcare NHS Trust, who held the allocated budget for the T&FG5 lead, an employee of the Trust. Walkgrove plc were awarded the contract.

The Concept outlined in the Project Initiation Document (PID) described the project plan:

- The learner joins an interactive e-learning ‘game’ to manage a ‘virtual team’.
- For relevance to all staff, the virtual team is selected from pairs of ‘people’ offer a similar personality and dilemma in either a clinical or a non-clinical context.
- The learner is presented with scenarios in which a range of health and well-being dilemmas are experienced and one action or decision must be selected from a list of options.
- Throughout the game feedback to the learner informs them of the possible consequences of decisions for themselves, the team, clients and for organisational performance.
- Learning Resources (e.g. relevant policies) are available on each page through a tab click link.
- Each decision made generates immediate feedback through a Red, Amber Green traffic light system to indicate whether health and wellbeing in the individual, the team and the organisation has improved or deteriorated.

Figures 6.11 – 6.18 below are screen shot extracts from the prototype version of the game. This is still in development at the time of writing this report. T&FG5 is funded from the overall health and wellbeing project to continue development work and to pilot the game. It is expected to be ready for widespread testing across the health economy by August 2012.
Figure 6.11. Following the Home Screen, the learner is presented with the Rules of Game.
Figure 6.12  The learner is prompted to select their virtual team

A mix of clinical and non-clinical staff is possible

Now choose your four team members to reflect your customary job role.

You can mix and match your team members, but only choose one from each personnel pair by clicking on the cards you want.
Figure 6.13. First task: the new manager (the learner) is preparing for their first team meeting after taking up their managerial role.

Your first move is to get everyone together in a meeting. Prepare for the meeting by looking at some basic personal details for each of the team members.

There is a personal note from your successor in each file.

These notes are off the record!

Select each label in turn for more.
Figure 6.14. Example 1 of the confidential note left by predecessor in each Personal record file.

( NB these notes are not necessarily advocating recommended HR good practice but are learning prompts for the purposes of the game )
Figure 6.15. Example 2 of the confidential note left by predecessor in each Personal record file.

Memo
Leah is Mrs. Reliable. Hard-working and conscientious. Works long hours and seems to live for her work, but noticeably more insular and 'snappy' over the last few months – with both colleagues and service users. Problems at home? She doesn't give much away.
Figure 6.16. Introducing Dilemma 1

You'll remember at the end of the last chapter, you found Leah after the team meeting with her head buried in her work. You asked her about a team get-together after work.

Good idea – mutual support and encouragement are important aspects of health and wellbeing.

So how would you respond to Leah's reply?

Select the response button.
Figure 6.17. Response options available to the learner
Evaluation of the training tool at the end of the development phase will be via user feedback during the pilot phase. Dependent on the success of the feedback method used, a method for longitudinal evaluation will be agreed by T&FG5 and Walkgrove plc.

After completion in August 2012, the manager’s game is expected to be freely available via NHS Local and or the National Learning Management System (NLMS)
6.6. Task & Finish Groups: Contributions to overarching project objectives

As a condition of approval of their workplan, each T&FG was expected to demonstrate how their mini-project would help organisations implement the recommendations of the Boorman Report (2009b) and/or the NICE guidelines on workplace health and wellbeing (NICE 2007, 2008, 2009 a,b,c) as this was the overall objective of the project (identified in Section 2). An overview of these links is shown in Figure 6.19

Figure 6.19: Task and Finish Groups contribution to overarching project objectives

Workstreams in Staff HWB project

- **Level 4**: Long term sickness and high risk
  - OH assessment and ongoing review
  - Individual, Manager and OH agree management plan
  - Planned return to work
  - Reasonable adjustments to workload or contract

- **Level 3**: Continuing problem, new risk identified or sickness absence trigger
  - Motivational support for behaviour change
  - Fast Track referral to expert services (e.g. Physio, OT, Counselling, GP, diagnostics, specialist service)
  - Referral to OH wellbeing service

- **Level 2**: Behaviour change wanted
  - Triage/health trainer assessment inc external factors
  - Signposting and referral inc training and development
  - Support through brief intervention programme (6/12 weeks)

- **Level 1**: Everyone
  - Health and Wellbeing culture
  - Health and Wellbeing at induction & regular discussion with Manager
  - NHS Health Checks & Ergonomic assessment
  - Health promotion information, signposting and resources

**T&FG4** Board level monitoring

**T&FG5** Managery skills

**T&FG1** Staff support pilot

**T&FG2** Resources for individuals & organisations

**T&FG3** Staff needs
6.7 Dissemination

The dissemination plan was outlined in Section 5. More detail is provided in this section.

The Project Manager submitted successful abstracts, achieving oral and poster presentations from January 2011 onwards. The project has been reported and presented at a number of conferences locally and nationally including:

- Skills for Health Conference, Glasgow January 2011
- DoH Public Health Newsletter, Spring 2011
- Modernising the NHS Conference London March 2102
- Herefordshire and Worcestershire Locality Board Annual Conference, 2010 and 2011
- An invitation has been received to present at the RCN Activists Conference in Birmingham
- The project was also referenced in the Royal Wolverhampton Hospitals Trust Nursing Programme 2012-2014

A range of other invited speaker invitations were accepted for meetings and conferences throughout the UK, responding to themes as diverse as Public Health, Workforce Development, Partnership, Research Methods, Modernisation and Management of individual and organisational behaviour change. Wherever possible, meetings and presentations were offered to Boards, Senior Executives, Non-Executive Directors, Union Officers and Workforce leads. Substantial efforts were made to engage with relevant SHA leads. The two Locality Board Managers utilised their own contacts and networks to promote and raise awareness of the project to invite collaboration and involvement.

A successful project dissemination conference was held on 1st February 2012 where each T&FG shared their learning and outputs. Dr Steve Boorman was the invited keynote speaker and acted as a valuable supporter for aims and outcomes of the project. To facilitate accessibility and visibility, all outputs from the Task and Finish Groups have been (or are in the process of being) uploaded to the e-resource website, which will be hosted for the sustainable future by NHS Local. All project partners are also able to link their local workforce health and wellbeing intranet home page directly to this web resource at www.healthandwellbeing.nhslocal.nhs.uk.

A formal dissemination activity plan was agreed by the Steering Group at their final meeting in March 2012. This activity is still under development at the time of writing this report but is being co-ordinated by the Black Country Locality Board Development Manager. Two NHS colleagues who have participated in the project have been appointed as Dissemination Consultants to undertake a planned programme of meetings and promotional activities to raise awareness, to share the project outcomes and to consider how these could be integrated with NHS, Local authority and Higher Education organisations across the Black
Country and Herefordshire & Worcestershire Localities. Activity will continue until Autumn 2012. A Publicity Working Group has been convened from the original Steering Group membership. Working with a copywriter and graphic designer and close liaison with T&FG leads, this group is supporting the Consultants to design a comprehensive information pack for decision makers and a range of publicity materials. The Consultants and the materials developed will highlight the key outcomes and resources from the project and signpost individuals to the e-resource at www.healthandwellbeing.nhslocal.nhs.uk.

6.8 Evaluation of partnership working

This project provided an opportunity to explore the challenges and benefits of bringing together a diverse membership to share a common aim. Although collaboration is relatively common in health and social care, it is perhaps a less frequent occurrence to convene a partnership group to develop a project as well as to deliver it. From the very first idea, the School of Health and wellbeing purposefully adopted a collaborative approach, acting as a support and communication hub to ensure that the focus, objectives and outputs for this project were determined by the needs of the participants, so providing an opportunity to explore how the partnership evolved as work progressed.

As described in Section 5, two methods were adopted: a monthly self-evaluation form invited anonymous feedback from Steering Group members throughout the project, and an online end of project survey was conducted, using Survey Monkey. Responses to both forms of evaluation were low so the findings must be treated with caution as they are not representative. However, although from a small sample group, formal evaluation data did correlate very closely with informal and anecdotal feedback throughout the project and the information in the end of project survey also correlated closely with the continuous self-evaluation data.

Steering Group continuous self-evaluation

Between 3-5 self-evaluation forms were returned each month. Responses were returned to the project administrator who ensured they were anonymised before forwarding to the Project Manager, who collated these and reported any key issues or trends over time to the next Steering Group meeting for discussion and resolution. The obvious advantage of the self-evaluation was the opportunity to highlight issues, concerns or criticisms anonymously and for concerns to be presented to the Steering Group in a non-personal form. Although it might be assumed that respondents would most frequently be those wanting to offer negative feedback, this was not generally the case as respondents were most frequently reporting satisfaction with the structures, progress and organisation of the project. Concern or dis-satisfaction about inequitable sharing of the workload and disproportionate contributions between partners were the most common negative theme. Critical feedback was returned at the point the project was ready to transition from planning to implementation, when concerns were raised about a need for greater decision making power within the Task and Finish Groups, for efficiency and ownership. The feedback enabled a problem solving discussion and a decision to devolve both budgets and authority from the Steering Group to the Task and Finish Groups. This had the dual advantage of generating ownership within the T&F Groups and freeing up a substantial amount of project management time to support and facilitate the T&F Groups rather than, as previously, being responsible for every aspect of the project.
End of Project Evaluation

Only five responses were received to the end of project survey, so it is impossible to identify themes.

From all five respondents, there was confirmation that the project systems and infrastructures had been supportive and efficient and that momentum had been maintained.

All five respondents felt strongly that the project had been worthwhile, generating valuable outputs and had remained solution focused through some challenging times:

- Partnerships within a single sector are challenging; this project has crossed sectors very effectively.
- This project has been a learning curve, at times stressful but I always felt supported by key members of the Steering Group.
- I have learned that perceptions of partnership vary widely, they take time to evolve and cannot be hot-housed.
- It takes time to build a partnership and this cannot be rushed.
- Allow plenty of time. Ensure everyone has a clear understanding of expectations from the outset.
- Having a wider regional perspective prevented duplication.

Responses to a question about the most positive aspects of the project suggested respondents had valued and gained learning both from the project topic and from working in a group:

- Working together across organisations and localities on a key topic.
  ....producing valuable outcomes.
- Being in a position to raise the profile and potentially to make a difference to workforce health and wellbeing.
  the breadth of vision, pooling ideas, sharing expertise, knowing that you have support,
  the diversity of interests and projects.
- Working through a period of transition to produce sustainable outcomes and a legacy.

The most negative aspects of being in the partnership were linked to the external landscape, and tensions among the group relating to the balance of power, authority and decision making:

- working through a period of transition, made it difficult to retain commitment from Trusts as landscape, infrastructures and priorities changed.
- the internal and external politics.
feeling marginalised

some partners were not very active, while others tended to dominate and therefore influence decision making

There were aspects of the external landscape and the partnership that made it both easier and harder to contribute effectively:

Positive enabling aspects were:

...shared commitment to the topic
...supportive environment
...appreciation of one’s knowledge/contribution
The allocated budget!

Meetings were open and constructive, members were encouraged to speak freely

Documentation was always sent out promptly and meetings took place as arranged. Good organisational structures helped things keep on track

Less helpful aspects were:

work overload
feeling marginalised

missing meetings due to conflicting priorities, made it harder to keep up and influence

keeping a clear picture of all the other T&FG workstreams if unable to attend a steering group meeting.

early in the project, information was not always shared openly between partners

They were less unanimous about the extent to which the behaviours of partnership had been evident. The Steering Group was perceived as functional and useful. Respect for others and trust were described as ‘evident’ and ‘good enough’ most of the time. All five respondents felt that conflict had been managed effectively by maintaining a focus on ‘getting on with the job’ but they were divided about how conflict was addressed. All agreed that it had been managed by ‘background negotiation’, but not always by consensus. This suggests some members conceded or were willing to compromise to maintain functionality of the group and forward momentum. Three respondents reported feeling unable to influence decision making while the remaining two felt they had been able strongly to influence. The small number of responses makes it impossible to speculate about these differences but do suggest further investigation of the mechanics of partnership working and partnership behaviours may be worthwhile, as identified by Yorkshire and Humberside Social partnership Forum (2011)

However, some tensions are inevitable in a large and diverse group of individuals sharing a project as complex and ambitious as this. The data suggested that the partnership had adequately sustained the project. Respondents felt they had both shared and achieved the
aims of the project, working and communicating effectively. All the respondents felt their knowledge of workforce health and wellbeing had increased, the partnership had enabled a wider exploration of the topic would otherwise have been possible and that they were better equipped to help their own organisations to develop a more integrated approach to staff health and wellbeing as a result of their membership of the group. Equally important, respondents reported that being a member of the project group was enjoyable, rewarding and interesting.

Gutteridge and Dobbins (2010) identified three key barriers to effective partnership working: unclear leadership, insufficient links and networks and organisational and cultural barriers. Feedback suggests a number of these potential barriers were managed or addressed; systems and infrastructures were in place, providing efficient and effective processes which were valued; there was felt to be a continuous forward trajectory with a clear solution focused direction. Most important, where barriers were encountered (for example, tensions were identified around equity of contribution and authority in relation to decision making), these were addressed before becoming a concern sufficient to undermine the project progress or to divert energy that might have prevented useful and relevant outputs being generated to achieve the project objectives.

The Project Manager enquired about the poor responses to both forms of evaluation. It was evident that operational pressures resulting from the systemic re-organisation in preparation for the Health and Social Care Bill (2012) made it difficult to focus on anything other than immediate priorities. Some participants felt there was little to be gained from exploring the process of partnership. There were also indications the elements of the project perceived by NHS partners to be ‘research’ were considered of less interest and secondary value than more tangible deliverables. Further work would be required to clarify this perception, which does not reflect either the NHS Research and Development Strategy (DoH 2006) or the Health and Social Care Act (2012). Both place considerable emphasis on the role of research in high quality services.

This section has summarised the main outcomes from the strategic partnership project to improve staff health and wellbeing. The final section of this report will summarise some of the learning points which may support continuing development of both a healthy and effective workforce and of partnership working.
Section 7. Project Learning

Feedback from all participants confirmed that this worthwhile project stimulated individual and collective learning. Sometimes this was pleasurable and enjoyable; at other times where deeply held views and sincere beliefs were challenged, this was more testing.

There has been a need to help partners recognise the tensions about and the value of collaboration over working individually. At times this has slowed progress, but working with others has also created a useful determination to deliver on planned objectives, as some aspects of the project could not be delivered without the outputs from another T&FG.

Project partners have evidenced the willingness for a range of organisations across public and private sectors to work together. We learned that in order to generate good quality and relevant outputs, it is important to take time to plan, to be flexible and to remain task and outcome focused while ensuring developmental discussion; this can be a new experience for cultures which have become increasingly target driven. Short funding timescales are insufficient to establish full impact and demonstrate sustainable long-term outcomes but effective networking and dissemination help achieve a legacy and are crucial to minimising duplication and repetition of effort.

Key strengths of this project were: the support of the two Locality Boards to enable the original one year timescale to be extended, allowing the project time to evolve and focus on quality rather than speed. Secondly, leadership from the Locality Boards which led to the development an explicit dissemination strategy using conserved project funds to enable several months of activity to disseminate and share the project outputs with decision makers and to discuss with all participating organisations how the outputs and resources could be integrated into their individual staff health and wellbeing strategies and implementation plans. Third, the determined focus on locally relevant solutions which helped practical outputs to be generated. Fourth, the co-ordination and communication hub and academic rigour provided by the University.

Communication with external organisations, such as the Strategic Health Authority and Department of Health, was not universally as effective as hoped. Where this liaison worked well, it was of enormous benefit in ensuring strategic alignment, collaboration, awareness raising and shared problem solving. Occasionally, territorialism seemed to exert influence and sometimes, the project members simply did not know whom to contact to achieve the most effective liaison. The project might have achieved more rapid integration if there had been a more visible representation earlier in the project life. It was also disappointing that the partnership group was unable to bid for Pathfinder funding to continue their work. Pathfinder bids for workforce development funding were required to be led by an NHS organisation. None of the project NHS partners had capacity to take this on, but non-NHS partners were not able to be nominated, despite the wishes of the group. To facilitate partnership working, the NHS may need to consider how other partners could take a leadership role in NHS service development and innovation, with the NHS being one of the active partners in a shared enterprise.

The investment required to create successful partnerships for innovation should not be underestimated. Although every member worked in a public sector organisation concerned with health and social care, the project contributors and participants comprised a diverse
group including commissioners and providers; senior, middle and junior managers; researchers and educationalists; clinicians and Human Resources leads; public health and occupational health; health, social care and education; IT experts; Quality and Performance Managers; accountants and administrators. Tensions were inevitably encountered and the project group itself formed a micro-social system which may accurately have reflected the challenges presented by partnership at the macro-system level.

Partnership is a challenging enterprise requiring sustained and continued dialogue which values all involved as equal contributors of expertise, together with flexibility and creativity. Popay and Williams (1998), Finch (2000), Macpherson et al (2001) and Gutteridge and Dobbins (2010) found that effective partnerships in health and social care require ownership and commitment by staff and strategic leadership to support the process and to enable the resources. Gutteridge and Dobbins (2010) argue that achieving meaningful involvement is not cost neutral but it can provide a value for money strategy.

Learning within the health and social care sector from initiatives to involve service users and carers may be transferable to workforce partnerships within and between organisations. There has been a greater and longer focus on partnerships with and for service users than with and for staff in relation to health and wellbeing. Additionally, the structural, organisational and cultural challenges may be similar. For example, working to involve mental health service users, Tew et al (2004) identified five levels of involvement and argued that for clarity of expectations and communication, it is vital to determine which level is appropriate for the project in hand:

- **Level 1: No involvement**: Intervention is planned without consultation
- **Level 2: Limited involvement**: Outreach and liaison with invitations to “tell your story” in a designated slot, and/or limited occasional input
- **Level 3: Growing Involvement**: Stakeholders are regular contributions to at least two of the following: planning, delivery, recruitment, management or evaluation; involvement is an allocated aspect of paid work
- **Level 4: Collaboration**: Stakeholders are involved as full team members in at least three of the following planning, delivery, recruitment, management; this is underpinned by a statement of values and aspirations; payment is offered or workload allocation made for involvement; stakeholders contribute to all key decisions; facility provided for cross fertilisation and sharing knowledge; regular provision of training, supervision and support offered; positive steps to enable all stakeholders to participate in interventions as individuals.
- **Level 5: Partnership**: All stakeholders work together systematically and strategically across all areas – and this is underpinned by an explicit statement of partnership values; all key decisions are made jointly; all stakeholders involved in the evaluation of impact; infrastructure funded and in place to provide involvement, induction, support and training; knowledge is shared and disseminated; long term contracts and networks established to ensure sustainability; positive steps made to encourage all stakeholders to participate and benefit from outcomes.
A local initiative by project partner Wolverhampton PCT reported as a case study on the Social Partnership Forum\(^6\) offered the following learning:

**Top tips from Wolverhampton PCT**

For successful partnership working:

- there has to be a genuine desire and commitment, initially from the top of both management and staff side: positive leadership is the key
- create a self-assessment to identify what needs to change; include staff interviews and focus groups to compare what staff feel with executive priorities
- identify those who are strong believers in partnership working and use them to help convince others
- develop joint agendas to work on and share the responsibility and work load
- develop a joint set of values, principles and aims and objectives
- develop a self-assessment tool, to measure progress and evaluate work done in the early stages.

and what to avoid:

- do not play at partnership working, otherwise credibility is rapidly lost
- do not put things in place that will be used only now and again; this has to be part of developing a new culture
- do not become disheartened when it goes wrong, it will at some stage; have a recovery plan and get things back on track.

Pratt et al (1999) explain that partnership needs change during the life of a project and that partnership behaviours also need to be flexible and adaptable. They proposed a typology of partnership behaviour intended to help Primary Care project groups and organisations appraise the type of collaboration and involvement desired and purposefully to facilitate the behaviours most likely to meet the needs of the partnership at different stages of evolution. This was later refined (Plamping et al 2000) and is shown in Figure 7.1

---

\(^6\) from the Social Partnership Forum website, an alliance between DoH, employers and Unions to promote effective partnership working: http://www.socialpartnershipforum.org/casestudies/Priority2/Pages/PartnershipworkingatWolverhamptonCityPrimaryCareTrust.aspx. accessed 08.04.12)
Figure 7.1. A typology of partnership behaviours

Working Whole Systems (from Pratt et al 1999)

The model is not intended as a hierarchy, but illustrates a range of options for partnership behaviours. The horizontal axis represents the continuum of goals sought; from individual to collective. The vertical axis represents the predictability of solutions and objectives, and the extent to which the behaviours needed to achieve these are known in advance. In the upper quadrants, only broad aims can be recognised and achieving these is dependent on working with and facilitating change in the behaviour of partners. Resilient, effective partnerships contain elements of all four quadrants and are likely to move between them over time.

To illustrate from the staff health and wellbeing project, partners encountered tensions between the goals of their organisation and the goals of the project; this had an impact on the speed at which individual members moved from competition (each partner has individual goals and knows how to achieve these) towards co-operative behaviours (where there may not yet be shared goals but partners have linked futures. In the early very early visioning stages of the project, partners used co-operative and co-evolution behaviours. Co-evolution behaviours work best when generating new possibilities and new ways of working when the objectives are unclear. Towards the end of the planning phase, co-ordination behaviours were more evident (intention to deliver set objectives based on a consensus about what works). When the project moved into the implementation phase, maintaining progress required a combination of co-ordination and co-evolution behaviours: both behaviours are focused around collective, rather than individual goals. Pratt et al (1999) and Plamping et al (2000) explain that co-evolving partnerships are about co-designing together for a shared purpose. During the process all partners co-evolve. Timescales are likely to be long, futures are linked and leadership is imperative to create the context in which sustainable relationships can emerge.
Section 8. Conclusions

All informal feedback and formal evaluation suggests this was a successful project which achieved the aims of developing an exemplar strategic framework and implementation tools with potential to improve health and wellbeing in NHS and other public sector staff across the West Midlands region. The outputs from this project will now be shared through a planned programme of dissemination so they are available to assist organisations more speedily to implement good practice derived from the Boorman (2009b) recommendations and the NICE guidelines on Health and wellbeing at work (NICE 2007, 2008, 2009 a,b,c) and to facilitate an integrated, coherent local and regional response to the Boorman Report (2009a, b) and to support individual employees who wish to look after their own health and wellbeing. The work was complicated by the significant changes to the NHS as part of the Health and Social Care Act (2012). Restructuring and redundancies have impeded the effort to build sustainable relationships with individuals and organisations. Even for those members who have remained in stable organisations, the operational pressures in the NHS and local government have made it hard for people to manage beyond immediate daily priorities.

Nevertheless, despite whole system change, thorough and detailed early planning ensured the project aims were sufficiently well aligned with the QIPP agenda and with national and regional objectives to remain relevant despite being delivered in a context of total re-organisation of health and social care, amid the greatest uncertainty public sector organisations may ever have experienced and in the midst of a recession and pensions reform. All these changes have challenged individual and organisational health and wellbeing as never before. Yet, the outputs have received positive feedback, are being utilised and the pilot of the individual intervention pathway ‘Your Health Matters’ appears to have had an impact on sickness absence.

8.1 Summary of Recommendations

The project outputs have created a network and set of resources which provide a sound platform for developing staff health and wellbeing and for long term impact evaluation of the project outputs. Research and health economic evaluation is also needed to understand the cost effectiveness and impact on service quality of investing in workforce health and wellbeing.

8.1.1 Developing staff health and wellbeing

Organisations are invited to use the outputs of this project further to develop their own workforce health and wellbeing strategies and implementation plans. The exemplar strategic framework (T&FG1) outlines the type of support needed by different individuals according to their health and wellbeing risk. The client pathway (T&FG1) offers a suggestion for the design of a staff support programme while the individual and board level scorecards (T&FG4) provide examples showing how changes in organisational and individual health and wellbeing can be monitored over time. A simple modeller (T&FG4) will help performance and finance teams predict cost savings from reductions in sickness absence and to build stronger business cases for investment in staff health and wellbeing. The evaluations conducted (T&FG3) contribute to the evidence base Finally, the interactive training tool (T&FG5) will help managers have more sensitive and effective health and wellbeing.
conversations with their teams while the website www.healthandwellbeing.nhslocal.nhs.uk (T&FG2) provides information and resources for individuals and their employers.

In addition, organisations are invited to make use of the planned programme of dissemination. As outlined in Section 6.7, Dissemination Consultants will be undertaking a programme of meetings and promotional activities to raise awareness, to share the project outcomes and to consider how these could be integrated with NHS, Local Authority and Higher Education organisations across the Black Country and Herefordshire & Worcestershire Localities. Activity will continue until Autumn 2012.

8.1.2 Evaluation of impact

Although it was unfeasible in the timescale to investigate the impact or cost effectiveness of investing in staff health and wellbeing, further work is indicated to appraise the value of the resources generated through the project and to undertake longitudinal evaluation of impact to address the following questions:

i) how and why does improving the health and wellbeing of the workforce reduce sickness absence over time

ii) to what extent does integrated working between individuals, employers and Occupational Health Services lead to more cost effective and efficient management of absence and free up resources to enable a greater focus on proactive health promotion

A more comprehensive evidence base is needed, while interventions need to build robust evaluation measures as integral aspects of the design rather than being bolted on. In particular there is a need for greater understanding of how to devise outcome measures that will differentiate between inter-related factors influencing health and wellbeing and enable like for like comparison across different workforce groups. It is very important also to devise both interventions and evaluation measures that are robust and critical but also engage staff in appreciative inquiry, not alienate them by appearing to be punitive.

Given the timescale and duration of this project it was not possible to begin to evaluate the impact of project outputs, nor to test their relevance in a proactive, integrated health and wellbeing strategy. Nevertheless, the project outcomes provide a platform for future robust empirical investigation of the correlation between workforce health and wellbeing and clinical productivity. A submission in November 2011 to the National Institute of Health Research Service Development Organisation Programme was ultimately unsuccessful, but there is a clear need to investigate the link between clinical quality and productivity and workforce health and wellbeing intention to enable the following questions to be addressed:

1. How much and by what means does increasing the health and wellbeing of NHS staff impact on clinical productivity?

2. What is the impact on team morale and productivity of enhancing middle managers' confidence and skills in managing health and wellbeing in their team?
8.1.3 Project Organisation

- Build-in to the design a timescale that offers maximum opportunity for good quality outputs and/or build in a flexible planning period post finding award to allow for delays eg in ethical approvals
- Plan a detailed dissemination strategy at the earliest point and conserve budget to enable this
- Continue dialogue to reduce and eliminate institutional and administrative barriers; eg to enable appropriate access to potentially sensitive data; to negotiate Intellectual Property Rights; to support pragmatic decisions about logos and branding
- Ensure sufficient project management capacity to ensure support and facilitation, speedy and effective infrastructures and efficient, timely process

8.1.4 Partnership working

- Seek out and make use of every opportunity to network and consult widely
- Continue partnership initiatives and use these as opportunities for reflexive learning.
- To facilitate effective partnership working:
  - Take time to establish shared and common goals
  - Clarify the contract and expectations at the start to minimise the opportunities for later confusion about decision making authority, responsibility, channels of reporting, budgets and accountability

In summary therefore, this project was delivered by an innovative and creative partnership group which achieved relevant and practical outcomes while also exploring the different ways of working needed to create a future proof health and social care sector. The extract below was published in 2000 but the issues remain pertinent and this project addressed the challenge outlined:

*Many people share government aspirations for partnership as a way of working but that does not make it easy to do in practice. There may be a sense of frustration and fatigue at present but that does not mean the solution is to throw the baby out with the bathwater. Working together is not a ‘once and for all and you never need to solve it again’ ambition. Thanks largely to a change in political climate, partnership is now ‘real work’ rather than an organisational hobby. Policy documents now emphasise change in behaviour rather than structure. But we should not underestimate the extent to which behaviour will have to be different if we are to create the conditions in which people can explore the possibilities and co-produce solutions*

Section 9. Project Contributors

Original Steering Group Members May 2010
Black Country Locality Board
Sandra Berns  Head of WF, Walsall Hospitals Trust
Mary Brassington  Head of Occupational Health & Wellbeing, Wolverhampton Hospitals Trust
Jane Hulley  BC Locality Board Development Manager
Jane Bayliss  Head of WF Strategy, NHS Walsall
Janet Hunt  Head of HR- WF, NHS Walsall Community Health
Stephanie Harris  Director of WF, Wolverhampton City PCT
Asi Malik  HR Business Partner & Workforce for the Future Lead, Sandwell PCT
Steve Mitchel  Deputy Director of WF and Learning Sandwell MH Trust
Ruth Olding  PH lead for Health & Wellbeing, Dudley PCT
Jayne Parker  Associate Director of Learning and Development, Dudley Walsall MH Partnership Trust
Jenny Powell  Head of OD and WF Strategy, Dudley PCT
Annette Reeves  HR Director, Dudley Group of Hospitals
Dr Peter Verow  OH Physician Sandwell & West Bham Hospitals Trust

Herefordshire & Worcestershire Locality Board
Sioux Breeze-Derrigan  Learning & Development Manager, Worcestershire County Council
Linda Dunn  Locality Board Development Manager
Julie Davis  Senior OH Nurse Manager, Hereford Hospitals Trust
Dr Ursula Ferriday  OH Physician, Worcester Acute Hospital Trust
Debbie Hill  HR Manager, Hereford PCT
Jennifer Tye  HR Manager, Hereford Hospitals Trust
Alison Wilmott-Miller  Senior HR Manager, Worcester MH Trust
These members represented Herefordshire & Worcestershire through a local group

SHA
David Elliott  Chair QUIPP WF Health & Wellbeing Group
Helen Kirk  Independent OH Consultant , WM Regional Representative for NHS Plus
Amanda Rose  Deputy Chair, SHA lead, QUIPP WF Health & Wellbeing Group, Programme Lead HR Regional Initiatives SHA
[Dr Peter Verow  West Midlands Health & Wellbeing Champion [also OH Physician Sandwell & West Birmingham Hospitals Trust]

WMAS
Kim Nurse  Chair, West Midlands Workforce Health and wellbeing Network, Director of OD & WF WMAS

Staff Side/ Unions
Lianne Brooks  UNISON, Chair Social Partnership Forum
Phillip Botfield  RCN, Social Partnership Forum & QIPP Health &Wellbeing group

University of Wolverhampton
Professor Linda Lang  Dean, School of Health and Wellbeing
Dr Robin Gutteridge  Principal Consultant in Health & Wellbeing, Project Manager
Steering Group at 31 December 2011

**Black Country Locality Board**

- Mary Brassington: Head of Occupational Health & Wellbeing, Wolverhampton Hospitals Trust
- Dr Mike Chamberlain: Director of Sport, University of Wolverhampton
- Julie Darby: HR Health & Wellbeing lead, Black Country Partnership NHS Trust
- Irene Hertzogova: HR Business Partner Walsall Council
- Jane Hulley: BC Locality Board Development Manager
- Janet Hunt: Head of HR- WF, Walsall Healthcare NHS Trust
- Ashi Malik: HR Business Partner & Workforce for the Future Lead, Sandwell PCT and BC Commissioning Cluster
- Jayne Parker: Associate Director of Learning and Development, Dudley Walsall Partnership Trust
- Sarah Potter: Health & Wellbeing lead, Walsall Council
- Jenny Wright: Workforce Health & Wellbeing lead Sandwell and West Bham Hospitals Trust

**Herefordshire & Worcestershire Locality Board**

- Linda Dunn: Locality Board Development Manager
- Dr Ursula Ferriday: OH Physician, Worcester Acute Hospital Trust
- Kate Leese: Worcester MH Trust - H & W Locality Board

**SHA**

- Alison Pope: E-learning Lead, Workforce Deanery
- David Elliott: Public Health & Wellbeing lead, Government Office West Midlands

**WMAS**

- Kim Nurse: Chair, West Midlands Workforce Health and wellbeing Network, Director of OD & WF WMAS

**Staff Side/ Unions**

- Lianne Brooks: UNISON, Chair Social Partnership Forum
- Phillip Botfield: RCN, Social Partnership Forum & QIPP Health & Wellbeing group

**University of Wolverhampton (member BC Locality Board)**

- Professor Linda Lang: Dean, School of Health and wellbeing
- Dr Robin Gutteridge: Principal Consultant in Health and Wellbeing, Project Manager
- Dr Ralph Leavey: Research Fellow
- Kim Turner: Project Administrator

**Task and Finish Groups Members**

Lead is shown in Bold type

**T&FG 1**

- **Kate Leese**: Worcestershire Health and Care Trust
- Linda Dunn: H&W Locality Board
- Dr Tracey Devonport: School of Sports Performing Arts & Leisure, UoW
- Dr Ursula Ferriday: Worcester Acute NHS Trust
- Dr Robin Gutteridge: School of Health and wellbeing UoW
- Professor Andy Lane: School of Sports Performing Arts & Leisure, UoW
- Dr Ralph Leavey: School of Health and wellbeing UoW
- Jayne McCullough: Worcestershire Health and Care Trust
- Chris Nash: Worcestershire Health and Care Trust
- Simon O'Loughlin: Worcestershire Health and Care Trust
- **Alison Wilmott-Miller**: Worcestershire Health and Care Trust
- Ann Wright: Worcestershire Health and Care Trust
T&FG2:

**Linda Dunn**
H&W Locality Board

**Alison Pope**
SHA

**David Elliott**
Government Office West Midlands

**Dr Ursula Ferriday**
Worcester Acute NHS Trust

**Dr Robin Gutteridge**
School of Health and wellbeing UoW

**Teresa Hewitt-Moran**
SHA

**Dr Ralph Leavey**
School of Health and wellbeing UoW

**Lucy Mackracken**
West Midlands Ambulance Service

**Ashi Malik**
Sanwell PCT/ Black Country Cluster

**Dr Petulia Nurse**
School of Applied Sciences UoW

**Jenny Wright**
Sanwell PCT

T&FG3

**Dr Mike Chamberlain**
Directorate, UoW

**Dr Robin Gutteridge**
School of Health and wellbeing UoW

**Dr Ralph Leavey**
School of Health and wellbeing UoW

T&FG4

**Dr Robin Gutteridge**
School of Health and wellbeing UoW

**Rachael Belleini**
West Midlands Ambulance Trust

**Dr Tracey Devonport**
School of Sports Performing Arts &Leisure, UoW

**Paul Deeley-Brewer**
NHS Walsall

**David Elliott**
Government Office West Midlands

**Professor Andy Lane**
School of Sports Performing Arts &Leisure, UoW

**Kam Mavi**
NHS Walsall

T&FG5

**Janet Hunt**
Walsall Healthcare NHS Trust

**Linda Dunn**
Worcestershire Health and Care Trust

**Dr Robin Gutteridge**
School of Health and wellbeing UoW

**Jayne Hulley**
Black Country Locality Board

**Dr Ralph Leavey**
School of Health and wellbeing UoW
Section 10. References


Baxter S, Goyder L, Herrmann K, Pickvance S, Chilcott, , (Nov 2009) Mental well-being , through productive and healthy working conditions, Sheffield, SCHAAR


Mooney H., (2012). *Doctors are told to “make every contact count” to reduce costs of poor lifestyles*, BMJ, 2012;344:e319; doi:10.1136/bmj.e319


Department of Health (2008). *The role of the Primary Care Trust board in world class commissioning*, London, Department of Health


Department of Health (2012a). The NHS Constitution the NHS belongs to us all, [www].


Department of Health (2012). *Partnership Agreement, An agreement between DH, NHS Employers and NHS Trade Unions*, Leeds, Department of Health


McPherson, K, Headrick, L, Moss, F (2001). Working and learning together: good quality care depends on it, but how can we achieve it?. Qual Saf Health Care 10: ii 46-53


http://www.socialpartnershipforum.org/SiteCollectionDocuments/YH%20BEHAVIOURS.pdf. accessed 10.03.2011
## Appendices

**Appendix 1: 20 Recommendations derived from the Boorman Review (2009a,b)**

<table>
<thead>
<tr>
<th>Rec No</th>
<th>Action needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Managers have skills and tools to support staff with mental health problems</td>
</tr>
<tr>
<td>2</td>
<td>Management training and Leadership development to include health and wellbeing</td>
</tr>
<tr>
<td>3</td>
<td>Identify a Board level champion and senior managerial support</td>
</tr>
<tr>
<td>4</td>
<td>Promote NICE guidance on mental health and wellbeing at work</td>
</tr>
<tr>
<td>5</td>
<td>Actively develop strategies for improving health and wellbeing in the workforce</td>
</tr>
<tr>
<td>6</td>
<td>Leaders and Managers equipped to recognise link between health and wellbeing and organisational performance</td>
</tr>
<tr>
<td>7</td>
<td>Provide health and wellbeing to staff centred on prevention of work related and lifestyle influenced ill health and which supports behaviour change</td>
</tr>
<tr>
<td>8</td>
<td>Adhere to nationally agreed service standard for early intervention</td>
</tr>
<tr>
<td>9</td>
<td>Core early intervention services should form part of the minimum service specification</td>
</tr>
<tr>
<td>10</td>
<td>HWB services commissioned follow a risk assessment process</td>
</tr>
<tr>
<td>11</td>
<td>Engage staff; provide a credible service</td>
</tr>
<tr>
<td>12</td>
<td>Provide a range of additional staff HWB services targeted at the needs of their organisation, through accessing what are the specific needs and requirements of staff</td>
</tr>
<tr>
<td>13</td>
<td>Provide consistent access to early and effective interventions for common musculoskeletal and mental health problems</td>
</tr>
<tr>
<td>14</td>
<td>Undertake a proper assessment of key staff health priorities and risk factors</td>
</tr>
<tr>
<td>15</td>
<td>Report on staff health and wellbeing in annual CQC reports, Quality Accounts and Monitor self- evaluations</td>
</tr>
<tr>
<td>16</td>
<td>Monitor and regularly assess and review staff health and wellbeing services</td>
</tr>
<tr>
<td>17</td>
<td>All initiatives to be available and accessible on an equitable basis</td>
</tr>
<tr>
<td>18</td>
<td>Develop a staff health and wellbeing strategy</td>
</tr>
<tr>
<td>19</td>
<td>Include staff-side when developing plans and initiatives</td>
</tr>
</tbody>
</table>
Appendix 2. Extract from Yorkshire and Humber NHS Social Partnership Forum. 10 behaviours of successful partnership working

10 BEHAVIOURS OF SUCCESSFUL PARTNERSHIP WORKING

At the Yorkshire and Humber social partnership summit in December 2008 participants identified the top ten behaviours which ensured successful social partnership working.

These are set out below.

- Having mutual respect
- Actively listening to each other
- Working from shared values
- Working in each others shoes
- Being honest with each other
- Being Solution Focused
- Acknowledging each others views
- Being inclusive
- Open communication and information sharing
- Trusting each other

These behaviours are clearly interrelated. If we fail to actively listen to each other, acknowledge each others views, share information openly and honestly it is highly unlikely that we will have mutual respect.

At the heart of partnership working is trust, building and maintaining trusts require us to practice each of the behaviours above consistently overtime. The model developed illustrates this (see page 3).

Building trust takes time, but it only takes an instance to damage or even destroy it.

Partnership working plays a crucial role in delivering highly motivated and committed staff who can continuously improve the quality of the care they provide to patients and their families, and who can be proud of the NHS.

It is therefore important that the members of social partnership forums regularly take time out to review how effective their partnership working is.

Set out on the following page is a simple model which Partnership Forums might wish to use to assess this, based on the Summit’s top ten behaviours for successful partnership working.

A number of questions have been associated with each of the behaviours which can be used as prompts for discussion together or for consideration as individuals to aid the completion of a simple rating scale scoring between 1 to 10 for each behaviour, 1 being poor, 10 being excellent.

As ‘trust’ is at the heart of the partnership relationship, this can be used as the overall parameter for the state of partnership working.

The idea is that using such a tool will enable the members of social partnership forums to spend sometime considering how their behaviours can both help and hinder the work they are engaged in, and support them in identifying how they can improve how they do business.

These behaviours are clearly interrelated. Yorkshire and the Humber have devised a simple model to illustrate the inter-relationships between factors. As a result of this model, a Partnership Behaviours Audit Tool has been designed (downloadable from the Yorkshire and the Humber section of the National Partnership Forum website) to help organisations explore current effectiveness with the ten behaviours of partnership working.
Direct link for the Audit Tool:

**Appendix 3. Steering Group monthly Self-Evaluation template**

**Improving Staff Health and Wellbeing – Steering Group Self-evaluation of progress**

<table>
<thead>
<tr>
<th>Considerations</th>
<th>5 Strongly Agree</th>
<th>4 Agree</th>
<th>3 No opinion</th>
<th>2 Disagree</th>
<th>1 Strongly Disagree</th>
<th>What works well?</th>
<th>How could improvements be made?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steering Group receives appropriate reports on finances/budgets, performance and other matters necessary to govern and direct the project</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steering Group meetings facilitate focus and progress on project objectives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reports are succinct and accessible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partnership is working effectively to progress the project</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision-making is supported by intelligent information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is rigorous and robust questioning of reports and proposals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A variety of viewpoints are discussed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time is well used in meetings – individual points are relevant and short</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each member seems involved and interested in the project</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Meetings are well managed
i) papers circulated in sufficient time
ii) Chaired/ Serviced effectively


Please answer all questions from your perspective NOW on the balance of your overall experiences.

1. Steering Group meetings have enabled progress on the project objectives

<table>
<thead>
<tr>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Most of the time</th>
</tr>
</thead>
</table>

2. In your view, to what extent has the project group achieved the following:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Agreed the aims of the project

Shared relevant information between members

Enabled each member to manage their time for the project to best effect

Been inclusive

Communicated effectively

Demonstrated mutual respect

Modelled open, transparent communication

Incorporated different viewpoints

Remained solution focused

3. What are the positive aspects of being in this partnership project?

4. Please list any negative aspects of being in this partnership project

5. How would you rate the degree of trust established between partners during this project?

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
<th>Very poor</th>
<th>Other</th>
</tr>
</thead>
</table>

(please specify)
Appendix 4 (cont.). Steering Group: Evaluation of partnership. Questions template

6. Please rate each of the following statements with regard to the partnership within the project

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My organisation has become more ambitious since working on this HWB Project.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It has been interesting to explore workforce health and wellbeing with this group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working together has enabled a wider exploration of health and wellbeing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My overall knowledge has increased through participation in this partnership.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As a result of being part of this project, I will be able to help my organisation develop a more integrated approach to staff HWB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being a member of the project group has been enjoyable and rewarding.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Please identify anything you have learned about achieving more effective partnership work in future

8. How well do you think the work of your Task and Finish Group(s) was understood by Steering Group members not involved in that T&FG?

1. Completely
2. Very well
3. To some extent
4. Not well
5. Not at all
6. I have not been able to attend sufficient meetings to assess
Other (please specify)

Appendix 4 (cont.). Steering Group: Evaluation of partnership. Questions template

9. How much respect for different views has been evident between members?
   A great deal Most good enough Some
   Could have been more at times Frequently unacceptable

10. How much do you feel you have been able to influence the direction of the project?
    A great deal Somewhat Occasionally Rarely Never Didn’t
    attempt to influence Other (please specify)

11. How well has this partnership come together over the life of the project?
    Not at all Not very well Neither well nor badly Moderately well To a high degree

    Shared values
    Supporting each other
    Sharing the workload
    Making proportionate contributions
    Setting challenging objectives
    Working harmoniously
    Learning from each other
    Achieving valuable outcomes

12. How do you anticipate the partnership working together in future? If not, please say why not.

13. How confident have you felt about raising concerns during the project?
    Very confident Mostly confident Neither confident nor unconfident
    Sometimes hesitant Not at all confident Other (please specify)
Appendix 4 (cont.). Steering Group: Evaluation of partnership. Questions template

14. To what extent do you feel the project group has achieved the following objectives?

<table>
<thead>
<tr>
<th>Objective</th>
<th>Completely</th>
<th>Mostly well</th>
<th>Neither well nor badly</th>
<th>Not too well</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing knowledge and experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimising duplication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working collaboratively to increase efficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working together to increase effectiveness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Producing valuable outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. How have actual or potential barriers to partnership working been addressed during the project? Please tick all that apply

- Constructive discussion
- Ignoring the issue
- Focus on getting the job done
- Background negotiation
- Someone giving in
- Assertively
- Aggressively
- Consensus
- Informal Mediation
- Conciliation
- Other (please specify)

16. How well has the project group enabled you to appreciate the contribution of others?

<table>
<thead>
<tr>
<th>Appreciation Level</th>
<th>Very well</th>
<th>Quite well</th>
<th>Not sure</th>
<th>Not well</th>
<th>Not at all</th>
</tr>
</thead>
</table>

V2.1 FINAL.29.05.2012
Appendix 4 (cont.). Steering Group: Evaluation of partnership. Questions template

17. What aspects of the project partnership made it difficult for you to contribute effectively?

18. What aspects of the project partnership made it easy for you to contribute effectively?

19. How would you rate the overall progress that you and your partners have made at this point of the project?
   Very good   Good   Average   Poor   Very poor

20. Thank you for responding to this survey. Please add any other comments in the box below.

Powered by SurveyMonkey
Appendix 5  
A strategic partnership approach to improving health and wellbeing in NHS staff  

**Steering Group Terms of Reference 2010 -2012.**  
The terms of reference were first agreed at the Steering Group Meeting on 26.07.2010 and updated following the Steering Group Meeting on 07.10.2010  

1. **Purpose**  
The steering group will:  
1. Support, direct and provide leadership and decision-making for the project  
2. Ensure the project aligns with, informs and influences Regional and National priorities and networks  
3. Agree work plans, outcomes and Key Performance Indicators to facilitate timely progress of the project  
4. Identify resources and facilitate participation in the Task and Finish Groups  
5. Support and contribute to the aims and achievement of agreed project work plans  
6. Contribute to shared learning, evaluation and dissemination of best practice  
7. Co-opt expertise as required  
8. Communicate with and contribute to the objectives of relevant Regional and National groups and networks  

2. **Membership**  
   i. All organisations currently represented by the Black Country and Hereford & Worcester Locality Boards have right to representation on the Steering Group and involvement in the project. This includes Local Authority, private sector organisations and Education providers.  
   ii. Some organisations may choose to nominate other members to represent their interests. Local partnership networks for extended communication and consultation will be utilised.  
   iii. The SHA and DoH will be represented by nominated officers from relevant Workforce QUIPP groups.  
   iv. The Chair of the West Midlands Workforce Health and Wellbeing Network will be a member
3. Key Documents

i. Project proposal and work plans

ii. Boorman Review

iii. NICE guidelines on staff HWB

iv. QUIPP reports NHS West Midlands

v. Reports from Aston University QUIPP HWB work

vi. OH Services Review National Task Force reports

4. Administration

i. The Steering Group will be serviced by the School of Health and Wellbeing, through the Project Manager

ii. Agenda and papers will be distributed 5 working days prior to meetings. Action points will be available to members no later than 10 working days after meetings

iii. Members will provide agenda items, papers and updates on action points at least working 10 days prior to each meeting

5. Quorum

i. A quorate meeting will comprise 6 members. This number must include the Chair and Project lead or their representatives, three representatives from different organisations in the Black Country Locality Board and one representative from organisations within Herefordshire & Worcestershire Locality Board

ii. Every member of the Steering Group will be asked to nominate an alternate who will hold delegated decision making authority for that member.

iii. If a meeting is not quorate, items on the Agenda may be deliberated. In this case, decisions may be held pending for up to 10 working days to allow the wider membership an opportunity to contribute to the discussion by electronic means. Members unable to attend meetings, send an alternate or contribute to the email discussion will be assumed to be in agreement with proposals for decision.

6. Governance

i. University of Wolverhampton, School of Health and Wellbeing will provide the project management team, including the project manager, research and administrative support. The nominated Project Manager is Dr Robin Gutteridge.

ii. The Steering Group will elect a Chairperson from within the membership.
iii. The Steering Group will receive reports and updates on progress from the designated working groups and the project management team. The Steering Group will submit a progress and a financial report quarterly and on request to both Locality Boards. A final project report will be submitted to both Locality Boards.

Appendix 5 (cont.).

7. Communication

i. Between Steering Group meetings, the Group will communicate by electronic means in the interim as necessary.

ii. The Steering Group will network, liaise, communicate and seek to work collaboratively with the following groups:

iii. The SHA Workforce QUIPP groups

iv. The SHA QUIPP Clusters

v. The National Health and Wellbeing Champions Network

vi. The West Midlands Workforce Health and Wellbeing Network

vii. This list is not exhaustive. There will be active liaison with other groups as relevant, eg The West Midlands HIEC’s, The Public Health Networks, The NHS Institute of Innovation and Improvement

8. Frequency of Meetings

i. The Group will meet monthly or as determined for effectiveness

ii. The Group will communicate by electronic means in the interim as necessary.

iii. Extraordinary meetings may be arranged with the agreement of the Chair or on the instruction of the Steering Group

9. Reviewing Terms of Reference

These Terms of Reference will cover the duration of the project. With the agreement of the Chair the Steering Group may review these terms of reference as necessary to ensure efficiency, effectiveness, good governance and to reflect any substantial changes in arrangements.

10. Standard Agenda Items

i. Update on Progress and Action Plan from each Task Group

ii. Summary performance and financial management report

iii. Forward Planning
Appendix 6. Factors outside work survey. Questions Template

1. What is your job role? Please select all that apply, including any voluntary work

- NHS Clinical
- NHS nonclinical
- Private, voluntary or independent sector 'clinical'
- Private, voluntary or independent sector 'nonclinical'
- Higher Education (HE) Academic/Research
- HE Admin/Academic Support
- Part time single role
- Full time single role
- Split between dual or multiple roles

NB All the remaining questions relate ONLY to your MAIN paid work for an NHS or HE organisation

2. In your paid work for the NHS or HE during the past three months: how often have you experienced the following?

Rarely  Sometimes  Often  Most of the time

I was too tired to be effective at work because of things I had to do at home

I was preoccupied with personal responsibilities while I was at work

The amount of time my personal responsibilities took up led me to work less than I wanted to

My behaviour at work was not as I normally expect of myself

3. When your work and home life are interfering with each other, how much is each of the following factors negatively affected?
4. When your work and personal life are interfering with one another, how strongly is each of the following aspects of job performance negatively affected?

- Ability to concentrate
- Quality of performance
- Amount of work that gets done
- Arriving at work on time
- Coming to work every day

**Appendix 6 (cont.) Factors outside work survey. Questions Template**

6. How easy is it to balance your work life and personal life where you work?

- Extremely easy
- Very easy
- Moderately easy
- Slightly easy
- Not at all easy

7. How confident would you feel in telling your Manager you were struggling to cope with something outside work?

- Very confident
- Reasonably confident
- Okay
- Slightly reluctant
- Very reluctant

8. Please explain briefly the thoughts that prompted your response to Question 7

9. Where would you seek help and support when struggling to juggle personal and work life?

- Most likely
- Quite likely
- Possible
- Unlikely
- Definitely not

- Family
- Friends
- Work colleague
- Manager
- Trade Union
- GP
- Occupational Health (OH)
- Staff support service (other than OH)
- Independent, voluntary or charitable sector, eg
- Counselling, Citizens Advice, Debt advice
- Other relevant expert: eg Lawyer
- Web based self help
10. What is your best tip for managing the dual demands of work and personal life?

11. Thank you for completing the survey. Is there anything else you would like to say?

Appendix 7. Task and Finish Group 1. Evaluation plan for Pilot of Staff Health and Wellbeing intervention pathway

Service Evaluation for T&FG1 Staff Support Pilot

Purpose of this evaluation:

Task & Finish group 1 is implementing a pilot Staff Support Scheme locally for staff of Worcestershire Health and Care NHS Trust. This will be funded by a 66k budget allocation from a bigger partnership project being funded by the Black Country and Herefordshire and Worcestershire NHS Locality Boards: The University of Wolverhampton is project managing the overarching project, which has 5 Task and Finish groups each running mini-projects. T&FG1 pilot will contribute knowledge and information to the overall Staff Health and Wellbeing Project and is expected to assist local Trust colleagues to build their business case for a sustainable staff support scheme. Evaluation of the pilot service is needed to enable knowledge transfer to the partnership and to facilitate an effective contribution to future business cases.

Pilot Site: Worcestershire Health and Care NHS Trust, xxxx Community Hospital

Planned Duration of pilot: 6 months from 1st November 2011

Inclusion criteria for the scheme:

Any NHS staff member who works at or is based at xxx a minimum of one day per week

Task and Finish Group 1 / Pilot project lead: xx

UoW Project Team contacts: xx

Pilot Intervention: will be co-ordinated through the Health Trainer Service

each individual intervention comprises three components: 1) assessment; 2) individual action plan 3) approximately 6 weeks of supported Lifestyle intervention

Service evaluation: will assess the impact on every individual utilising the pilot staff support scheme

Two evaluation strands are suggested:

1. Strand 1 will be used for all participants and managed by the local Implementation Group assisted by the UoW Project Team

2. Strand 2 is an optional addition, available until 31 January 2012. This strand will select up to 10 participating individuals for a more in depth interview of their experiences and changes resulting from participation If the local Implementation Group wish to utilise Strand 2, interviews would be conducted by the UOW Staff Health & Wellbeing Project team.
All data collection tools, participant information and consent documents will be supplied by UoW

Appendix 7 (cont.). Task and Finish Group 1. Evaluation plan for Pilot of Staff Health and Wellbeing intervention pathway

**Evaluation Strand 1. For all participants:**

Measures will be administered, collated and analysed by the Health Trainer Service, supported if wished by UoW until 31 January 2012

All participants will be measured three times:

- at the point of assessment,
- at the conclusion of their supported intervention
- 3-6 weeks post-completion.

At each of the three measurement points, participants will complete three measures:

i) the WHO-5 (English) Wellbeing Index, 1998 Version;

ii) the new General Self-efficacy Scale (Chen Gully and Eden 2001)\(^7\);

iii) a visual analogue scale of their self-perceived current state of general health.

These evaluation tools may be either self-completion or assisted completion (by the Health Trainer) as convenient for the participant. *All participants will be assigned a code to anonymise their data.*

All the standardised measures (i-iii) are already available to Health Trainers and can be collected without undue strain on resource or individual session time. These measures will be especially useful because the National Health Trainer data set also contains data returns from these measures. If this collated national data could be made available, it has potential to provide a control group which would provide useful comparators and increase the robustness of the findings from this service evaluation.

Quality of the relationship between client and Health Trainer may also be a factor influencing the outcome. It will be possible to identify the staff member assigned to individual clients to assist discussion of this factor, but no performance related information will be elicited and no information about individual Health trainers will be disclosed to the Service unless unethical practice is disclosed by clients.

---

Appendix 7 (cont.) Task and Finish Group 1. Evaluation plan for Pilot of Staff Health and Wellbeing intervention pathway

Strand 2: for up to 10 consenting individuals

Optional addition, to be conducted and resources by UoW Project team. Must end on 31 January 2012.

10 individuals who are participating in the Staff Support Pilot will be asked to participate in a purpose designed semi-structured interview approximately 1-6 weeks after their assessment. Individuals will be approached by their Health Trainer at assessment and given a participant information sheet explaining Strand 2. If consenting, the contact details will be passed to the UoW Project team. The first 10 consenting individuals will be included. This interview will explore the factors relating to motivation and perceived self-efficacy that promoted participation; and the changes arising as a result of participation in the programme. We predict that effort invested may be related to participant belief in the programme. Therefore the interview will also assess the extent which each participant believes that the intervention will work. Telephone, Live Chat, Skype or face to face interviews will be used as convenient for the participant.

Analysis

Both survey and interview data will be anonymised, collated and subjected to thematic or statistical analysis as appropriate. The Health Trainer Manager and UoW Project team will work co-operatively to ensure i) Strand 1 measures are working smoothly so these can continue seamlessly by the local implementation group once the UoW Project team funding has ended (on 29 February 2012) ii) that the Strand 2 interviews are completed, analysed and reported by 29 February 2012.

As no prior evaluation has been conducted, there is no intention to generalise. This service evaluation is intended to explore the qualitative experience and impact on the user arising from their decision to participate in the staff support pilot.
Appendix 8. Individual wellbeing survey

These questions ask for your views about YOUR health over the past month. Please answer every question by ticking one box that best describes your feelings. If you are unsure about how to answer a question, please give the best answer you can.

A. To what extent have YOU felt the following over the last month:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Moderately</th>
<th>A great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Happy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Anxious</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Sluggish</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Gloomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Energetic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Calm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Angry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Downhearted</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. How often have YOU felt the following over the last month:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Fleeting</th>
<th>Once or twice</th>
<th>A Few times</th>
<th>Every week</th>
<th>Few times weekly</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emotionally drained</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Burned out</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Invigorated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. How have you felt about your overall health over the last month

1. Overall, how would you rate your health during the past month?

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Overall, has your health over the last month been better or worse than usual?

<table>
<thead>
<tr>
<th></th>
<th>Much better</th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
<th>Much worse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>