NHS

Health Development Agency

Health at Work in the NHS: an evaluation

Foreword

Ten years ago the Department of Health held a series of regional workshops, attended by over a thousand people from the NHS, which set out their key issues for improving the health and welfare of NHS staff. This was the start of Health at Work in the NHS, an NHS-wide project that had the aim of making the NHS 'an exemplar employer in the field of staff health and welfare' – an aim some said was 'unattainable'.

A decade on, the project managers and the Health Development Agency have taken the brave step of evaluating the impact of the project on the NHS and looking at where it has succeeded and where it has failed. However, no team brought in from outside to evaluate the project could hope to measure the impact it has had on raising awareness across the service or the importance that should be given to looking after the health and welfare of our biggest asset – NHS staff.

Health at Work was in the vanguard of those aiming to raise awareness of the importance of looking after staff. Now, as the project comes to an end, we can see the influence it has had on the human resources framework, Working Together, and the Improving Working Lives standard. It is a tribute to the project that guidance it has produced over the years is still in print and being used by colleagues in the field as core documentation for issues such as absence management, managing risks and assessing staff needs.

I would like to take this opportunity to thank the workplace health team at the Health Development Agency for all of the hard work they have put into improving the working lives of their NHS colleagues over the years and to congratulate them on behalf of those colleagues on reaching the end of this ground-breaking project.

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Introduction

This report presents the practical experiences and lessons learned from 16 NHS sites that implemented the Health at Work in the NHS initiative. These sites vary considerably in their function, size, and make-up, providing a rich source of insight and reflection relevant to not only other NHS organisations, but also others in the public and private sectors interested in promoting health and wellbeing among staff.

Health at Work in the NHS

Launched in 1992, Health at Work in the NHS (HAW in the NHS) was a ten-year initiative that aimed to achieve the improvement of the health and wellbeing of NHS employees through a variety of workplace health programmes, integrating approaches from health and safety, occupational health and health promotion.

In particular, HAW in the NHS sought to take the focus of health improvement initiatives away from the individual, towards a focus on how organisations affect the health of those they employ. To assist with this aim, the *Framework for Action* was developed to provide guidance for senior managers on how to establish an integrated and sustainable programme of activities which reflects the priorities of both employees and the organisation.

The HAW in the NHS initiative provided a framework in which to promote health in the workplace, while also complementing other initiatives and schemes such as Health Promoting Hospitals and Health Action Zones, and was a precursor to the Improving Working Lives initiative. This initiative has many parallels with HAW in the NHS and aims to support its staff who are 'entitled to belong to an organisation which can prove that it is investing in their training and development, tackling discrimination and harassment, improving diversity, applying a zero tolerance on violence against staff, reducing workplace accidents, reducing sick absences, providing better occupational health and counselling services, conducting annual attitude surveys asking relevant questions and acting on the key messages' (*NHS National Plan: A Plan for Investment, a Plan for Reform*, 2000).

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For more information concerning this publication please contact the workplace health team at the HDA.

Main findings

Some key issues were highlighted by the case studies. The main points are summarised as follows.

- Among the case study sites visited, there was an enormous amount of enthusiasm for and commitment to the initiative.
- The organisations interviewed were at varying stages in developing the initiative. While many were implementing their strategy and evaluating their processes, a couple of sites were still at the stage of setting up support structures, and others only just developing their strategy. Those that had made less progress had generally been through extreme organisational change, suffered from a lack of senior level commitment or simply lacked the human resources to take the initiative forward. A combination of all three factors was often the case.
- In the trusts visited, successful implementation can largely be attributed to the enthusiasm and dedication of the implementers and their colleagues on Health at Work (HAW) groups or equivalent.
- Some trusts approached were not willing to participate due to the amount of organisational change currently taking place in the trust.
- Most trusts had not conducted a systematic health needs assessment of staff. Many were relying on a review of organisational statistics (sickness absence, accident reports, etc.) and ad hoc feedback on which to base their initiative. Some had conducted staff surveys with specific questions focusing on occupational health and stress. Few had thought to delve deeper, to investigate and address the underlying causes of stress, accidents, etc.
- Members of HAW groups were able to lend their own interests and expert knowledge to developing the initiative. Most trusts that had experienced the greatest success with their HAW initiative had used the HAW group as a resource pool for implementing the initiative.
- Many trusts did not see a clear link between HAW in the NHS and health and safety issues. A formal process of risk assessments as part of strategy development was not widespread.
- Inadequate resources, in terms of time and people, was the main barrier to developing and progressing HAW in the NHS. A lack of commitment from senior management was also a common problem. Several case study sites felt that senior management were giving lip service to the initiative without making the commitment to address underlying issues. Other trusts, however, were positive that senior managers were committed to the initiative. It was found that greater success was experienced by trusts where senior management publicly demonstrated their commitment to the initiative and made resources available where possible.
- Successful communication of the initiative and the various activities was seen by all case study sites as key to their success.
- Many trusts demonstrated an innovative approach to overcoming barriers such as limited resources.
- Initiative overload was also a major issue and mentioned by many case study sites. The inability to focus and carry through one initiative, before the next one landed on desks, compounded the existing resource problems, and invariably diverted attention away from the initiative.

Methodology

The underpinning aim of the research was to gain practical and wide-ranging reflections on 'what works and what doesn't work' within the HAW initiative, capturing lessons learned and suggesting guidance for the future.

To achieve these aims, a qualitative case study methodology was developed that combined informal interviews with HAW regional coordinators; semi-structured interviews with local HAW implementers and the HAW group; and, where appropriate, focus-group discussions or surveys of staff to assess the impact of HAW activities. Each stage of this methodology is described in more detail below:

Stage 1: Identifying the case study sites

To ensure that a broad cross-section of HAW sites was included in the research, case studies were selected according to the following criteria. Regional HAW coordinators assisted with the identification of the case study sites.

It was agreed by the project team and the Health Development Agency that the case studies should cover:

1 **A range of HAW activities.** Collectively, the case studies provide coverage of the following Health at Work areas of interest:

- Sickness absence management
- Risk assessment
- Workplace health needs assessment
- Strategic planning and workplace health
- Health and safety
- Mental health
- Staff support services
- Training and development
- Individual health and wellbeing policies
- Partnership working.

2 **Awards/other programmes.** The case studies include a HAW Award site and several hospitals with Health Promoting Hospitals status.

3 **Trusts of varying types and sizes.** The case studies include acute and community trusts, an ambulance trust and a health authority.

4 **A geographical spread.** This has been achieved through selecting trusts from most NHS Regional areas in England to be included in the research.

Stage 2: Context interview with local implementers

A semi-structured interview, lasting between 60 and 90 minutes, was conducted with the local HAW implementers to gain a broad understanding of the HAW activity at each case study site. In particular, the interview sought to understand the background to each organisation's HAW initiatives, their HAW strategy (if present), their approach to implementing HAW activities, the resources deployed and any barriers encountered. The semi-structured interview approach was chosen to allow participants to expand on their responses and include issues that they considered to be particularly important or relevant to the research.

Stage 3: Interviews with the HAW group (or equivalent)

Interviews were then set up with key members of the HAW group (or their equivalent if such a group was not

in place). Where it was possible to meet with the whole group (usually after a formal HAW meeting) a focus group of six to ten people was facilitated. On these occasions it was also possible to gain a practical insight into the workings of the HAW team.

The aim of these discussions was to fill gaps left from the context interview, to validate understandings and to gain a deeper insight into the issues faced by each site in implementing HAW initiatives. In particular, the discussion focused on implementation barriers, the reasons for particular successes and failures, and any lessons learned.

Where relevant, this stage of the research process also involved gathering data on the impact on staff of the HAW initiatives that were in place at each site. This data was usually available in the form of a staff satisfaction survey, attendance and staff turnover figures and/or other key management information. Where relevant information was not available, a staff survey or a focus group was conducted. The choice of assessment tool depended on the actual HAW initiatives and the nature and extent of evaluation procedures already in place at each site.

Summary of the case study findings

This section has been divided into the following topics, reflecting the format of the individual case studies:

- Starting points – gaining commitment and setting up the HAW group
- Resources
- Strategy planning
- Identifying the activities
- Communication strategies
- Examples of HAW activity
- Barriers to progress and success
- Evaluating the impact of HAW.

Starting points – gaining commitment and setting up the HAW group

Several key issues concerning the initial 'setting up' stage of HAW can be identified from the case studies.

Delay

For many of the organisations that took part in the study, there was a significant delay in the initial implementation of the process. Many trusts found that it took a long time to get key personnel committed to and involved with the overall HAW initiative, and to set up a team of people to identify objectives and actions. HAW requires a holistic, interdisciplinary approach among the trust's human resources, occupational health, health and safety and health promotion departments.

As a result, no single individual or team has an obvious responsibility to seek initial 'buy-in' to the process. Subsequently, it was/is often down to the commitment of interested individuals and chance that initiatives get/got off the ground. As an example, in one of the trusts a new recruit noticed documentation about the initiative buried in their filing cabinet several years after HAW in the NHS was launched, and thought it would be a good idea to push this forward. Another implementer found out about the initiative by talking with an equivalent role-holder at a conference and only then realised that HAW activity should be part of their job.

Organisational change

Many of the organisations that took part in the research have experienced fundamental changes to their structures and management systems during the period since the start of the initiative. Many trusts have experienced mergers and many are now moving towards the primary care model. Such programmes of change have placed extreme pressure on already limited resources, pushing voluntary initiatives such as HAW lower down and in some cases completely off the strategic agenda.

Commitment and initiative overload

Many of the people best placed to ensure HAW is implemented throughout the organisation have not provided the commitment that is needed to ensure its success. Furthermore, the terms 'initiative burnout' and 'window dressing' frequently emerged from the discussions with the HAW groups, indicating cynicism stemming from tiredness with implementing initiatives that are perceived to have little chance of success. HAW in the NHS was seen by some to fit into this category because its stated aim to 'turn the NHS into an exemplar employer' was not perceived to be matched with a commitment of resources from the centre.

Other initiatives taking precedence

Recently the Improving Working Lives initiative was established, which has dedicated resources and performance standards, giving it more focus and making the aims of the initiative easier to achieve. With greater potential for success, it is likely that those in senior positions will commit more attention and time. While in some organisations Improving Working Lives has been

happily integrated with HAW work, in others it has pulled human and financial resources away from HAW activities. As a result, the scale and in some cases the future existence of HAW activities has been challenged.

Conclusions and recommendations

What works?

- An interdisciplinary approach among human resources, occupational health, health and safety and health promotion departments.

What doesn't work?

- Lack of senior commitment to HAW initiatives.
- Limited human and financial resources to manage HAW programmes.

Resources

A series of success factors relating to both human and financial resources can be identified across the various case studies. Human resource factors underpinning the success of HAW in the NHS operate at the individual, HAW group, organisational and sector levels, as outlined below. A lack of dedicated financial resources was found to impede the development of HAW activity. In some trusts, however, a lack of resources had a positive impact, by stimulating creativity through staff needing to find alternative ways to resource HAW projects.

Human resources issues at the implementer level

It was generally the case that the higher the grade of the implementer, the lower the likelihood of there being significant barriers to implementing HAW activities. Across the case studies, many different people, at different levels of the organisation, took on the role of HAW implementer. In one of the more successful case study sites (Case study 11 – Hull and East Riding Community Health NHS Trust) the director of corporate development had taken on overall implementation responsibility. By the nature of their position, an individual at a senior strategic level tends to have access to key resources, can integrate HAW into the strategic core of the organisation, and has the skills and communication networks to coordinate HAW across different departments. Where trusts had achieved less in respect of the aims of HAW in the NHS, the implementer tended to have less access to resources. In one particular case (Case study 1 – North West Cardiothoracic Centre – Liverpool NHS Trust) a HR assistant had taken on the implementer role, and was experiencing difficulties accessing resources and gaining commitment from others in terms of time. Here, activities took longer to arrange and were on a much smaller scale.

Another key issue relates to the finding that the implementation of HAW in the NHS is a person rather than a role-based activity – it relies on individual personalities and interests to ensure that it is taken forward. Many problems were found to relate to this. Once an individual takes on the responsibility for HAW (which is largely dependent on individual interest as discussed above), there may be little funding and limited time resources to make HAW an integral part of that person's job. Frequently, HAW has not been recognised as being of strategic significance within the organisation. As a result, HAW responsibility is rarely written into job descriptions and as such it is given much less priority than other core tasks. Furthermore, when implementers move out of their position the next job holder may not continue with the initiative as it was never embedded into the job description. This problem is compounded when new recruits are not aware of the initiative.

Human resources and the HAW group – the importance of size and structure

At this level various success factors were identified. Of primary importance was the finding that HAW group members need to be interested in the initiative and have the time available to dedicate to HAW activity. The most successful HAW trusts tended to use the HAW group as a resource pool for implementing activities – they were not relying on the individual implementer to do all the work. In this respect the size of the HAW group was important. Where the HAW group is large, the potential resource pool is large and HAW activity has been shown to be less of a drain on any one individual's time.

Linked to the importance of size is group structure. A sub-committee approach was found to be particularly effective at guarding against day-to-day problems stifling enthusiasm, creativity and 'push'. This approach enabled the main group to stay focused on ideas and strategy, while sub-committees focused on the day-to-day implementation of individual activities.

Having relevant health experts (such as occupational health and health promotion professionals) available to

work on or with the HAW group emerged as another important success factor. Where HAW had progressed further, such professionals provided crucial guidance at the planning stage, and actively helped design and implement relevant interventions.

Human resources at the organisation level

Another key success factor related to the opportunity of the HAW group to access a wider pool of people in a variety of different functional areas, to identify and instigate activities that the HAW group alone could not consider. For example, in Case study 8 (Anon.) the implementer was the HR manager. This individual was able to draw on the skills and creativity of the whole HR team and ensure the mainstreaming of HAW into the HR department's strategy. Where HAW activities had failed to progress throughout the organisation, it was often because the group had exhausted its power base and influence.

Expanding the resource pool by developing partnerships with other organisations

- **Partnerships with other NHS trusts.** Success with HAW was also linked to an organisation's ability to establish partnerships with HAW groups from neighbouring trusts and to share ideas, experiences, and responsibility for running and resourcing particularly large-scale activities. Different types of trust carry different expertise relevant to HAW (such as specialist health advisers) and so it makes sense to collaborate to share specialist knowledge and expertise.

- **Partnerships with other public sector organisations.** Some trusts formed partnerships with local further education colleges which could provide training rooms, training courses and sports facilities (see Case study 11 – Hull and East Riding Community Health NHS Trust). These relationships were built on the basis of both institutions trading specialist knowledge or facilities. HAW groups provided guidance to the college on setting up HAW programmes in return for college facilities.

The case studies also provided examples of partnerships with local police forces, which were able to provide specialist knowledge about the prevention of violence in the workplace. This was done in return for the provision of occupational health services such as stress management (eg Case study 15 – Parkside Community Trust).

- **Partnerships with commercial organisations.** Some HAW groups also took the concept of partnership out into the private sector. It was recognised that certain suppliers of health products could sponsor events and provide incentives for people to attend. Again, the benefits to the partner company were related to PR and access to specialist knowledge on HAW issues. Further, partnerships with private organisations were beneficial in relation to income generated from activities and events conducted in the client organisation. This helped to boost budgets for HAW activities within the trust.

Financial resources

In those cases where HAW progressed successfully over the years, funds were obtained from a variety of sources:

- Other departmental budgets – HR, occupational health, health and safety, through the allocation of funds to specific activities that fell within their remit
- The board – in some cases specific budgets were granted
- Private sector sponsorship for HAW events
- The development of income generation streams, with all income earmarked for HAW activity – eg HAW consultancy to non-NHS organisations and the provision of external occupational health services.

Where there was no allocation of resources, two contrasting effects have been felt:

- Lack of resource experienced as a barrier. Scarce finances limited the type of activities that were progressed, leading in some cases to staff disappointment as expectations had been raised through the health needs assessment process.
- Lack of resource experienced as a creative driver. In some cases, the fact that the HAW group had no dedicated resources motivated the group to think 'outside the box' and develop creative solutions for gaining financial support, such as corporate sponsorship, partnership working and income generation from consultancy. At one case study site (Case study 2 – Bedford General Hospital), the HAW implementer made the identification of potential resources, from both internal and external sources, as the first priority for the group. Once a realistic understanding of likely resources had been achieved, the group then turned its attention to the

identification of appropriate interventions. Unrealistic expectations were not raised, and the group had given itself the time to innovate and secure funds from a diverse range of sources.

Conclusions and recommendations

What works?

- Implementers who are from high grades and strategic positions in the organisation, with access to resources, power to make key decisions and a position to persuade members of the board to support HAW.
- Responsibility for HAW is built into job descriptions of those who take on the implementer role.
- HAW groups are often most effective with a sub-committee structure, so increasing the number of staff involved in the initiative who have a specific responsibility to the group.
- Success is also linked to the active involvement of relevant health experts to advise and help design specific activities.
- Effective HAW groups tend to be strategic in choosing members that give access to wider mainstreaming channels and have the power and relationships to actively utilise resources outside the group.
- Placing priority on understanding and pulling together all potential resources, both inside and outside the organisation, before moving forward with identifying and implementing specific HAW activities.

What doesn't work?

- One person being responsible for the implementation of the initiative so there are limited resources for conducting activities and limited expertise to rely on to cover the different elements of HAW, such as HR, health and safety and occupational health.

Strategy planning

Objectives and aims of HAW group

Strategic planning is crucial to the success of the initiative. Those trusts that spent a significant amount of time on strategy planning either initially or on an ongoing basis found that they were more focused about what they wanted to achieve, what fell within their remit, and realistically what they could achieve with the resources and expertise available in their trust. Where this process had not been conducted within a trust, they were more likely to encounter problems in relation to funding activities, and selecting activities that may not be supported in the trust due to following what they believe to be relevant to the staff 'on a hunch'. Groups that overlooked the strategic planning phase were also in danger of being overwhelmed by the potential enormity of the task they were setting themselves.

In places where the HAW initiative was most successful, the group had been fully trained by the implementer and therefore understood the core aims of the HAW initiative, and were made aware of the relevant issues. HAW groups that had this understanding were able to bear this in mind throughout the strategy planning process, and when discussing potential activities.

Action planning

Most seemed to undertake action planning, but those sites that were most successful had in place short, medium and long-term aims. This prevented the group from becoming overwhelmed by the wide variety of work that could be undertaken and from setting unrealistic targets and deadlines. Other successful sites agreed on how to evaluate and review individual activities. The most successful organisations considered this at the early planning stages.

Evaluating and reviewing activities throughout the initiative ensured that HAW groups were focused on what was working in their trust, were able to respond quickly to staff needs, and could see a clear indication of the positive and negative impact of initiatives.

Conclusions and recommendations

What works?

- Integrating initiatives into trust objectives makes funding more likely to be available. That is, where strategic planning includes setting objectives; linking them back to the organisation's aims; focused actions for achieving the objectives; making sure the objectives are the 'right' ones; and clearly defined resources.

What doesn't work?

- Where there is no strategic planning things can still be made to happen, but are less likely to have the desired impact as the initiative will appear removed from the other day-to-day activities of the trust.

Identifying the activities

Three main approaches were taken by HAW groups when determining their activities:

- Identifying the main areas of interest at the government/national level: for example the key issues discussed at national conferences and the issues covered by national campaigns (eg smoking cessation).
- General brainstorming by the HAW group. The types of issues identified would be determined largely by the make-up, and often the personal interests, of the group.
- Direct consultation with staff to identify the types of activities or changes that they perceived would have a positive impact on their health and wellbeing, and to identify the events and activities that would have the widest appeal and be most effective.

The most progressive HAW sites used a combination of these approaches. They first identified what they could and could not achieve, given the resources already available and those they might additionally obtain. Only when the boundaries had been set did these groups consult with staff (so as to avoid raising unrealistic expectations) and consider areas of national/government interest. Many trusts also found it beneficial to draw on the experiences and expertise of other HAW groups in other organisations. In contrast, the sites that were less successful in implementing the scheme gave staff insufficient input into the types of activities that would be available, and instead almost randomly selected areas of focus. Alternatively, some trusts sought staff suggestions too early in the process – before identifying what could practically be achieved and so raised staff expectations. This in turn placed pressure on the HAW group to deliver activities that were not practicable.

Conclusions and recommendations

What works?

- To avoid raising unrealistic expectations HAW groups determined their boundaries, having identified actual and potential resources, before seeking staff input.
- In consultations, the most successful HAW groups allowed staff to identify health needs and suggest organisational changes, but within the boundaries set.

What doesn't work?

- Lack of consultation with staff leads to prescriptive approaches and lack of 'ownership'. Staff are then less likely to attend events and activities as the activity is not relevant or interesting to them.

Communication

The most appropriate and effective methods of communication for HAW depended on current communication practices within each trust. Communication between HAW groups and staff proved to be most effective where a trust already had successful communication strategies in place.

While formalised communication strategies were important to ensure that the scheme was accessible to all staff, another effective method of communication was found to be through word of mouth. This was used effectively when as many staff members as possible were practically involved in HAW activities.

Across the 16 sites, a variety of communication strategies were adopted.

- Ensuring that HAW becomes a core item during team briefings. While this approach, where used, ensured that HAW reached all staff, its limitation was that it relied on the full support of managers at all levels, in particular line managers. However, this approach was fundamental to demonstrating senior management commitment to the initiative.
- Newsletters proved especially useful where a specific page/section was dedicated to health issues. This was found to be a reliable, timed source of communication. However, it was also necessary to have other methods of communication available for use between newsletters (for example, when staff need a last-minute reminder for an event).
- Intranet sites provided a direct communication channel that could be updated quickly and so provided a reliable source of information for staff. In some instances, HAW was linked to personnel policies, while in other cases there was a separate website dedicated to HAW issues. However, not all staff had access to the intranet, so information may not have reached everyone and dissemination of such information was reliant on the willingness and commitment of managers or those with PC access.
- Email reminders were found to have the advantage of being quick and effective, though again all staff may not have had access to computers and/or email to benefit from this approach.
- Noticeboards proved to be both an effective and weak form of communication, dependent on their physical

location (and therefore how readily accessible they were to staff). In most trusts this approach to communication had been superseded by other methods.
- Posters and leaflets had the advantage of being accessible to all staff members, though they also proved to be time consuming to produce. In many cases, there was a resource implication in the production and distribution of posters.

The most appropriate methods of communication varied significantly according to the nature of the organisation, the message that was being communicated and the audience being targeted.

The most successful communication strategies employed a reliable, regular core communication method that was accessible to everyone (for example, a newsletter and/or the intranet) supplemented by a variety of different communication methods (taking into account different groups' ability to access them) to inform staff about upcoming activities and events.

Conclusions and recommendations

What works?

- The most appropriate method of communication was determined by considering the nature of the organisation, the message being sent and the audience it is directed towards.
- When determining the most appropriate communication method, it was particularly important to consider the ability of all staff to access the information. Commonly, not all staff have access to all forms of communication such as email or the intranet due to nature of their job.
- The most successful HAW communication strategies employed a reliable core information source (which was accessible to all staff) supported by a range of advertising methods to publicise events.
- Several different methods of communication, including reminder emails for events.
- Staff are given an information source from which they can 'pull' the information that they may need, eg personnel procedure guides from the intranet or regular section of the staff newsletter.

What doesn't work?

- Reliance on one method of communication, unless this is particularly effective.

Implementation of HAW activity

The research highlights that the activities pursued by different sites tend to reflect the make-up of the HAW group. Where representation from key functions is missing (for example, HR, health and safety), the group was less likely to place as much emphasis on this area of HAW activity. It was assumed that the required activity was occurring anyway, due to lack of specific knowledge, and it was far easier to focus activity where expertise lies.

It is important that the work of the group is guided by strategic planning. If time is allocated to consider the broader issues linked to the initiative, such as the impact of HR implementing a whistle-blowing strategy on potential stress felt by the informant, the HAW group is more likely to identify those areas that are otherwise likely to be missed. In other words, it enables thinking to be more lateral/holistic and also stops the work of the group from growing organically in one direction by forcing the group to:

- Think through the underpinning issues and the causes of problems to be addressed
- Identify those areas, not represented on the group, that need to be involved.

If the HAW group allocates time to think creatively and laterally about all the issues that are relevant to HAW, then this will limit the risk of initiatives being too focused on one or two areas of interest. So a more holistic approach to the initiative will be taken. For this to work, the right mix of people needs to be at the strategy planning stage.

HAW groups tend to focus on activities that are highly visible, easy to understand, do not require specialist knowledge and which have easily measurable outputs. The case studies show that often the fundamental issues within the organisation become lost or pushed aside, such as those which might practically address the underlying causes of stress within an organisation – for example, a culture that supports or expects long working hours, or staff shortages that place unreasonable demands on employees.

HAW initiatives were more likely to have a positive impact on staff health where the five different components, as outlined in the *Framework for Action* as being essential to a workplace health programme, were covered – namely,

human resources and management practice, health and safety, occupational health, transport and environment, and lifestyle. However, only two trusts (Case study 7 – Pinderfields and Pontefract Hospitals NHS Trust; Case study 11– Hull and East Riding Community Health NHS Trust) in this study addressed all five areas of activity.

Interventions in human resources and management practice, health and safety, and environment were more likely to address the fundamental causes of workplace stress and ill health. Interventions within these areas, however, were harder to develop and implement because they required specialist knowledge, senior level commitment and resources. As a result, interventions tended to focus on occupational health and lifestyle initiatives that were, generally, easier to implement.

Human resources and management practice

HAW groups generally focused on lifestyle activities (such as healthy eating, fitness, etc), and occupational health. Generally, they did not target HR policies and health and safety assessment because the HAW group may have felt that these areas fell outside their remit or expertise. It was often the case that the HAW group did not have the expertise or power to try and instill HAW thinking into the policies and practices of established departments such as HR and health and safety. This emphasises the importance of senior representatives from these key departments working closely with the HAW group.

Health and safety

Many sites included in the case studies did not see a clear link between health and safety issues and HAW, and others assumed that it was already in place within the trust and therefore not in need of attention.
One trust did see a clear link between health and safety and HAW, as the person accountable for the initiative was the trust's risk manager, and the health and safety group within that trust was accountable for developing the HAW initiative. It is noteworthy that policy development was the main focus for this group, with less focus on organising specific activities or occupational health.

Occupational health

The case studies suggest that occupational health was a popular area to address. People involved in the initiative clearly identified HAW as related to stress and other core occupational issues – vaccinations, ergonomics, occupational health screening. It may be that the 'Health at Work' term is linked more clearly to the remit of occupational health practitioners within these organisations. Many of the issues that fall under the umbrella of occupational health, such as stress management and individual health, are obvious areas to approach within the context of such an initiative and present measurable results and outputs. It is noteworthy that occupational health was the one department that was generally always represented on the HAW group, in contrast to HR and others.

On the downside, the activities that were invariably organised under the occupational health banner tended to be of a 'plastering over the cracks' nature – dealing with the symptoms, rather than the underlying causes. Therefore the long-term, sustainable impact on employee and workplace health could be called into question.

Transport and environment

- **Transport.** HAW activities relating to transport focused mainly on providing bike storage facilities if they were not in place. Other related facilities such as showers and changing rooms were only provided in a few trusts. One trust managed to secure funding for such investment by demonstrating to senior management the alignment of such a development with the local council's green ideology, and by outlining the strategic sense of this approach. Generally though, a lack of facilities was regarded as a barrier to taking this area of the HAW initiative forward rather than being seen as a core issue for the group to address.
- **Environment.** Environment issues were rarely addressed by the HAW group. Again, these are issues (adequate heating, ventilation) that cannot be addressed at anything below senior management level. Because environmental change generally requires extensive capital investment in facilities, senior management commitment was essential to its success.
- **Lifestyle.** This area of activity was the most straightforward for the HAW group to implement. For example, the introduction of healthy eating options into staff restaurants, encouraging physical activity and the provision of complementary therapy. As a result, most HAW activity tended to be in this area. Many of these lifestyle interventions were in line with the personal interests or skills of the HAW group members.

Conclusions and recommendations

What works?

- A holistic approach to HAW that encompasses all five components of a healthy workplace programme.
- Senior management commitment to provide support and, where necessary, resources to ensure the successful implementation of activities.
- Demonstration of the strategic impact of activities to gain senior level commitment.
- HAW groups that have broad and senior-level representation including health and safety and human resources.
- Activities which go beyond the superficial and look at addressing underlying root causes that will have long-term sustainable effects on employee wellbeing.

Barriers to progress and success

The key barriers identified by participating case study trusts have already been outlined in some detail in this summary. However, the research has also highlighted that for many trusts some of these barriers have been more significant in the extent to which they hindered the development and success of their HAW strategy, with perhaps the most significant being major organisational changes such as mergers and widespread restructuring.

Drawing on the knowledge gained from the in-depth discussions with the HAW implementers and the HAW groups at each site, it is possible to list the barriers that have been identified.

- Trust mergers and other strategic changes were found to draw senior management attention away from HAW to other more pressing priorities. If this was coupled with a change of personnel at the board level, commitment to HAW had to be re-established, and in some cases a new HAW group identified. In many of the trusts interviewed, these high-level changes significantly delayed progress of the initiative, and in many cases, almost knocked HAW off the strategic agenda. It is worth noting that many trusts did not wish to participate in the research because of the extent of organisational change they were facing.
- A lack of senior management commitment, often as a result of cynicism, disinterest and failure to recognise the strategic benefits of enhancing employee health and wellbeing.
- Limited human resources allocated to working on the implementation of the initiative, often stemming, in part, from a failure to include HAW responsibility in job descriptions.
- A lack of funding, which stunted the progress of many HAW groups (but conversely has also had the effect of encouraging groups to be more ingenious about seeking alternative solutions to implementation or generating income through other means).
- Lack of physical space within which to host events, such as health fairs, yoga/fitness classes and training.
- Where there were multiple sites within a trust, it had been difficult to get commitment to attend events and to gain the full support from staff. Communication was a greater challenge and of even more importance to the success of initiatives in multi-site operations.
- The shift systems operating within trusts meant that it was difficult to hold events and activities at a time that suits even a large minority of staff. Fitness and canteen facilities, moreover, were often not accessible to staff working night shifts.
- Staff shortages and the pressurised working environment made it difficult for staff to attend organised activities, or participate in HAW groups.

Evaluating the impact of HAW

Virtually all the HAW groups discussed the difficulty of measuring the impact of HAW activities on the health and wellbeing of staff. It was generally perceived that routine management information, such as sickness absence statistics and turnover rates, provided a helpful indication of where problem areas were within the organisation. However, this data could not be relied on to provide a full and accurate assessment of the effectiveness of a particular intervention or programme of change. It was widely accepted that the very concepts of health and wellbeing are complex, and that many 'uncontrollable' factors outside the organisation and specific to the individual could mask any benefits of certain actions.

Some trusts commented that they doubted the reliability of their sickness absence figures. For example, they believed that a reasonable percentage of their absence figures were due to people with caring responsibilities for children or relatives taking time off, and not due to personal ill health. Until the culture in the organisation changed to make it acceptable for people to record the

real reasons why they were absent from work, it would be impossible to track the true impact of any workplace health endeavours.

To try and overcome some of these difficulties, the most progressive HAW groups tended to use a combination of different methods to understand the impact of specific events and the HAW initiative as a whole:

- Employee satisfaction surveys
- Feedback from attendees of specific events/ participants of specific schemes
- Sickness absence statistics
- Employee turnover
- Actual attendance at events – if people are getting benefits from activities they are more likely to attend future ones
- Increase in referrals to specialist services
- Analysis of exit interviews.

What has also emerged from the discussions at the different case study sites was a dilemma concerning the very definition of the concepts 'effective' and 'impact'. It is questionable whether an intervention has achieved its aims and effectively improved the health and wellbeing of staff if only a small number of people have reaped a positive impact (as with smoking cessation programmes) and especially if this has directed resources away from other wider ranging interventions.

It is also worth noting that most interventions tended to be of a lifestyle nature, so placing the onus on the individual to manage their own health, rather than focusing on organisational level action. For example, staff interviewed in one trust were cynical that such an approach emphasised the need for the individual to make lifestyle changes and manage their own stress, while the organisation did nothing to address the problems of under-resourcing and under-staffing that resulted in staff being stressed in the first place. Furthermore, many of the initiatives depended on individual self-selection to participate and often only appealed to a minority audience within the trust (eg running clubs and 'keep fit' classes).

Case studies – practice and learning points*

Starting points – gaining commitment and setting up the HAW group

- **Framework for Action guidance followed**
  Case study 4 – Luton and Dunstable Hospital NHS Trust, p27
  Case study 11 – Hull and East Riding Community Health NHS Trust, p50
- **HAW included in trust business plan**
  Case study 5 – Royal United Hospital, Bath, p30
- **Large HAW committee for good 'resource pool'**
  Case study 7 – Pinderfields and Pontefract Hospitals NHS Trust, p38
- **Leadership for health group** Case study 13 – Anon., p57
- **Health Promoting Hospital** Case study 13 – Anon., p57
  Case study 14 – Walsall Hospitals, p61
- **HAW coordinator and HAW implementer posts**
  Case study 15 – Parkside Community Trust, p63
- **Structured support for welfare, health, environment and community, and operations**
  Case study 16 – Kent Ambulance Trust, p66

Resources

- **Director of corporate development taken on overall implementation policy; partnership with other public sector organisations**
  Case study 11 – Hull and East Riding Community Health NHS Trust, p50
- **Internal and external resources identified as a priority**
  Case study 2 – Bedford General Hospital, p20
- **Staff lottery fund**
  Case study 7 – Pinderfields and Pontefract Hospitals NHS Trust, p38
- **Occupational health review group**
  Case study 9 – Anon., p44
- **Clinical psychologist**
  Case study 12 – Birmingham Children's Hospital NHS Trust, p53
- **Link workers** Case study 14 – Walsall Hospitals, p61
- **Set of committees addresses staff health. Committees include the board, risk management, clinical standards, health and safety, welfare, and sickness monitoring** Case study 16 – Kent Ambulance Trust, p66

Strategy planning

- **Constitution/terms of reference for HAW committee**
  Case study 1 – North West Cardiothoracic Centre – Liverpool NHS Trust, p17
  Case study 7 – Pinderfields and Pontefract Hospitals NHS Trust, p38
- **All events and activities evaluated**
  Case study 4 – Luton and Dunstable Hospital NHS Trust, p27
- **Personnel business plan; workplace stress study**
  Case study 9 – Anon., p44
- **HAW steering group**
  Case study 12 – Birmingham Children's Hospital NHS Trust, p53

*This is not an exhaustive list of all examples

Identifying the activities

- **Staff health survey**
  Case study 2 – Bedford General Hospital, p20
  Case study 5 – Royal United Hospital, Bath, p30
  Case study 6 – Anon., p34
  Case study 15 – Parkside Community Trust, p63
- **Stress index** Case study 8 – Anon., p41
  Case study 9 – Anon., p44
  Case study 12 – Birmingham Children's Hospital NHS Trust, p53
- **National campaigns**
  Case study 15 – Parkside Community Trust, p63
- **HAW group brainstorming**
  Case study 1 – North West Cardiothoracic Centre – Liverpool NHS Trust, p17
  Case study 7 – Pinderfields and Pontefract Hospitals NHS Trust, p38

Communication strategies

- **Health and safety newsletter/magazine**
  Case study 4 – Luton and Dunstable Hospital NHS Trust, p27
  Case study 11 – Hull and East Riding Community Health NHS Trust, p50
  Case study 12 – Birmingham Children's Hospital NHS Trust, p53
- **Health promotion booklet**
  Case study 7 – Pinderfields and Pontefract Hospitals NHS Trust, p38
- **Occupational health website**
  Case study 14 – Walsall Hospitals, p61

Examples of HAW activity

- **Health fairs/health promotion days**
  Case study 1 – North West Cardiothoracic Centre – Liverpool NHS Trust, p17
  Case study 4 – Luton and Dunstable Hospital NHS Trust, p27; Case study 10 – Anon., p47
- **Staff support document**
  Case study 2 – Bedford General Hospital, p20
- **Work-life balance consultancy**
  Case study 3 – Teddington, Twickenham and Hamptons Primary Care Trust, p23
  Stress management software/stress management courses/stress policy Case study 4 – Luton and Dunstable Hospital NHS Trust, p27
  Case study 8 – Anon., p41; Case study 10 – Anon., p47
- **Employee assistance programme helps tackle stress**
  Case study 5 – Royal United Hospital, Bath, p30
  Transport and parking policy/green travel plan
  Case study 5 – Royal United Hospital, Bath, p30
  Case study 13 – Anon, p57
- **Male health issues** Case study 6 – Anon., p34
- **Whistle-blowing** Case study 8 – Anon., p41
- **Plan for staff health clinic** Case study 8 – Anon., p41
- **Employee development scheme**
  Case study 11 – Hull and East Riding Community Health NHS Trust, p50
- **Fast-track back treatment for nurses**
  Case study 13 – Anon., p57
- **Implementation of the five HAW *Framework for Action* areas**
  Case study 7 – Pinderfields and Pontefract Hospitals NHS Trust, p38
  Case study 11 – Hull and East Riding Community Health NHS Trust, p50
- **Limiting violence policy**
  Case study 15 – Parkside Community Trust, p63
- **'Watch' scheme for better shift working**
  Case study 16 – Kent Ambulance Trust, p66

Barriers to progress and success

- **Lack of support at senior level**
  Case study 6 – Anon., p34; Case study 13 – Anon., p57
- **Trust mergers/change of personnel**
  Case Study 6 – Anon., p34
  Case study 7 – Pinderfields and Pontefract Hospitals NHS Trust, p38
  Case study 8 – Anon., p41
  Case study 13 – Anon., p57
  Case study 14 – Walsall Hospitals, p61
- **Lack of formal recognition for HAW responsibilities**
  Case study 2 – Bedford General Hospital, p20
  Case study 6 – Anon., p34; Case study 13 – Anon., p57
- **Initiative overload**
  Case study 10 – Anon., p47
  Case study 13 – Anon., p57
- **Multiple sites and effective communication**
  Case study 2 – Bedford General Hospital, p20
  Case study 12 – Birmingham Children's Hospital NHS Trust, p53
- **Shift systems – exclusion of staff**
  Case study 4 – Luton and Dunstable Hospital NHS Trust, p27
  Case study 5 – Royal United Hospital, Bath, p30

Evaluating the impact of HAW – methodology

- **Employee satisfaction survey**
  Case study 4 – Luton and Dunstable Hospital NHS Trust, p27; Case study 8 – Anon., p41
  Case study 11 – Hull and East Riding Community Health NHS Trust, p50
- **Feedback from attendees of specific events**
  Case study 1 – North West Cardiothoracic Centre – Liverpool NHS Trust, p17
  Case study 2 – Bedford General Hospital, p20
  Case study 8 – Anon., p41
  Case study 12 – Birmingham Children's Hospital NHS Trust, p53
  Case study 14 – Walsall Hospitals, p61
- **Sickness absence statistics**
  Case study 1 – North West Cardiothoracic Centre – Liverpool NHS Trust, p17
  Case study 8 – Anon., p41
  Case study 12 – Birmingham's Children's Hospital NHS Trust, p53
- **Increase in referrals to specialist services**
  Case study 4 – Luton and Dunstable Hospital NHS Trust, p27
  Case study 5 – Royal United Hospital, Bath, p30
  Case study 12 – Birmingham Children's Hospital NHS Trust, p53

Key conclusion

Many HAW groups are not addressing the fundamental issues. They are often not operating at a high enough strategic level to identify and question the underlying issues that are causing ill health at work. Those HAW groups without board-level representation have less organisational power, and so less access to and direction over the resources required, resulting in the need to overcome a significant barrier to effect real change. Instead, the type of activities that are being conducted are sometimes of a 'lifestyle' nature, focusing on individual action, eg smoking cessation, healthy eating and fitness. Such initiatives are the easiest to implement given a limited power base, and do not require change or a shift in culture within the organisation.

Key recommendations

- The instigation of HAW as an initiative needs to be implemented at director level to ensure there is the authority to build HAW into the core strategies of the organisation and to advocate the importance of HAW to the rest of the organisation.
- Senior level commitment to the initiative should be publicly demonstrated and resources, financial as well as key personnel, made available where possible.
- A board-level champion for HAW is essential to its success and will help to obtain funding for key strategic initiatives.
- HAW groups should be given a clear remit by senior management. The work of the group should be considered strategic to the organisation, and incorporated into business planning, while also including staff consultation in the planning process. HAW groups should develop action plans and report regularly to the board on their progress.
- HAW groups should develop their strategy and draw up clear success criteria. Evaluation and review methodology should be considered at an early stage of strategy development.
- The HAW group should comprise individuals with a broad remit and from different levels and parts of the organisation. Senior representation from areas such as occupational health, human resources and health and safety is essential. Staff at lower ends of the hierarchy should also be included in the group to ensure that the group is representative of the organisation.
- Implementers and HAW group participants should not work in isolation. Establishing and maintaining links with similar groups in other trusts can be a useful learning experience, avoids re-inventing the wheel and often enables trusts to pool or share limited resources.
- Groups should not be put off by limited resources – many trusts have achieved a range of activities by taking an innovative and creative approach, gaining community sponsorship and utilising links with other organisations to mutual benefit.
- Organisations should endeavour to establish staff needs through monitoring organisational records, consultation with staff, and staff surveys. Although the initiative has flourished where members of staff have a personal interest in HAW, they should avoid the initiative being driven purely by those interests as the broad focus of the initiative may be lost.
- Success will be achieved by going beyond the superficial and investigating and addressing the real issues causing ill health. High incidences of absence through back pain will not be resolved by providing fast-track physiotherapy, although it may help to decrease absence times. Identifying the cause of the problem and campaigning for improvements, whether it be procedural, cultural or technical in nature, will demonstrate long-term sustainable benefits to the organisation.
- Establish a clear communication strategy. Find out what forms of communication are most favoured by employees. Ensure that communication is targeted at the widest possible audience. Review and revise communication if necessary.
- Endeavour to approach all five components of a healthy workplace programme. Do not simply focus on the easy option. Seek advice from other organisations if necessary on how to develop a broad approach.
- Ensure that the HAW group is made up of people with relevant expertise and experience. Commitment to the cause and drive to make things happen is also an essential requirement for participants.
- Ensure that people within the HAW group take ownership of different aspects of the initiative. The implementer is the coordinator of the strategy within the trust and should not be required to do all the work.

Appendix: Case studies

Case study 1 – North West Cardiothoracic Centre – Liverpool NHS Trust

Background

The trust is a small-sized hospital of fewer than 1,000 staff, with no A&E unit. It has a limited amount of space within which activities can be organised. Financial funding for the trust's HAW group is available from several different trust budgets, but there is no direct budget available for the initiative. The HAW coordinator and the HAW group members identified the types of activities that could be conducted within the bounds of the trust's spatial and financial constraints.

Implementation process

Starting points

The commencement of the initiative in this trust began through interest of members of the HR team rather than at an organisational/strategic level. In 1997, one member of the HR team, who was working in partnership with local NHS trusts on other health promotion initiatives, realised that the trust should also be involved in HAW activities. Based on the activities in these other trusts, the HR officer recommended to the head of HR that the trust should be doing something in relation to HAW. This prompted further investigation into the initiative and the setting up of the HAW group.

The HR officer considered the types of activities that HAW could include, and based on this, identified who should be included in a HAW committee. The committee then refined the list of activities that the group would focus on. Since establishing the committee, there have been some personnel changes. The group is currently chaired by another member of the HR team. To ensure that the work of the group was structured and comprehensive, the regional coordinator recommended to the HAW chair that an action plan be developed. This plan identified what had been done so far in relation to HAW issues and what still needed to be done in the trust. This document is regularly reviewed by the HAW coordinator with the support of the rest of the group during quarterly committee meetings.

Resources

The HAW committee was selected from a cross-section of staff, based on volunteers who were interested in or who had expertise in the type of activities planned. Inclusion in the committee was not linked to any functional post within the trust. The group included a dietician, physiotherapists, nurses and members of HR, among others. Since the initial set up of the HAW group, new members have been elected as projects/activities have developed and different expertise or skills have been needed. One issue for the group has been the lack of representation from occupational health, due to lack of resources in that department. The group would also like more involvement from doctors, but work patterns often compete for priority.

The HAW group meets formally every two to three months and staff are given work time to be involved in the group's activities. Likewise, the coordinator, although not allocated specific time in their job description, generally has time available to dedicate to the group. It is felt that the group would benefit further if one person had perhaps half of their time formally allocated to coordinating the work of the group.

The group reports to the board of directors, which controls several other related committees, such as the health and safety committee, which also has HAW as an

agenda item. Therefore there is wider support for the HAW remit than those directly involved in the HAW group. The board of directors is very supportive of the group, with the HAW initiative included on meeting agendas and funding is forthcoming for activities as needed. Currently, no member of the board is on the HAW group; however, a HR manager is joining the group and is a member of the HR development group, which reports to the board.

There is no separate budget for HAW activities but financial support is available to the group as required. For example, the board is able to offer resources from various trust funds to support activities.

Strategy planning

Once the committee was set up, it formalised a constitution outlining what was expected of the group and what the objectives were (see panel for example of contents). Based on these objectives, it outlined 12 action points (see panel for example action points). With the support of the regional coordinator, the HAW group has become more formally managed since 1999. The trust has received a lot of support from the regional coordinator, who has provided a checklist to assess and evaluate the work done, and guidance on structuring the activities.

Example of contents of workplace health strategy document

1 Definition of workplace health and its related strategy.
2 Aims and objectives of the strategy with regard to human resources and management practice, health and safety, occupational health, transport and environment, and lifestyle.
3 Resources allocated to strategy.
4 Definition of responsibilities of the HAW group and other similar groups, such as health and safety committee and human resources and how they will contribute to the HAW group.
5 Examples of activities that the HAW group may support/lead.
6 How evaluation of activities will be carried out.

Action plan

Example action points include:

- Organise a health open day
- Attend external events on HAW and network ideas
- Keep abreast of the HAW work in other trusts.

The idea for the constitution being put in place originated within the trust, as all other steering groups within the trust have a remit for their work. This constitution has allowed the group to both identify what it should be doing and how the activities of other workgroups affect the group; it has also allowed it to differentiate its work from other committees such as the health and safety committee. For example, a HR development group would be responsible for monitoring the effectiveness of the HAW communication strategy and publicity which, as mentioned earlier, reports to the board.

Identifying the activities

The constitution also details how the group identifies and evaluates its activities. At present, members of the HAW group discuss ideas with staff from their division/department. The HAW members then have the responsibility to report those ideas back to the committee. The group recognises the need to improve consultation processes and is planning to add HAW questions to the annual staff survey and conduct a stress and health audit. Gradually, these surveys will be used to evaluate activities and the overall impact on staff health, and help form future action planning.

Communication strategies

HAW group members are responsible for feedback to members of the division they represent on the committee. Staff are able to communicate to the HAW group through staff council meetings as a member of the HAW group is also on the staff council. Emails are sent informing staff regularly about activities and events.

The group has found that it is difficult to communicate to all staff through one method of communication; for example, nurses do not have direct access to their own computer, so prefer posters on an allocated noticeboard. There is a section in the staff newsletter to inform staff about HAW activities which is accessible to all staff but cannot be used for short notice events. The staff are likely to know where to find information about HAW if they are looking for it.

Generally, a large amount of the communication is done informally as staff come into HR about another matter. There is also a noticeboard for HAW notices. Team briefings are a good form of communication for larger events. Only a few items are allowed on the core team briefing agenda each month, and smaller events are not always considered a priority agenda item.

Examples of HAW activity

In the current action plan, the most successful activity identified is to conduct a health fair for all staff in the trust. This is a repeat event based on the success of the fair held the year before. The HAW coordinator managed the organisation of the previous fair. Staff who had training in aromatherapy and massaging supported the event by giving staff free 20 minute sessions, as did an aerobics instructor, chiropodist and dietician, who were all trust staff. The trust's PR manager used contacts to arrange support from local companies for the fair.

Staff felt that the day had been well advertised through emails, posters and fliers in payslips though some of the nursing staff were still unaware of the event, showing that it can be difficult to reach all staff. At the end of the fair, feedback was sought from attendees through an evaluation questionnaire, with all staff reported to have enjoyed the day and feeling that it increased their awareness of the health initiative more generally.

The event was thought to be popular among staff as there is less time to wait for these types of health checks when compared with GP waiting lists. The checks were also free of charge to staff and so were viewed to be a benefit of the job. Feedback that will be considered for next year's event include the need for a specific health fair for men and the inclusion of a dentist in the list of health professionals.

The barriers

There is a lack of space for activities. For example, aerobics classes can no longer be conducted on site as there is no room available which is large enough. Likewise, due to demand from staff, the health fair would be even more successful if there was more space for activities.

Impact on staff health

There has been a drop in recorded sickness absence of just under 1.5%. Although the work of the HAW group is not necessarily a causal link to this reduction, it would be difficult to assess the impact of the group's work. For example, there has been a change in the recording of sickness absence which may have affected the statistics reported. Conversely, long-term increases in pressure in the work environment can affect sickness figures and so this may not be considered a highly reliable indicator of the work of the HAW group. The HAW group's composition is also being reviewed so that additional members who may have interests in new projects can be included.

Lessons learnt

What went well?

- Liaison with regional coordinator about strategic issues and evaluation techniques to gain understanding of good practice examples.
- Gaining the support of local companies to help set up the health fair – they offered expert volunteers while limiting the overall cost of the event for the trust.
- Using a variety of communication strategies in an attempt to access all staff groups about at least some, if not all, activities.

Things to improve

- Insufficient staff were aware of a funded counselling service. This has now been addressed by a poster exercise.
- Aerobics classes were moved to another location offsite, as there was no space. With poorer access to the new location there has been a drop in support for the activity. The trust has now found a new location offsite for pilates classes.
- Lunchtime lectures were well attended by office staff but less so by medical staff who were less likely to be available at this time.
- There is evidence from the research that the differing perspectives of what staff want and what activities were being conducted by the group may be affecting the support of various activities. More active consultation with staff during action planning stages would be beneficial – this is now happening under the umbrella of the Improving Working Lives initiative.

What would they have done differently?

The HAW group would prefer to have a coordinator who has specific responsibility for the initiative included in their job description. It is thought that this would reduce the number of group members who have responsibility for implementing different activities and would ensure that at least one individual would have adequate time to manage the overall strategy.

Case study 2 – Bedford General Hospital

Background

The trust is an acute hospital which employs approximately 2,000 staff. Some work had previously been linked to the HAW initiative, but the majority of activity has occurred since the arrival of the current HAW implementer in early 2000.

One of the main focuses of the trust in relation to HAW is to empower staff to address their own health needs, providing information to staff about what they can do to improve their health, including conducting activities such as yoga classes.

Implementation process

Starting points

Prior to the implementation of the initiative in the trust, there had been some work conducted by the occupational health department on health promotion. Activity has mainly been in place since mid-2000, although some work was conducted by the HAW group from 1997. During this time there had been a few meetings which focused on setting up the trust's approach to HAW and ensuring that a post was funded for a coordinator who would be responsible for moving the initiative forward in the trust.

Resources

The coordinator's post has been funded part time by the trust, although additional responsibilities of the post are linked to the HR and occupational health teams, including sickness absence management and service delivery management, respectively. The main performance targets for the post are linked to reducing sickness absence and indirectly relate to the improvement of health of staff in the trust. In relation to personnel, only the implementer has responsibility for HAW included in their role profile. Some activities are therefore difficult to implement as not many staff have much time available to be involved.

HAW group meetings are conducted every two to three months. An agenda for the meeting is distributed to attendees prior to attendance at the meeting so that staff have the opportunity to add any additional items. The HAW coordinator encourages the group to be quite informal during the meetings as it is felt that this supports more creativity and discussion. The coordinator offers healthy refreshments during the meeting, such as drinks other than tea and coffee and dried fruit rather than biscuits.

Once the minutes and related activities have been discussed, the group then considers more strategic issues. These could be new events to hold, and national changes that may affect the group such as the introduction of the Improving Working Lives (IWL) initiative. IWL may affect the reporting structure of the group as HAW may come under its umbrella.

There is no specific financial budget within the trust for HAW activities, although it is able to obtain some money from the HR and health and safety budgets. Funding in kind is received from local companies such as LA Fitness, Jordans, Tesco, Sainsbury's and Boots, through vouchers and reps attending the health open days giving advice. Vouchers are included in quizzes to encourage attendance at the fairs.

Strategy planning

The HAW coordinator set up an action plan with completion dates expected for each event and activity. This plan is updated at the quarterly HAW meeting. In addition to the action plan for the HAW group, the initiative has also been included in departmental action plans so that all staff take some responsibility for their health in the workplace.

The coordinator supports departmental managers in designing plans for training workshops that aim to increase awareness about a variety of workplace health issues. This includes violence at work training, which addresses exposure to violent behaviour from patients and maybe other staff. These departmental plans are then forwarded to the implementer, who is able to see what individual departments are doing and collate this information for a strategic view of HAW within the trust.

Identifying the activities

Staff attitude surveys help to determine the action plan for the HAW group. Occupational health (OH) surveys are also carried out to assess staff health needs and to identify services that staff would like from the OH unit. Activities are evaluated and reviewed through a post-activity feedback questionnaire.

Initially, events were identified by the HAW group, such as a health fair, which took place in late 2000. After this event, staff had the opportunity to complete a feedback questionnaire, which asked them about suggestions for new activities and also whether they would like to be involved in the overall health promotion initiative. The questionnaire was available to staff involved in running the fair as well as to those who attended the event. These suggestions were then followed through by the implementer and introduced at the HAW group meeting to assess potential support for the activity and what could be practically done. For example, the introduction of sports teams to the hospital was suggested with the prospect of increasing social interaction among staff while being in the context of health improvement. The group looked into the introduction of a staff social committee, which is now in place and includes a member of the HAW group.

The trust also aims to identify possible HAW activities through targeting internal users of the occupational health service via a specific satisfaction survey for users of the service. Questions included in the questionnaire involve identifying the level of staff awareness of what the OH service provides and ideas about what should be provided in the future. This information has then been used to consider the introduction of new services that can be linked to HAW group activity. The trust has also conducted a staff opinion survey that will support the review of what has been done so far.

Communication strategies

Posters and fliers are available for staff with details of who to contact for certain activities. For example, a leaflet is available for the counselling service, containing information about the service as well as a direct line contact number so staff do not need to go through occupational health to see the counsellor. The back page of the trust's newsletter is dedicated to OH and HAW issues.

Another example is a hospital watch scheme, the aim of which is communicated to staff by a colour leaflet that includes information about what to do if they want to report an incident and the information that they need to do so, as well as more general information about maintaining security.

Many staff have informal links with members of the OH and HR teams, who are able to advertise upcoming events by word of mouth as well as sending posters and fliers via internal mail to teams and departments. Information is also sent out with payslips and communicated through team briefings as appropriate.

Examples of HAW activity

A staff support strategy document has been written as a manual for staff to identify the different activities that the trust conducts that are linked to HAW. This document collates the different activities that already relate to the HAW initiative as well as those that are implemented by the HAW group. It is important to address what is already being done.

The trust has conducted awareness days or weeks on specific topics. These sessions were identified as a HAW activity through staff consultation from feedback questionnaires. For example, in 2001 the trust held an awareness week about the NHS zero tolerance campaign, including violence at work and the health and safety implications for staff. The HAW committee has identified the necessary training required for individual employees; assessed the security levels for staff at all times; given staff equipment to help them protect themselves; and ensured that visitors and patients who are abusive are reported and receive a letter of warning from the chief executive.

A workshop was conducted to inform conference attendees, including executive directors and directorate managers about violence in the workplace, and identified what else could be done in relation to tackling violence at work in the trust. Information about what other trusts have done was also collated and presented at the workshop. The feedback received from the workshop was used to update the current personnel policies that the organisation has in relation to violence at work.

Leaflets are available to staff, such as information on complementary therapies, which may be booked via the HAW coordinator. The complementary therapies are offered at a discount to staff and a proportion of the cost is given to the hospital charity.

The barriers

- The implementer has no recognised deputy in another post, so if he or she is away or leaves then there will be a lack of continuity and knowledge of activities and history of the post will be lost.

- The fact that the buildings are physically spread out has created some communication difficulties within the trust; for example, noticeboards and posters have not been found to be effective in reaching all staff. However, this barrier has been overcome by using alternative methods of communication such as departmental posters, which are the responsibility of the team to place somewhere in their area.

Impact on staff health

There are feedback questionnaires available to attendees at events which allow staff to comment on their experiences as well as suggestions for other activities. The trust has recently conducted a general staff attitude survey which, as one of its objectives, will assess the impact that the HAW activities are having on staff health and welfare.

Lessons learnt

What went well?

- It was ensured that one person was not made solely responsible for too many activities as they are less likely to volunteer in future, especially if they have limited time. The resources available were spread across the different activities.
- Resources and companies in the locality were identified that can support different initiatives and a database of these resources is maintained with information about what services organisations are willing to offer. This can include internal resources too. Resources may also include pupils from a local college, such as beauty students, who need experience but will not necessarily charge.
- The objectives/remit for the group were defined to maintain focus of what activities it is responsible for on a long-term basis. In this way, the team does not lose direction of what the HAW initiative is aiming to encompass. The implementer also identified the roles of the members of the HAW group and made them aware of what is expected of them as part of the team.
- A staff support strategy document has been collated, which can then be distributed to staff so they are able to see the various activities that are available to them both on and offsite.
- In-house staff expertise has been used to collate information for staff on health-related issues, which was then included in the staff support strategy document.
- There has been a closer working relationship between the HR and OH teams, as the HAW initiative has linked some of the work of the two groups together.

What went wrong?

The HAW implementer believes that there has not been any major problems with the initiative or individual activities, but they do try to learn where they can improve.

What would they have done differently?

The HAW group would have liked to have included HAW questions in the most recent general staff survey rather than relying on feedback from those staff who have attended events, as this would allow the HAW committee to reach a broader audience of staff for consultation. However, HAW related questions are included in the recent staff attitude survey.

Case study 3 – Teddington, Twickenham and Hamptons Primary Care Trust

Background

The organisation is a small primary care trust with fewer than 200 employees. It has recently been transformed into a primary care trust. The person with ultimate accountability for HAW in the NHS is the human resources manager, who joined the trust in the last 18 months. Prior to this appointment, the trust did not have its own HR function. As the trust has been through an extensive period of organisational change, HAW in the NHS was not on its list of priorities. Since the HR manager's appointment, HAW has become a priority, and action is beginning to take place.

The role of HAW is not included specifically in the job description of the HR manager, but it is regarded as an essential HR initiative and therefore resides logically within this role. There is no specific budget available for funding the initiative.

Implementation process

Starting points

Prior to the appointment of the HR manager, no work had been done in this trust on HAW in the NHS. The trust had an occupational health structure in place, which was basically a 'pay as you go' service offered by a neighbouring hospital. The only health initiative that the trust provided was a health assessment for new employees on their appointment. So there was no activity on HAW in the trust unless someone from the occupational health service highlighted a specific need – for example, if someone required smoking cessation, the trust would organise something as and when required.

The trust management took the view that they had a duty to comply with the initiative, and included it in their HR performance indicators. With increasing management rigor as the trust grew in size and underwent extensive change, the need for management to address the issue of support for employees became apparent.

As the organisation is small, the same individuals generally end up on different committees and work pressures make it difficult to recruit new people to such committees. The decision was taken that, to avoid duplication, the newly formed health and safety committee would assume responsibility for implementing the initiative. There is no over-riding HAW strategy in the trust, although the health and safety committee has drafted action plans for each of the different initiatives the trust is pursuing under the HAW umbrella. However, there is no clear specification for what the trust is hoping to achieve through the promotion of HAW.

Resources

The health and safety committee. As people are under pressure in this small trust, it was believed that it would not be feasible to set up a separate HAW group. The trust's health and safety committee is the key group for taking the initiative forward. The committee was selected from volunteers from a cross-section of the organisation, and includes representatives from the different union and professional bodies, plus representatives from all levels of staff, including staff nurses, clerical and administrative staff.

As the trust is so small, it buys in a lot of skills, such as the fire adviser, estates adviser, and the health and safety adviser, all of whom sit on the committee. The committee also has representation from the general management team, including the head of human resources, the director of clinical services, and the community services manager. Due to the level of representation, the health and safety committee has relatively high clout within the trust. The health and safety committee meets every two months.

Management support. Managers within the trust are responsible for implementing various aspects of HAW. The trust has a very small management structure, and managers have recently been focused on the organisational change process, so attention has largely been targeted at implementing the change rather than focusing on HAW. It is anticipated that this change process will pull the organisation away from fully addressing HAW for the foreseeable future.

The new chair of the trust, who has publicly expressed her commitment to Improving Working Lives (IWL), will be heavily involved in taking both initiatives forward. She has, so far, acted as a champion of the IWL initiative and is dedicated to seeing improvements in the occupational health structure, in particular. However, the committee is well aware that managers need constant reminding that

they need to be committed to both the HAW and IWL initiatives.

Financial resources. There is no separate budget for HAW activities but funds have been available to the group as required. Getting money for some initiatives has been problematic. One initiative involved bringing in external consultants, and in particular this has been difficult in terms of funding. The general view is that there are a lot of ideas with limited money to back them up.

The appointment of a new finance director in the last year has been an advantage to the group and the development of the initiatives, as he has a new approach. Since his appointment, there has been no need to fight to get HAW items onto the finance agenda.

Strategy planning

In terms of the Workplace Health Cycle, the trust is at the early stage of setting up the initiative, and is confident that it has built a healthy foundation on which to launch its strategy. For implementing HAW, it has been a mainly top-down approach with the management team agreeing with human resources which initiatives can and should be implemented, with responsibility for taking the initiatives forward falling to the health and safety committee.

A relatively ad hoc approach has been taken to implementing HAW in this trust. The trust has not used the *Framework for Action*; no formal model of change management has been used to implement the various initiatives. The HR manager says that while she recognises that she should have followed the *Framework for Action*, she has not seen a copy of the document since arriving in post at the trust. However, the *Framework for Action* has recently arrived on her desk, and is currently being considered.

The HR manager regrets being unable to attend many of the meetings organised by the local HAW coordinator, due to time constraints, as these meetings offered an opportunity for learning from others. However, networking and social contacts with other colleagues in other trusts enabled this sharing to happen on an informal, ad hoc basis.

Identifying the activities

A general awareness that the existing 'pay as you go' occupational health arrangement with a neighbouring hospital was insufficient meant that the first focus of attention was that a occupational health service should be provided at the trust. Feedback from management and staff indicated that there was a need to enhance the level of support offered to staff.

Feedback from the staff attitude survey also contributed to the focus on improving services in occupational health. Within the trust major concerns for staff revolve around safety. In the latest survey the only real issue to emerge regarding HAW was access to counselling. Counselling services have always been available to staff but on an ad hoc basis, so the committee has aimed to address this through the proposed enhancements in the occupational health service.

To further inform the strategy, it was decided to focus on finding out what the main recruitment and retention issues are within the trust. The trust believes that a key benefit to employees is that it is a flexible employer but at present it is not using this as marketing tool in the recruitment strategy. Some money has been received through the HAW initiative to start a project to identify the flexible working issues in the organisation.

Consultation with staff highlighted that there is an issue with violence and aggression at work, which has provided another focus for the committee. There is also a focus on sickness, especially stress. Although the trust does not believe that it has a particular problem with sickness levels (current sickness rates are lower than other trusts, and are less than the national average), it is aware that there are some long-term sickness issues within the organisation and feels that it would be beneficial to investigate the reasons behind these particular cases, and lower the current sickness rate to an agreed target level.

For the benefit of staff and their general wellbeing, the committee has decided to focus on smoking cessation, and healthy eating advice to individuals, on request. Support will be provided to managers on how to provide a healthy workplace. Sessions will be also be run at each site to monitor weight, blood pressure, and cholesterol levels. A number of stress management courses are also in the pipeline.

The committee is aware that the initiatives under development are not focused on specific groups of people, but are confident that all employees will benefit

from improved flexible working arrangements and health promotion activities. The training on violence and aggression will be of benefit to all employees, particularly those working in high risk areas. It is likely that initiatives focusing on long-term sickness will be targeted at areas with particular problems with stress; for example, where staff are dealing with psychiatric patients.

Communication strategies

The committee has addressed communication through a number of different channels. It believes that staff will be supportive of endeavours in which they see personal value. The group is confident that staff will be interested in the health promotion sessions, and staff demonstrated interest in participating in the research on work-life balance/flexibility issues (see p26).

Most initiatives are communicated through team briefings, which demonstrates management commitment to the various initiatives. Briefings are generally backed up by posters, promotional flyers, and articles in the staff newsletter *Check Up*, in which there is a regular human resources update section.

The members of the health and safety committee are also used as key links in the communication process, by using their knowledge, skills and experience to the best advantage. Their role is not only to disseminate information to staff and raise interest in the overall programme, but to get feedback with which to inform the committee.

Examples of HAW activity

Agreeing the new occupational health service. The human resources manager worked in conjunction with the community service manager and the occupational health manager to scope out the required occupational health service. The specification was drafted on the basis of the level of service they would like to provide to staff, which would involve every new member of staff attending a face to face meeting with occupational health (as opposed to simply completing a questionnaire), and regular health check sessions. The specification was sent to the management team for approval, and to the occupational health department for a feasibility assessment. The finance department was consulted as additional resources were required. They were successful, thanks largely to the new finance director, in getting an additional funding, which enabled them to implement the policy and the various health promotion sessions and courses.

Work-life balance. This initiative involved using external consultants to come in for a week to look at existing policies (eg job share, caring policies), and to run focus groups to consult staff on what they would like to see the trust focusing on to improve the flexibility of working conditions. Management were also consulted with regard to the dilemmas of balancing what people want with the business needs.

The objective of this exercise is to focus the trust on addressing what it can introduce to meet staff needs and wishes, while at the same time keeping the business going. This work has now been completed, and it is envisaged that the committee will focus on reviewing policies where necessary, and look at alternatives for childcare provision. As a result of the research, the HR manager will work with an external consultant to develop a skeleton business case for flexible working patterns and policies, which will be submitted to the board.

Smoking cessation. There are a number of issues concerning the need for a smoking policy within the trust. Currently, there is a major debate on whether to ban smoking altogether, with a particular focus on how such a policy will affect visitors and patients. There is concern that many staff are subject to passive smoking by allowing visitors and patients to smoke in some parts of the building. The health and safety committee has drafted a smoking policy, which is currently under consultation.

Violence and aggression. The health and safety committee has drafted a policy to address this issue. Committee members have all attended training in dealing with violence and aggression, which will ultimately be rolled out to staff. The policy focuses on how to safeguard individuals in different areas of the trust, as they are all subject to different types of risk. Individual safety in the workplace, as previously mentioned, is a major concern for most employees.

The barriers

The development and launch of the initiative has been slow because of other priorities in the trust over the past year. Lack of resources, both financial and human, have been the main barrier to getting HAW off the ground. The process is regarded as time consuming and costly and it is essential to sort out evaluation methods to be

able to demonstrate that the initiatives are making a difference. The difficulty is in finding the resources to do all of this comprehensively.

Impact on staff health

As the initiatives are only in the development phase, it is impossible to evaluate the impact or success of the work. There is some concern that there are no clear success criteria laid out at this stage, but it is believed that it will be possible to measure the success of the initiative. In particular, the occupational health policy will be easy to monitor. There is a belief that monitoring HAW in the NHS is difficult as the remit is so vague but that the Improving Working Lives initiative will be much easier, as trusts are required to make a pledge and monitor their progress against that.

The trust hopes to be able to measure the success of its initiatives through sickness rates and turnover levels. Stress levels will be useful, but the trust has not yet defined how it will measure the impact. Exit interviews will also be a useful source of information and HR will integrate information from exit interviews into the trust's retention strategy. HR is aiming to establish a process whereby initial meetings with staff on why they joined the trust will be followed up six months later to see if expectations are being met.

It was envisaged that the benefits of the occupational health contract would begin to show by late summer 2001. The focus groups investigating the flexibility issues have raised a lot of interest in HAW within the trust and staff are beginning to become focused on the initiatives and what is on offer.

Management expects to measure the impact of the initiatives through the feedback they receive from service managers. For example, they expect that service managers will begin to face dilemmas on how to meet staff needs for flexibility while still meeting the business needs.

Lessons learnt

What went well?

- The involvement of management people on the health and safety committee, demonstrating real commitment from top management.
- The support of the trust chair.
- The support of the new finance director, who put the HAW initiative on the finance agenda.
- The different levels of staff on the health and safety committee, and the use of the different skills of those members.
- The autonomy given to the committee in developing the initiatives – very little interference from management, but great levels of support.
- Being very 'driven', and focusing on action points – the need to keep the initiative on the agenda and generating action points at all times.
- The ethos/culture in the trust meant that real commitment to the initiative was there from the top down. The more senior people involved in taking such an initiative forward, the easier it is to integrate the activity into the ethos of the organisation.

Things to improve on

- Ensuring a greater level of involvement with the regional coordinator's network for sharing and learning, and to gain an insight into best practice in other trusts.
- Need to raise the profile of HAW in the trust – should have pushed the profile of HAW as an overall strategic issue, rather than pushing through each individual issue.
- Ensure that there is real commitment to the initiative. Need to be aware that often these initiatives are given lip-service.

What would they have done differently?

If people resources were not an issue, the trust would have a dedicated group focusing on HAW issues. The trust also recognises the need to take a more strategic and focused approach. There is a strong belief that more involvement in the local network would have helped the HR manager to take a more strategic approach by learning from the experience of others.

Case study 4 – Luton and Dunstable Hospital NHS Trust

Background

The trust has about 2,500 employees. The occupational health services manager has overall responsibility for the HAW in the NHS initiative within the trust, and has been chair of the HAW group for the past year. The occupational health department has a leading role in the overall process of health promotion within the trust, and so it is logical that the responsibility for HAW falls to the occupational health services manager. Health promotion is a recognised part of the manager's job description, but involvement with the HAW group and the work they do within the trust is not recognised in any formal way.

Implementation process

Starting points

The main drivers in the trust for the instigation of HAW in the NHS are to improve staff morale and to reduce sickness/absence figures. The HAW group has endeavoured to identify initiatives on the basis of staff feedback. The group followed the *Framework for Action* and the specified standards, made sure it had relevant policies in place and evaluated and compared against the *Framework for Action* at all times. The group is rigorous about evaluating the effectiveness of its work at all stages of the process. Future initiatives are largely guided by what staff say they want through the evaluation forms.

Training is built into the plan where relevant. For example, training for managers on how to recognise people who may be experiencing difficulty coping with work is an essential part of the stress management process. Trust directorates are in the process of organising 'away days' and they aim to include health topics, which may be run by occupational health.

The group believes that it is responsive to specific needs and will bring in external specialist support if appropriate. Safe-handling training is given to the whole trust and also targeted at individual departments which have more specific problems. They also have a fast-tracked physiotherapy service for people with musculo-skeletal problems affecting their work.

Resources

The Health at Work group. The group meets every quarter. It adopts the view that anything which makes working life better will have a beneficial impact on the health of employees, and therefore is relevant to its remit. The group was set up about five years ago. Originally, it focused on drafting and reviewing policies, but has taken a more proactive approach in recent years towards organising HAW-related events and activities. The group had very clear terms of reference from the outset:

- To develop, manage and evaluate a HAW programme for the trust
- To ensure that members of the group work to an agreed action plan including evaluation
- To communicate the plan across the trust, and consult with staff at all opportunities
- To report annually to the trust board, and meet quarterly to review progress
- To ensure networks are established on a local and national level, to ensure congruence with national quality standards for HAW.

The group followed the *Framework for Action*, and set out with the intention of achieving the Health at Work Award, but the process of setting up the initiative took much longer than anticipated. The HAW group comprises the occupational health services manager, the general manager for health promotion, the catering manager, the genito-urinary medicine manager, backcare adviser, and two senior nurses.

Management support. The HAW group believes that there is good commitment from senior people in the trust. The directors take part in 'lunch & learn' events, and the chief executive demonstrates support by opening large events. All directors are thought to be champions of the cause. However, there is less commitment from the medical side. The group does not need to get approval from the trust board to go ahead with various initiatives.

Financial resources. A small fund (of a couple of thousand pounds) was originally made available for the HAW group. Currently there are no financial resources available. The occupational health department generates income, which is useful for funding initiatives. Many initiatives which the HAW group pursues, however, do not require funds, and it is adept at getting volunteers to

donate their services. However, the group recognises that it could do a lot more if it had money.

Strategy planning

Staff needs and wants are generally the drivers behind initiatives. The focus for planning is based on survey feedback, statistics such as sickness/absence, and accident reports. Investigating the primary reason people are absent – for example, back pain – might indicate the need for an initiative within the trust.

The accident reporting process, while a useful indicator of the need for action, is recognised to be flawed, as it is thought that people may often fail to report accidents. For instance, reports of violence to staff appeared to be quite low but there was concern that this was due to low reporting levels and the difficulty of the reporting process. As a result, the group has addressed and reviewed the accident reporting procedure to make it easier for staff to report incidents.

The HAW group avoids being guided by staff whim and preference. While it takes heed of survey feedback, it is more likely to prioritise activities suggested by hard statistics. Staff in occupational health are aware of the real issues and problems within the trust, especially problems such as bullying, harassment and stress. The specific interests or expertise of people on the group may also influence the direction taken.

While a number of policies have been reviewed by the HAW group, the three policies to have resulted from HAW activity are the bullying and harassment policy, the control of smoking, and prevention of violence and staff aggression.

All events/activities are evaluated. Evaluation forms are given to participants at each event to seek feedback on:

- The extent to which the event met or failed to meet expectations
- The ways in which participants have benefited from attending the event
- Recommendations on how to run events in the future
- Whether participants would recommend the event to others, and why
- Input of ideas for future events.

The usual reward for completion is entry into a prize draw.

Identifying the activities.

The focus for activities has been based on staff feedback in surveys, evaluation of existing initiatives with reference to future activities, and statistics, such as absence/sickness records, and accident reports. General awareness within the occupational health department about issues within the trust has also guided activity. The expertise and interest areas of members of the HAW group has also led to the initiation of some activities.

There was awareness within the trust that some of the existing policies needed to be updated. For example, the trust originally had a no smoking policy, but it was recognised, on the basis of staff feedback, that this policy was unrealistic. Therefore the policy was reviewed and replaced with a 'control of smoking' policy. This new policy is more specific, and identifies where smoking room facilities are located. The violence and aggression to staff policy was also reviewed to be more specific, and explains the type of support which is available to staff if there is an incident, and makes reference to the availability of training on how to deal with, and avoid, workplace violence.

Communication strategies

The group believes that it is essential to approach communication from all angles, but feels that well-positioned, bright posters are the most effective medium. Email is becoming an increasingly used and effective medium, but not everyone within the trust has access to PCs. Good managers communicate initiatives through the team briefing process once a month. The main communication channels used are as follows.

- All staff receive a half hour induction session from occupational health or personnel on joining the trust. The purpose is to explain the various benefits that are available to staff, including the HAW initiatives.
- The health and safety newsletter is a key communication source and focuses on an occupational health issue each month. To make the issue of occupational health more accessible and relevant to readers, the group developed a character called Occy Elf, who is an investigator of health and safety crime. In each issue, Occy Elf reports on an issues related to occupational health in a story format. This approach has gone down very well with readers; eg Occy Elf drinks too much coffee; a word of warning from Occy Elf (drugs); Mrs Xmas getting drunk; the diary of Occy Elf aged 34 (putting on weight); etc.

- Recently, policies have been put on the intranet. In the past all the polices were in a manual in the manager's office. Putting them on the intranet will make them a lot more accessible, although it is recognised that there are still a lot of staff in the trust who do not have access to electronic forms of communication.
- Staff newsletter.
- Bright yellow posters for 'lunch & learn' are placed on staff noticeboards.

Examples of HAW activity

A number of initiatives have been instigated under the HAW in the NHS umbrella. The details of the key initiatives are as follows.

Health promotion open days. The HAW group has organised a number of open days focusing on different aspects of health promotion. These events have been highly interactive and have focused on raising awareness of alternative therapies. Events are held during work time and are free to staff. Fitness testing, alcohol services, and alternative therapies conducted by students from local colleges are just some of the activities organised. The greatest barrier to attendance was time to participate and get involved.

Lunch & learn. These are regular lunch-time sessions which are designed to encourage employees to participate or learn about something new, generally health related. A healthy lunch is provided by the staff restaurant. The HAW group has organised sessions on healthy food, Alexander technique, belly dancing and other imaginative ways of keeping fit, women's health issues, and a well-man clinic, focusing on testicular cancer. The lunch & learn events have also focused on smoking (which is never popular), aromatherapy, and personal safety in conjunction with the local police.

Stress management. The occupational health department has invested in a stress management software package (CALM) which generates a stress audit used to target stress in departments that have expressed concern about stress levels. The audit focuses on working conditions, management support, problem solving, work variety, and working hours. The questionnaires are confidential, but provide managers in specific areas with an indication of what the issues may be and how to tackle them. The audits are repeated every six months to compare results and identify where improvements have been made.

Occupational health also offers stress management sessions that focus on how to identify stress in others and in yourself. Staff who feel that they are suffering from stress can refer themselves to occupational health for assistance, or may be referred by their line manager. Occupational health will aim to determine if the problem is home or work-related – if work-related, it recognises the need to address the work issues causing the stress rather than simply referring the individual for counselling.

Prevention of violence and aggression to staff. Although there was a policy addressing violence and aggression, the HAW group was proactive in updating and expanding the policy. A system has since been introduced that involves security staff handing out red cards to visitors who are abusive towards staff. Visitors who continue to be abusive are ultimately banned from the hospital. Research has shown that visitors to the hospital are most likely to be abusive towards staff, particular in accident and emergency, and the maternity ward.

The barriers

The main barriers to the success of the initiative are limited funds and the limitations of the hospital environment, which makes it difficult for employees to get time to participate in events organised during the day.

Impact on staff health

The HAW group believes that evaluation of each activity is important to ensure that efforts are addressing the needs of the trust, and to engender continued support and commitment from management.

The HAW group is confident that the HAW in the NHS initiative overall has had a positive impact on staff wellbeing. One way of measuring this will be to compare the current staff attitude survey with last year's, in terms of staff morale. The group also assesses the effectiveness of the occupational health service by sending out questionnaires on the performance and use of the department.

The staff survey and stress audits are used to report progress and developments to management. Changes in

the stress audits are particularly relevant if local action has resulted in a reduction in reported stress levels. Unfortunately, it is difficult to use sickness and absence records as an objective measure of effectiveness, as the the group does not believe that the current system really reflects why people are taking time off work (eg people may be taking time off with sick children but reporting it as their own illness). Partially to address this problem, the trust now has a crèche, but there needs to be a culture shift to encourage people to be honest about why they need time off work, otherwise it will continue to be difficult to show a clear relationship between HAW initiatives and sickness levels.

Lessons learnt

What went well?

- Trust board and management commitment.
- Enthusiasm of the members of the HAW team and their willingness to persevere.
- Having the nerve to ask external organisations to volunteer their services to save the need for funding.
- Keeping the emphasis on fun.
- Communication through every available channel.
- Having a 'mover and shaker' on the group who can get things done and agreed.

Things to improve

The group has learnt that when organising training initiatives it is better to organise a whole day event than to target an hour here and there. Feedback indicates that it is easier for staff to get away and organise cover for a whole day than a few hours.

What would they have done differently?

There is a need to get greater staff involvement in the HAW group – and the group has now disbanded and reformed as the staff involvement group, with responsibility for taking forward the Improving Working Lives Initiative within the trust. The staff involvement group has representatives from clerical and 'shop floor' staff.

The new group believes this is essential to gain an insight into what is wanted by all staff in the trust, and to generate interest through word of mouth with staff at all levels and in all functions. The group would also ensure that people who join the committee are prepared to be proactive and involved in the process, and to take ownership of tasks.

Case study 5 – Royal United Hospital, Bath

Background

Royal United Hospital, Bath has approximately 3,500 employees, many of whom are part-time workers. The occupational health (OH) clinical director has overall responsibility for HAW within the trust. Although this function is not referred to specifically in his job description, it is an essential feature of his role to promote and maintain the health of the workforce at RUH. Although a designated HAW group had been in place within the trust for many years, the initiative is now the remit of occupational health.

A fair amount of activity has taken place under the HAW umbrella and OH is currently developing the evaluation phase of its work. There is no specific pool of funds set aside for HAW activity.

Implementation process

Starting points

The decision to pursue HAW was not driven by any key concerns within the trust, but out of a desire to follow suit with what was being encouraged and with what other trusts in the country were doing. The key motivation is thought to be the recognition that instigating this initiative would provide an opportunity to improve the health of the workforce, which would benefit employees and the organisation in general.

HAW is embedded into the culture and ethos of the hospital and is included in the trust's business plan. The trust's annual report also contains an update on what is being done to promote staff health, lifestyles and wellbeing. The trust board has demonstrated its commitment to HAW by working with occupational health on initiatives as and when required, participating in events, and ensuring the provision of funding where appropriate.

Resources

The HAW group. A HAW group was in place for many years within the trust, with a remit as per the *Framework for Action* literature. The HAW group is no longer in place, however, as it was found that the majority of the

work was being carried out by members of occupational health in alignment with key contacts within the trust. The decision was therefore taken to integrate HAW into the day-to-day work of the occupational health department, with support from other people within the trust as required.

A written action plan was drafted for HAW some years ago, but work has moved on considerably since then and the plan has not been revisited.

Financial resources. There is no set budget for HAW activity and events, so each time funding is required a new business case must be submitted. To date, no ideas or initiatives have failed through lack of funding. Whenever possible, requests for funding are tied in with other initiatives, which may make it easier for funding to be granted.

Strategy planning

From the 12 action points in the *Framework for Action*, key areas were identified by the HAW group, and subsequently the occupational health division. Decisions were based on the following criteria:

- The feasibility of achieving a difference
- Practicality of the endeavour
- The endeavour was of interest to members of the group.

For example, the occupational health director had a particular interest in pursuing smoking cessation, mental health and wellbeing, and physical activity.

Responsibility for training and development within the trust lies with the personnel department. Personnel is accountable for developing any training to accompany HAW initiatives.

Most of the HAW activity has been focused on practical, tangible endeavours. Only three policies have been developed specifically in response to HAW – the smoking policy, which is still in the development phase, the stress management policy, and the trust's transport and parking policy, which focuses on the development of greener methods of transport. The impetus for this particular policy is a combination of parking limitations on the hospital site and an endeavour to be supportive of Bath and North East Somerset Council's green agenda.

Identifying the activities

The main focus of activities for the hospital has been on:

- Mental health
- Smoking
- Healthy eating
- Physical activity
- Drafting policies (smoking, transport and parking, stress management)

The initial focus for HAW within the hospital was based on a staff attitude survey which was initiated by the HAW group. The areas which the group chose to pursue were the main points for action arising from that survey. These action points were also complemented by a perceived need for action in certain areas, based on the expertise of individuals in the HAW group.

The staff survey identified stress and smoking as the two key areas that staff would like the HAW group to address. The issue of stress and staff mental health was pushed onto the agenda in response to this survey, and was a particular interest of the occupational health clinical director who had come from another trust where a very successful employee assistance programme (EAP) had been established. At that time, the hospital did not have an on-site counselling service for staff, but used an off-site provider. Despite perception by management that this was a good and adequate service, feedback from staff indicated that the perception of the service was poor and therefore the decision was taken to provide an on-site programme that would be available to staff during working hours.

The survey highlighted that approximately 25% of staff at the hospital were smokers, and on the basis of this statistic, the HAW group decided that the level of smoking within the trust was problematic. Smoking was placed at the top of the HAW agenda.

The decision to pursue healthy eating in the canteen was in line with the trust's ethos to move towards everything that is healthy or promotes employee health and wellbeing. Similarly, the emphasis on physical activity was supported by the management team.

Communication strategies

Communication of initiatives is mainly done through email as there is a good network across the site which links in to other NHS areas as well. Posters are also used.

For a lunchtime conference held in 2001, the decision was taken to rely on electronic communication – the higher turnout than in previous years has informed occupational health that this is the most effective channel of communication.

Both the employee assistance programme and the occupational health service are listed on the trust's website as services that are available to staff, and occupational health is currently in the process of developing its own web pages.

Consultation with staff representatives suggests that communication of HAW activities is not as effective as the occupational health group perceives. The majority of the staff interviewed said that email was not an effective channel for communicating such events, as many people on the site do not have direct access to email, but are reliant on a ward or division manager to relay the information. The general consensus among the group interviewed was that payslip notices were the most effective way to reach the majority of staff, and that information about the HAW activities should be stepped up to maximise their impact.

Examples of HAW activity

Mental health. An employee assistance programme (EAP) was established on the basis of feedback that stress in the organisation was a problem and a growing awareness that staff were dissatisfied with the existing off-site EAP provision. It took the group 18 months of negotiation, producing and revising business plans, to argue the case for the EAP. When finally agreed by the trust board, it was recognised that it would be done initially as a risk venture to be funded for a period of a year and to be reviewed after that period.

A small core team (two people) set up a network of 13 self-employed counsellors who were paid only for the hours of counselling they did, which ensured the programme was cost effective. It was obvious that the EAP was successful and appreciated by staff and therefore there was no question of the trust board not allowing it to continue.

To support the EAP, occupational health also developed a stress management policy. Some stress management training, on how to identify stress in others and personally manage stress, is available and run in conjunction with the personnel department.

Smoking. The survey feedback highlighted the need for a smoking policy. The trust's goal is to have a smoke-free site, both grounds and buildings. Occupational health recognises that this is not going to happen in the immediate future, although it has done some work towards achieving that goal by restricting the areas where people are officially allowed to smoke. Currently, there are two smoking rooms designated for staff. However, staff, visitors and patients continue to smoke in the grounds, and OH is trying, somewhat unsuccessfully, to stop people from smoking around the entrances to buildings. Despite putting up signs, and indicating areas where people should not smoke, a lack of policing and enforcement of the policy means that people continue to smoke in these areas.

There is also a recognised problem with smoking in the psychiatric hospital, which is not part of the trust but one of the external trusts to which occupational health provides a service. Staff in the psychiatric areas are subject to passive smoking as most patients on psychiatric wards smoke heavily, but to date a solution to this problem has not been found.

In another trust to which occupational health provides services, one employee has particularly bad asthma, and the group is proud of the work done with that trust to encourage it to make various structural changes to the building to accommodate that person's needs. This includes confining patients to particular areas of the building where smoking is allowed, not allowing smoking in other areas, confining smoking to one floor, and the installation of ventilation/extraction systems.

The other major intervention is a smoking cessation clinic run by occupational health, which provides counselling and support on a one to one basis, and nicotine patches at cost. An early evaluation of this project found that a good percentage of the users had given up smoking as a result of the programme, and were still not smoking at the time of the survey.

Healthy eating. The trust's focus on promoting healthy eating in the canteen is part of its ethos to move towards everything that is healthy. The process began by liaising with the catering manager to make healthy eating options more widespread for both staff and patients. A report was commissioned from the catering manager to outline what was currently being done in the drive towards healthy eating. Continuing to develop healthier

catering is part of the long-term strategies for the trust. Feedback from employees suggests that there is not widespread awareness of the healthy eating campaign in the trust. Of the staff interviewed, only one member of staff used the canteen facilities on a regular basis. Although that member of staff was particularly complimentary about the quality of the salads, her feedback suggests that enhanced publicity of the healthy options within the canteen would be beneficial.

Physical activities. The focus on physical activity began in 1998 with a lunchtime exhibition/conference which was open to all staff. This event was attended by about 100 people. The conference involved presentations and exhibitions from a local sports company, bike shops and a local gym. It also included an exhibition from the trust about activities throughout the trust. (Facilities on site include a small outdoor pool, which is open in the summer, two squash courts, two tennis courts, a gym, room for badminton which takes place one evening per week, lunchtime yoga classes, occasional aerobics classes, football games.)

The next major push came when someone in the trust started a team race up the hills surrounding the grounds, which attracted about 100 people. This event was repeated three years running. The trust then entered a team into the 1999 Bath Half-marathon. The trust has also arranged other running and walking trips which have been very successful and raised money for the hospital's charity. The physical activity initiatives have been successful because they were organised and enjoyable, and encouraged team spirit.

Occupational health more recently asked people to come forward with their ideas for initiatives within the trust. This resulted in the establishment of a weight-loss group, which was a failure and very poorly attended. The team decided to re-promote the smoking clinic, and ran the half marathon again. Additional hill walking trips were organised for the year 2000 but these did not take place in 2001 due to the foot and mouth crisis.

Staff interviews suggest that the enthusiasm of the occupational health clinical director has been important in getting these activities off the ground, although many would like to see more emphasis on different types of physical activities such as yoga. The opening hours of the on-site facilities are seen to be a barrier for many staff on shifts to get involved in physical events.

Transport and parking policy. The hospital has limited parking spaces available to staff. As a result, the trust has decided to encourage staff to walk, run and cycle to work. The trust has developed good changing facilities, and invested in a lockable cycle shed which accommodates 100 bikes. These facilities are well used, particularly during the summer. The HAW committee believes that the council's green agenda was helpful in enabling the trust to get funding for these facilities, as NHS money could legitimately be spent on staff facilities without the Department of Health questioning expenditure on staff, not patient, facilities.

The barriers

The only barriers to implementing the HAW initiatives in the trust is opposition to the smoking policy, as well as time to draft policies properly and work on initiatives. The draft smoking policy is currently being held up. Staff interviews suggested that there is general support among staff for a non-smoking policy, but they did raise concerns about preventing visitors and patients from smoking on site, and suggested that a 'control of smoking' policy with designated smoking areas would be a more sensible and practical approach for the hospital to take.

Impact on staff health

At present, occupational health has not specified clear success criteria for its initiatives but is in the process of developing them. The overall impact of HAW has not yet been measured but ways to do this are currently under consideration, and it is envisaged that evaluation will be a major project for occupational health.

The group is looking at other ways of conducting evaluations and developing questionnaires. It aims to work with the Institute of Health and Medicine to use its expertise in developing the evaluation project and to conduct surveys and gather qualitative information from staff.

Some specific evaluation has been done, but not on a major scale. For example, occupational health has sent out targeted evaluation forms to people who have attended the smoking clinics, and to those who expressed an interest in running the first half marathon, the results of which have now been published.

The occupational health group also provides staff health services to other organisations (four NHS trusts in the locality and other businesses) and it is important that the effectiveness of these services are evaluated. To do this, occupational health initially set up a user group for the NHS but found that this method of collecting feedback did not work, as the various trusts involved did not feel comfortable talking to each other.

When the group was disbanded, a questionnaire was developed to look at ways in which the service could be evaluated and developed. The feedback was very good, and highlighted that the main area for improvement was communication, which has been addressed by attending more meetings, producing literature, and beginning to develop a website.

Staff feedback suggests that the HAW activities have not made a huge difference to many employees because of the following reasons:

- Difficulty to get time away from work to participate, due to understaffing and heavy workloads
- Lack of effective communication
- The EAP only addresses the symptoms of stress, rather than dealing with the potential cause
- The trust culture is thought to promote long hours and needs to be addressed if employee wellbeing is to be enhanced.

Lessons learnt

What went well?

The general culture at the hospital is supportive of healthy and active behaviour; the ethos of the organisation supports the principles underlying HAW. Involvement in activities is thought to be widespread and at all levels. The focus on making physical exercise interesting, enjoyable and a team activity has, the group believes, encouraged widespread involvement. Half-marathons and walks have been linked with the hospital appeal, which means that costs are subsidised by fund raising. The trust has worked hard to overcome the image of physical activity being linked with pain by instead linking it with fun.

What would they have done differently?

The trust would have pushed the smoking policy harder and not given in to pressure from resistant groups. The HAW implementer believes that taking more time to develop the policy and to introduce the measures would make it successful.

> *'Try to make it less of a threatening policy to smokers to reduce resistance and promote the site as smoke free to staff and the community. Ensure that people realise they are coming to a smoke free environment, with as much emphasis as possible on support for smokers, rather than dictating to smokers.'*

Case study 6 – Anon.

Background

The trust includes several city site acute hospitals which have recently merged from two main trusts into one larger trust. The new trust covers four sites based within a city and suburbs. There have been difficulties encountered in the trust due to the merger process, such as a lack of dedicated resources and limited commitment from senior management due to competing priorities.

Throughout this case study, there will be reference to what the two separate trusts had done prior to the merger, as well as what the new trust is doing now. The original trusts are referred to as trust A and trust B.

Implementation process

Starting points

In trust A, the implementer, who was also a regional HAW coordinator, was identified by the senior management team as needing to have the responsibility for HAW as the main role in their job description. The implementer was able to attend national and regional meetings to find out what other trusts were doing and gain a better understanding of other national projects. Trust A had received a HAW award.

In trust B, there had been less support from the senior management and so no HAW implementer was formally identified as being responsible for coordinating the initiative. Instead, the remit of the occupational health team was identified as being the most closely linked to the objectives of the HAW initiative and therefore given the responsibility for its implementation. However, there

were no additional resources offered to the occupational health manager, placing some pressure on the occupational health team to implement the additional demands of the initiative.

Since the trusts have merged, the implementer from trust B has left, and the implementer from trust A has taken over the responsibility temporarily for the initiative for the whole of the merged trust. Due to the recent introduction of the Improving Working Lives initiative there is uncertainty about how the trust will strategically move forward with the two initiatives, and the implementer from trust A is still based in occupational health.

Resources

In trust A there had been funding from the trust to support the HAW implementer full time. Based on the requirements of the HAW initiative, the implementer identified who should be on the committee, including representatives from different departments as well as several union representatives. There was also some funding set aside by the trust for conducting HAW activities.

In trust B the occupational health team was responsible for implementation and so there was no formal HAW group identified. Financial resources were allocated from the OH department budget. The OH manager was identified as the HAW coordinator/implementer. However, the implementer believes that it is important to have a member of the management team involved in the initiative as this would support more cross-team working, especially with HR and health and safety staff. The reason for this is that the OH team is focused mostly on health issues and so is not in a position to consider the policy and stress issues that could also be fundamentally relevant to this initiative.

The current HAW committee has only recently been set up and aims to meet every two to three months to discuss actions and progress. The committee is based on an amalgamation of the HAW group in trust B and occupational health representatives from trust A. It includes representatives from nursing, health and safety, HR and OH, as well as the regional coordinator, who tries to attend most meetings of the group. The current HAW group feels that it is important to recruit new members of the trust into the group to have the main players available for reference during decision making and action planning meetings as well as implementation. These staff are being identified through the action planning process; for example, service and facilities managers such as the catering manager for healthy eating activities. It is felt by the group that if these stakeholders are not involved then it will be more difficult for the group to move forward.

After restructuring the HAW committee and as a result of development of new national initiatives, the focus of the group is currently being re-established to take into consideration both Improving Working Lives and HAW. There is a separate Improving Working Lives group that will include management staff, with the HAW committee reporting to the group. The OH manager will be attending both committee meetings.

The whole of the HAW group takes responsibility for implementing initiatives within the trust. There is also support from other NHS trusts in the area, including the community trust. This partnership working is felt by the HAW team to be greatly beneficial to the HAW initiative as the resources for conducting activities are that much greater and the number of people within the target population is greater when joint activities are conducted. One of the OH consultants from the community trust is planning to work more closely with this HAW team to pass on knowledge, experiences and good practice ideas, as well as contributing to activities being run by the trust.

Strategy planning

In the current trust, strategy and action planning has been guided by the *Framework for Action* documentation. The five main areas for action identified by the document are human resources and management practice, health and safety, lifestyle, transport and environment, and occupational health. These different areas are separately addressed in the action plan currently being developed. Each area for action has been passed to individuals with specialist experience who are then identifying good practice actions that the trust could follow through in HAW implementation. The responses from these experts have been collated and included in an action plan for the group.

Identifying the activities

In trust A, staff were sent a lifestyle survey which asked them to identify the types of activities that they would like to have available within the trust. Feedback from staff identified access to counselling, especially trauma debriefing, and also smoking cessation and

aromatherapy. Since the initial survey, staff have received trauma debriefing, but only in relation to the specific incidents occurring in the hospital in particular departments. Staff now want this counselling to be extended to other groups of staff within the trust. The new implementer and HAW team are considering this possibility in their current action planning. Other activities had also been identified from the survey and implemented.

In trust A, staff in the OH department expressed concern that very few male staff were attending the service for support or advice. OH decided to survey the male staff to identify some of the reasons for their low attendance. Specific male-related events were designed to target this group of staff.

As a result of the merger, the HAW group is planning to conduct a post-merger stress audit. A previous staff survey used by the first trust was felt to have been anecdotal and not targeting the issues that could be addressed. The HAW group feels that it is important that the survey addresses the main health issues and expectations of staff more closely. The overall aim of the activities is that both staff and patients are supported in relation to health promotion.

Communication strategies

Communication has so far specifically related to action planning, and therefore has been directed at those individuals in the trust who have overall responsibility for the areas identified for action, based on the recommendations in the *Framework for Action*. As part of the action planning process, the group is planning to conduct a stress audit which will initiate communication channels with staff. Further communication strategies have not yet been discussed in detail.

Examples of HAW activity

The approach of trust B had been to introduce several different activities to increase staff awareness of workplace health, including an information bus that staff were able to visit during an awareness week on staff support. However, due to the HAW group membership there was limited support for implementing activities as few members of the group had either the resources or the time to commit to the activities or, as was the case for the union representatives, were not in a position where they were able to offer any time outside the HAW meetings.

Trust A also targeted stress in the workplace, which had been identified in the lifestyle survey as being a particular problem in the hospital. The survey was analysed to identify those who are suffering most significantly from stress; these included those working in women's and children's wards and those in intensive care units. Once identified, these staff were approached to be involved in focus groups to discuss the impact that stressors were having on their health and lifestyle.

As a result of staff consultation in trust A, the OH team decided to set up lunchtime lectures (with sandwiches to attract greater attendance) which focused on increasing male awareness of male health issues such as prostate cancer. Men were able to attend and discuss issues on a one to one basis with an OH adviser or attend a group session to discuss issues of concern. They were also able to attend the session just to collect some information documents if preferred.

One of the activities being implemented by the current HAW group relates to the policies of the trust on mental health issues. The OH consultant from the local community trust is helping to produce an information pack for staff on the relevant issues and the responsibilities of individuals in the trust. The director of HR has become involved in ensuring that mental health policies have been designed and implemented in the trust. Implementation would include communicating the policy as well as ensuring that managers have been trained about the salient issues and addressing the culture of non-referral of staff to OH for these issues.

The barriers

- In trust A, there had been some HAW activity through the HAW group, but there had been some problems due to the make-up of the committee resulting in low resourcing for organising activities.
- Responsibilities for HAW implementation had been linked to employee positions within trust A as opposed to volunteers, who are commonly more enthusiastic about their role, which had a negative impact on implementation. Other staff within this trust have not had HAW included in their job description and so the resources available to the implementer were limited.
- Further, most of the work was conducted by the implementer, who was solely responsible for the initiative. This negatively affected the implementation

of larger events and setting up of activities due to lack of people resources.
- In trust B, there had been little support from senior management, and the initiative was tackled by the occupational health team, so resulting in a limitation of HAW through focusing specifically on occupational health activities.
- There has been a significant impact on the implementation of the initiative within the organisation due to the mergers of the trusts. The merger has created the need for readjustment and reorganisation, affecting the progress of the initiative.
- Support for the committee from senior management is still limited in the trust, which the team feels has been a hindrance to progress. It is felt that higher grade staff on the HAW committee would help to move issues forward, as they are able to coordinate their staff and influence higher levels of management.

Impact on staff health

Due to the early stage of implementation in this trust, there has been no assessment of the impact of HAW activities on the health of staff. The occupational health team in trust A believes that it has had a positive impact on increasing the health awareness of male staff through targeted events, as this group of staff less commonly visit the occupational health department for advice and information.

Lessons learnt

What went well?

- The group is starting to work in collaboration with other trusts in the local area and is using the expertise from the local community trusts, including OH consultants and psychologists, to adapt best practice approaches and use them as a resource for activities.
- The group is also working in partnership with other organisations in the local area such as the health authority and the police, which may allow the NHS trusts to be identified as an exemplar employer in the area.

What went wrong?

- In trust A the people resources available were too limited to support the implementation of some activities.
- In trust B, the OH team, which was made responsible for the initiative, was only able to approach the initiative through an occupational health perspective and was not able to tackle organisational policies or risk assessments and other aspects of HAW.
- The approach taken previously by the two implementers was very different and so there has been some difficulty in setting up the new HAW committee due to the sense that they are having to start over again.

What would they have done differently?

- In trust B, there could have been more partnership working with other trusts in the area to increase resources and support.
- The HR manager or director would have managed the initiative, as this would have a more holistic, coordinated approach, particularly among the different departments such as HR and OH. For example, the HAW committee would then have greater ability to influence policies, appraisals and job responsibilities.
- The implementer in trust B would have increased the consultation with staff at an earlier stage to identify the needs of the staff more clearly.

Case study 7 – Pinderfields and Pontefract Hospitals NHS Trust

Background

Two trusts underwent a merger during 1997, resulting in the current acute trust which employs approximately 4,500 staff across several sites. The initiative was introduced by a new member of the HR team, the assistant director of HR.

Implementation process

Starting points

After the merger, there was a period of strategic readjustment prior to the HAW initiative being introduced. The current HAW implementer joined the trust as an assistant director of HR in December 1998. The assistant director had been a HAW implementer at their previous trust and so had experience in coordinating the initiative. During the first year of being in post, the assistant director aimed to have HAW addressed by the trust board as an important initiative for the trust to establish.

The implementer felt that it was important that the committee had a large resource pool so that individuals would be able to take responsibility for issues/activities that reflected their particular expertise/interest and availability. A large HAW committee would also support the group being divided into sub-committees for certain main activities as well.

To set up a large committee, the implementer felt that it was important to gain the support of managers in different parts of the trust at an early stage and so involved them in identifying representatives who would be included in the HAW committee. The implementer contacted the head of each department and clinical unit, requesting that the manager identify a volunteer from their team to be their representative on the committee.

It was recommended that the volunteer be nominated according to their interest in the potential work of the HAW group and their eagerness to communicate the work of the group to colleagues. The implementer felt that the involvement of each manager in this process would positively influence their support and gain their commitment for the initiative.

About 20 staff were selected for the HAW committee, all of whom attend the meetings quite regularly, although some are more active than others in their participation. The chairman of the trust and the chaplain were identified as potential additional members at the first meeting of the committee. The implementer felt that it would be important to have a non-executive director as a member of the group as this could have more impact on senior management strategy planning and maintain the group's high profile in the trust.

Resources

The main personnel resources are the implementer and a secretary, who both have HAW included in their responsibilities and in their performance review. The HAW group comprises a cross-section of staff from all departments and clinical units. At present, there is the main HAW group and three sub-committees: gym facilities, healthy eating and healthy transport. The sub-committees include staff who are on the main

Terms of reference for HAW committee

Overall outcome

The overall work of this group should aim to demonstrate good quality occupational health, health and safety and health promotion services working together to maximise the potential of each discipline for the benefit of each individual employee and the trust.

Terms of reference

- **To ensure the trust, as an employer, promotes a healthy workplace and thereby contributes to the health and wellbeing of our employees.**
- **To comply with the relevant health and safety legislation and closely adhere to the occupational health guidelines, to provide a working environment which minimises the risk to physical and mental wellbeing.**
- **To support a health enhancing lifestyle.**
- **To provide an appropriate forum for health education and information.**
- **To recognise good practice and provide information and a coordinated approach to improving the health of all NHS staff.**
- **To set up and assess needs and develop a framework for action with built-in monitoring, evaluation and target setting.**
- **To communicate/publicise healthy workplace initiatives as an aid to recruitment and retention.**
- **To develop initiatives which support staff at work.**

committee. Group members are expected to report back to the group the actions that have been taken since the last meeting. The HAW group meets quarterly, while the sub-committees meet in the interim. Initially, when the sub-committees were being set up, the implementer attended and chaired the meetings; however, once the groups had identified their course of action, the implementer did not need to attend.

The trust has a staff lottery fund whose proceeds are to be used for activities which benefit the staff generally; the implementer identified these proceeds as being a possible resource for HAW activities. Funding from the lottery has been used to buy bicycle sheds for staff to promote cycling to work.

Strategy planning

The implementer felt that once the membership of the HAW group had been arranged, it was important to identify its purpose. Therefore, the agenda for one of the first meetings was to discuss terms of reference and designing overall aims and objectives (see panel). The implementer also considered it important in the early stages that the group identified what the trust had already implemented in relation to health promotion. This information was documented so that staff were able to see immediately the health promotion actions.

The group believes that it is important that, due to the nature of the work conducted, staff have a high level of awareness about their own work/life balance and how their job can impact on their own health.

> *'Healthcare employees need to be aware of how much of themselves they are giving to others, and therefore how much they need to put back to continue to give their best.'* (HAW implementer)

More recently, there has been some impact on the focus of the group through the national introduction of the Improving Working Lives (IWL) initiative, the focus of which appears to overlap with the remit of the HAW group. It was recently decided by the HAW committee that the IWL initiative should be linked to the remit of the group and the IWL committee should have staff representatives from the HAW committee.

Identifying the activities

The implementer initially identified topical issues that could be addressed, through their knowledge of national health promotion topics such as smoking cessation. The implementer then consulted the HAW group about these issues and the focus of activities was agreed by the group. Once these initial activities were agreed, the group decided that it would be important to consult staff more broadly and so health promotion questions were included in the staff opinion survey that was already in place within the trust. This information is then used to identify new activities that staff would like to have available.

The implementer periodically reviews the committee representatives to include relevant experts and role models in the committee or included in sub-committees. For example, the staff restaurant manager was identified for inclusion in the healthy eating sub-committee. Activities may become more or less well-attended due to fashion, so the HAW group needed to regularly review attendance and interest in activities. The group recently agreed to form a new sub-committee to investigate the potential for aromatherapy and reflexology sessions, as a result of much interest from staff.

Communication strategies

The group has collated a booklet outlining all of the activities that the trust has in place for health promotion for staff. The information includes a list of activities, timetable/location, charges, and trust employee to contact for further information. This booklet is available to all staff, with the aim that they should become empowered to take responsibility for their own health.

The trust is split over several sites, including two main sites, so the group needed to identify methods of communication that were not dependent on staff being in one location. Generally, there are good communication networks in the trust across the different sites, and this is a benefit to the HAW group in communicating activities/events that they are planning to undertake. Information was distributed through the intranet – for example, minutes of HAW meetings – also through team briefs and attachments to payslips.

However, it was found that using payslips was time consuming for such a large trust as information had to be attached individually to each payslip. Informal communication processes were also encouraged through HAW committee members who are representatives from each department and who were expected to report to their team the new activities and events being introduced.

Examples of HAW activity

One of the lifestyle activities that has been organised by the HAW group is yoga. The HAW implementer's secretary has taken the responsibility to coordinate the logistics for this activity, including attendance and liaison with the external provider. The provider, vetted by the implementer, offers a tailored course to address staff needs, which are regularly reviewed. To encourage staff to join, the classes have been subsidised for three months from the staff lottery.

Due to the high demand for this activity, staff have been divided into two groups who attend on alternate weeks, so allowing more people to have access to the classes. When a member of staff is unable to attend a session, the coordinator is able to contact members on the waiting list to offer them a place on that session. This ensures that the classes are usually full. However, the yoga classes have only been set up at one of the trust sites, and there has been a significant level of interest at the other main site. The implementer is currently encouraging this site to set up its own classes.

Other lifestyle activities that are currently run by the trust are managed by a variety of staff who have received support from the HAW group, especially the implementer and their secretary. Example activities currently run include circuit training, swimming, yoga, relaxation and chiropody. External activities need to be vetted before the group will recommend them to staff. Once accepted, the group negotiated discounts for staff with the external providers. Staff are able to contact a hotline for any queries about work-related issues affecting them. Where relevant, the implementer and other experts respond to the hotline questions in a published staff bulletin.

The barriers

- The merger of the two trusts had a significant impact on the implementation of the HAW initiative. This was thought to be due to competing strategic priorities, which resulted in uncertain resources and restructuring of staff for various initiatives conducted within the trust.
- Ensuring that there is enough ongoing support from staff for activities such as dance classes to finance an external instructor. The HAW group does not have a significant budget to fund activities when there is less attendance than expected and so this concern can be a barrier to setting up activities.
- Space and maximum class sizes for certain activities means that not all staff have access to some of the most popular activities such as yoga.
- Female staff are more likely to respond to consultation about health needs than male staff and so many activities become female-oriented. Men do attend these classes, but are not as active in identifying new activities. This is a potential barrier to men's health improvement as their specific needs may not be as well addressed.
- Through performance appraisal of the implementer, the director of HR is able to monitor and ensure the progress of the initiative within the trust.
- Having identified the interest from staff in the provision of a gym at one of the sites, there is no space at the site to accommodate the gym, although some space may be earmarked in one of the new building developments, so this activity may be instigated in the future.

Impact on staff health

The committee believes that it is having a positive impact on the health of staff due to the significant support that staff have for activities being conducted. For example, the yoga classes have waiting lists for people to attend; the bike sheds are used.

Lessons learned

What went well?

- The trust has been fortunate that the implementer had experience in HAW group coordination from their previous position in another trust, and the implementer felt that this benefited their approach to setting up and running the network of staff required for the implementation on the initiative.
- There has been support from the trust directors and having a non-executive director in the HAW committee has raised the profile of the group within the trust.
- A significant amount of time has been spent on setting up the necessary support structures for the HAW initiative. Staff who attend the committee meetings are representatives for their department or clinical unit and have the responsibility to represent the views and opinions of the staff in that department at the quarterly meetings.

- There is some flexibility in attendance at the quarterly meetings as the committee is of a significant size. The implementer believes that this is especially beneficial as these staff form part of the broader support network for individual activities.
- Staff are empowered to initiate activities for themselves. The implementer believes that this is especially important considering the locations of the sites and reduces the demand on the HAW committee for time resources.
- Sub-committees are focusing on specific activities such as healthy eating in the staff restaurant. Such delegation of work allows the main committee to remain focused on strategic decisions and new activities.
- The implementer feels lucky as the majority of those who attend the HAW meetings are very enthusiastic about the initiative and so are very willing to become involved. Likewise other staff enjoy the opportunities that they have available and so attendance is high.
- Funding is available from various sources within the trust such as the staff sports and social club and the staff lottery; however, this funding is limited.

What went wrong?

- The merging of two trusts resulted in a delay in setting up the initiative within the trust.
- Due to the nature of the activities they have been oversubscribed, resulting in waiting lists for some staff.
- The healthy eating sub-committee recently ran a healthy eating day, with sponsorship from a local food manufacturer. Feedback from one member of staff though was that the day replaced 'roast day' which, as he was in a physically demanding job, he had been looking forward to. It was suggested at the HAW committee meeting that healthy eating options should be made available rather than replacing the foods normally on offer.

What would they have done differently?

Staff do not consider that there has been anything that they would have done differently. There have been no initiatives that have not been successful and support structures in the trust are considered to be very stable.

Case study 8 – Anon.

Background

The trust has been involved in a merger over the last two years and has very recently become a medium size primary care trust. These changes have been a significant barrier to the implementation of HAW in the trust. The fact that the HAW implementer worked in the HR department, which suffered high turnover of professional staff in the first year of the merger, also hindered progress. The merger of the two trusts and the more recent change of remit to a primary care trust has not only had a significant impact on the implementation of the HAW initiative but has also affected the number of potential work-related stressors that staff may be exposed to. So the focus of the HAW initiative within the trust has been to address the organisational culture to reduce potential stressors and to develop formal support structures for staff who are suffering from stress or harassment.

The HAW implementer, based in HR, has approached the implementation of HAW by identifying that the trust should focus on developing/updating policies and support structures to allow staff to take active responsibility for their own health needs as opposed to trying to improve staff lifestyles or health-related habits. This approach is, for example, to increase support for staff by auditing the harassment policies and procedures currently in place to make an assessment of the extent to which the trust supports its staff if they report an incident of harassment.

Implementation process

Starting points

The HAW implementer in the trust took on the responsibility, due to their management position in the HR department. Having looked at the work of other trusts in the area, the team realised that HAW would be an initiative that the trust could and should instigate themselves. To gain support for the initiative from the board of directors, the HAW group produced a strategy document and presented it to the board. However, since 1999 there have been competing organisational priorities and broader uncertainty for the future of the trust in relation to its organisational structure and funding. On a positive note, the trust's recently appointed chief

executive is particularly interested in the HAW initiative and there is currently a business case being submitted for further activity and a request for funding.

So it has been difficult for the implementer to introduce HAW activities into the trust so far. However, while waiting for a decision regarding funding from the board of directors, the implementer believed that it was possible to promote health in the workplace through means other than health promotion events and activities. For example, it was decided to review and audit the relevant personnel policies and procedures to ensure that they support/promote staff health.

A HAW committee was set up prior to the 1999 merger, although the group disbanded shortly afterwards. One of the main activities that was being considered by the group was the introduction of a staff health clinic which would be available for advice, information and appointments to see experts about any health issues. The majority of the experts would be staff within the trust able to offer spare time or receive overtime pay to staff the clinic.

Resources

Prior to the merger, the implementer wanted to ensure that the HAW committee would be representative of different departments and grades of staff within the trust. Having asked for volunteers to join the group, the implementer then identified where there were gaps in representation and the appropriate staff were approached to join the group. For example, the implementer believed that it would be important for a psychologist to be one of the group's resources. HAW group membership eventually included representatives from occupational health and various departments around the trust.

With the focus of trust attention on the merger, and the staff shortages within the HR department, the group disbanded, and only one other member of the HAW group remained active in pursuing the initiative with the implementer. This was a therapy manager who is currently still working closely with the implementer to gain funding from the board of directors to introduce the staff health clinic. In addition to the work within the trust, the implementer is working with the health authority in partnership with other organisations such as Marks and Spencer, Bentalls and local councils with which they are able to share advice and ideas through the local health network forum. A HAW network group meets regularly to support policy development, share good practice, identify resources, access appropriate funding, and develop training for the group to develop effective healthy workplace environments.

In common with other NHS employers, the trust received £25,000 from the Improving Working Lives (IWL) initiative to be used to fund projects that responded to needs identified by staff using such tools as the staff attitude survey. The implementer felt that it would be appropriate for the staff health clinic to bid for a significant proportion of this budget, as the clinic could be considered to be closely linked with the objectives of the IWL initiative. A questionnaire was being drawn up to audit staff interest in such an initiative, along with other more traditional ones such as provision of carer support.

Strategy planning

When the HAW group first formed in 1998, a significant amount of time was spent ensuring that members understood the exact nature of what was required from the HAW initiative and identifying the types of activities that could be conducted within the trust. As part of the strategy planning process, the HAW group wanted to identify what the trust was already doing in relation to health promotion in the workplace. The implementer was, at the time of the group's formation, working on an assignment for a university course which involved a review of all the information documents available within the NHS about HAW. This review led to the production of a strategy to ensure the trust adopted an integrated approach to HAW.

Identifying the activities

Due to the future uncertainty and organisational change issues affecting staff within the trust, it was decided to carry out a staff attitude survey to assess the impact these changes were having on staff. The results from the survey illustrated that there were many stressors within the trust, possibly caused by these organisational issues. Further, staff felt that there was a lack of support from the trust to help them to deal with their stress.

The HAW implementer identified that there was a need to assess what the trust already does to support staff suffering from stress and to ensure that the formal structures in place, such as reporting procedures and first-contact officers, are available for staff to approach for support. The implementer saw the need to identify

the stress 'blackspots' in the organisation using staff attitude consultation, accident figures, sickness absence rates and disciplinary findings. It was considered important that managers be trained in relation to their responsibilities for managing stress within the workplace and that staff be offered support to avoid potential stressors and deal with any stress felt. Accordingly, stress management as well as time management courses were designed and developed by HR in conjunction with the psychologist member of the HAW group and are run in-house.

Communication strategies

The communication strategies used within the trust are mainly linked to the updates of policies and the implementation of training courses. There have been no specific activities requiring posters and other communication methods.

Examples of HAW activity

One policy that the trust has in place relates to whistle-blowing. However, at the time of interview, the implementer was concerned that this policy would have significant practical impact on the stress felt by the people involved, especially during any ensuing investigation. As a result of her concerns, the implementer has become involved with the team setting up this policy to look at how to ensure there would be support for those staff involved to help them deal with stress. Support would include the training of mentors who would lead the employee through the process. Likewise, the implementer is raising with the training and development manager the need to train more first-contact supporters to facilitate the harassment policy.

The implementer has outlined a business plan for the staff health clinic identifying where the trust will be able to set up the clinic, the financial and personnel resources needed and the potential income. Some of the staff would be paid overtime to manage the clinic or be a resource for advice.

The implementer has also suggested that further resources may be available if customers from outside the trust, such as from partnership organisations, are able to use the facilities or phone for advice. The health clinic will aim to offer information and advice to staff, sessions in traditional therapies such as reflexology and aromatherapy and practical advice/support group mechanisms to help staff deal with situations such as divorce or caring for older relatives, as well as information on diet and exercise. The implementer also anticipates that the clinic will at times be staffed by nurses who will be able to blood pressure tests.

The barriers

- The trust has been involved in a merger over the last two years which has been a barrier to the implementation of the HAW initiative due to the uncertainty of restructuring.
- There has been no space available for lifestyle activities such as aerobics to be implemented, although it is anticipated that this may change with the new health clinic.

Impact on staff health

For the training courses run for managing stress and time management, there are feedback questionnaires which allow staff to state what benefits they have received from the course as well as asking what further courses they would find beneficial. Should the staff health clinic receive the necessary funding there will be monitoring mechanisms put in place to ensure it is effective in promoting staff wellbeing. Indicators such as sickness absence figures and the mandatory annual staff attitude surveys will obviously be useful here. The overall requirement for the trust to demonstrate progress in meeting the Improving Working Lives standards will also facilitate the monitoring of all HAW initiatives in the future.

Lessons learnt

What went well?

- The HAW group was effective in grasping the concept of HAW and recommending a strategy for the trust which ensured an integrated approach.
- The approach promises to place the trust in a strong position for tackling the IWL initiative.
- Training courses given to managers have had very positive feedback as these have increased their awareness of issues in and outside the workplace that act as potential stressors for staff, and so made them more confident about tackling such issues.
- The HAW initiative has been integrated into the work of the HR team.

What went wrong?

The barriers to the implementation of HAW within the trust had an impact on the implementation of various potential activities.

What would they have done differently?

To ensure momentum and continued priority for the HAW initiative during a time of great organisational change, and high staff turnover within the HR team, it would have been better if a board member had chaired the group.

Case study 9 – Anon.

Background

The trust employs 2,500 staff. The development of a HAW strategy within the trust is still at the development stage, with the current focus on identifying the key issues from a staff perspective to build buy-in to a targeted, practical and achievable action plan. The trust's personnel manager is accountable for HAW.

Implementation process

Starting points

Activities focused on HAW within the trust have been initiated in 2001 for the first time. This follows the personnel manager for the trust taking managerial responsibility for staff occupational health issues. Previously, occupational health came under health and safety.

The catalyst for focusing on HAW came from the partnership forum. This is a trust-wide consultative group and is the main vehicle for development of policies affecting employees. Staff-side members of this group raised occupational health issues as requiring attention.

During 2000, an occupational health review group was formed to address the topic of workplace health. A trust-wide employee opinion survey is currently underway, and includes sections on both stress and occupational health. The outcomes of this will be used to identify priorities and build commitment to action. The provision of occupational health services is currently under review; however, limited resources have meant that little has been done historically to actively promote workplace health issues.

Resources

Personnel manager. The personnel manager, who reports to the director of nursing, is responsible for progressing HAW. The annual HR business plan includes a specific section on the trust's focus on HAW during 2001. Embedding the HAW action strategy into the business plan is seen as critical to the success of the initiative. In approving the plan, the organisation is demonstrating top-level commitment to the initiative.

Occupational health review group. The occupational health review group, established last year, was formed to focus on HAW. It addresses functional occupational health activities, and also looks at support and services for staff under the HAW umbrella.

Membership of the group includes:

- Non-executive director
- Executive director
- Chair of staff-side group
- Occupational health nurse
- Health and safety manager
- Assistant director of nursing
- General manager
- Personnel manager
- Consultant in elderly care.

The objectives of the occupational health review group reflect those set in the business plan. These were developed from a discussion paper following a visit to Sandwell by the personnel manager and director of nursing to look at good practice, compare baselines of occupational health standards and identify basic criteria. Objectives for the group include:

- Reviewing action taken by another trust
- Identifying a range of core services
- Development of new systems and practice; for example, the development of new referral forms, as well as looking at approaching GP services for the temporary registration of staff in transit
- Considering the concept of shared services; for example, joining forces with a community health trust, which has more occupational health resources.

A strategic stress management group is also in place as a result of recommendations made to the board by a working group mandated to identify the causes of stress. It is anticipated that the stress management group and the occupational health review group will combine in future to form a single HAW group. Other relevant groups, such as one addressing violence and aggression towards employees, may also be incorporated to develop a holistic and structured approach.

Strategy planning

In moving forward with HAW, the trust aims to focus on the basics rather than become too ambitious. The underlying strategy is to establish a realistic baseline for action by identifying root causes and planning simple, achievable actions. This needs to be done in a way that builds engagement, understanding and buy in. The aim is to build leverage through the use of survey data. The employee opinion survey currently underway will therefore be critical to the strategy development.

Objectives identified within the personnel business plan are as follows.

To analyse the cause and effect of existing ill health:

- Establish systems in occupational health for collecting data
- Identify reasons why staff attend occupational health
- Assess numbers of staff who have retired/left on grounds of ill health.

Review of occupational health service:

- Document and assess current level of service provision
- Identify areas of provision which need strengthening
- Put forward proposals for the development of OH service provisions and an OH policy.

Develop a HAW strategy:

- Undertake an assessment of the key priorities of the health needs of the organisation.

Management of stress:

- Explore options for a staff support programme including extended counselling sessions and subsidised services for dental, chiropody and physiotherapy treatment.

A need to re-market occupational health services internally to build a more positive profile has also been discussed by the occupational health review group. This follows staff-side feedback that the service may be seen as a management tool. Agreement on the triggers that should instigate the involvement of occupational health is one way that understanding of the role of the service is being developed.

Identifying the activities

Historically, the trust has not gathered significant amounts of central data on occupational health. A review conducted during 1998 focused primarily on health and safety aspects (risk assessments, Control of Substances Hazardous to Health regulations etc.), and confirmed that the trust was providing a basic level. Information gathered routinely includes sickness absence figures, monitored at directorate level, enabling trends and hotspots to be identified. Feedback on referral patterns to occupational health (self-referral or via manager) is also gathered, and risk assessments are undertaken regularly.

During 1999 the trust participated in a study by Leeds University into workplace stress. Findings identified that occupational stress was not a significant issue for staff within the trust. In recognition, however, that this may change the trust's 2001 employee opinion survey addresses occupational health and has a detailed section on stress. While it is anticipated that this will provide clear indicators, additional work to probe key areas is also being planned. An external consultant who specialises in occupational stress is likely to carry out this work.

Priorities for action within HAW will be determined by the survey results. Once these are available, clear success criteria will be established and achievable interventions put in place. The focus will be on defined, tangible outcomes, so that improvements can be measured. Identifying initial areas where actions can make a real impact on employee wellbeing and health is recognised as being of primary importance.

Communication strategies

The early stage of development on HAW means that communication activity has yet to be initiated.

Examples of HAW activity

As the trust is still at the stage of developing its HAW strategy and identifying areas for action, it is not possible to outline the details of any activities. In planning

activities, the trust hopes to learn from the work it has already done to minimise stress; for example, developing the employee support programme to provide counselling for issues ranging from debt management to career development.

The trust is aiming to take a holistic approach to addressing employee health and wellbeing, and therefore recognises that assessing needs against the profile of the organisation will be crucial. For example, the mature workforce means that people may reach a plateau in their careers. Helping people to see how they can develop their careers, or reviewing their personal resources against the needs of their job, could be an area for focus. The trust is therefore anticipating that its range of activities will go beyond the more obvious workplace health interventions.

The trust has always ensured compliance with all legal requirements, and has undertaken specific initiatives in the past – for example an anti-smoking campaign including support for those wanting to quit smoking. A confidential listening service is also in place, with the facility to refer individuals requiring further counselling. Staff also have access to a weekly fitness session.

The barriers

The lack of occupational health resources has been a barrier to action in the past. Total resource has been one occupational health nurse and one part-time secretary. Staff have had access to only two sessions with an occupational health physician per week.

While the overall principles and framework for HAW are recognised as being good, the lack of specific standards associated with HAW in the NHS has been a barrier. This lack of 'teeth' means that each trust may interpret what they need to do differently – with the potential outcome that HAW may slip as a priority. The standards that have been put in place for the Improving Working Lives initiative, together with the audit process and external assessment teams, should help overcome these issues. Linking HAW to the HR Performance Framework would also help in providing specific standards.

Workplace health is a complex issue, and is affected by many different things. Separating out specific health issues, and identifying where to start, is difficult. The conceptual style of the HAW literature can make it difficult to apply on a practical level, and the time required to read the volume of reports and link different pieces of literature together is also a barrier. Furthermore, the *Framework for Action* is perceived as a sophisticated process for strategy development, which may not be appropriate if the focus in a particular trust needs to be on addressing the basics.

Impact on staff health

Too early to say as no activities are established as yet.

Lessons learnt

What went well?

- Getting the relationship right between HAW and health and safety: it's easy to feel complacent with overall health and safety performance and not deal with staff issues.
- It's important to listen to the organisation and not assume that you know best. The key stress issue may turn out to be car parking!

What would they have done differently?

At this early stage in the development of the strategy it is difficult for the trust to assess what, if anything, it would have done differently. However, it would like to see trusts provided with a highly practical toolkit for implementing such initiatives in future, which would facilitate the identification and planning of different stages in the process, and which would provide some examples of good practice. The trust also believes that a more prescriptive approach to undertaking such initiatives would ensure an immediate focus on action, rather than wasting time having to think through how to move forward. (*Managing Attendance in the Public Sector: Putting Best Practice to Work*, published by the Cabinet Office, is an example of a helpful format.)

Case study 10 – Anon.

Background

The trust has been in place since April 2001 when the former community care trust was dissolved. There are more than 1,300 employees on different sites. Overall responsibility for HAW within the trust is with the director of human resources. The chair of the HAW group within the trust is led by the risk management coordinator, who is responsible for risk management, health and safety, fire and security within the trust, and who reports to the HR director. HAW is not a specific remit of the risk management role. HAW responsibilities are not included in job descriptions and are not included in any performance indicators. The HAW group is considered to have collective responsibility for HAW within the trust.

April 2001 saw the dissolution of the community care trust and the formation of two new trusts. The HAW group is now split across these two trusts, but continues to carry on their responsibilities for HAW within one site.

Implementation process

Starting points

It is thought that the *Framework for Action* was used by the initial HAW coordinator within the trust. The trust decided to promote HAW because it was strongly advised that trusts do so, and because the board recognised the organisational benefits of promoting a healthy workforce. The HAW group has tried to develop policies on the basis of survey feedback, government initiatives, or 'word of mouth' within the trust, ie hints and tips received from staff on what they would like to see happening in the trust.

Clear success criteria were not instigated for or set by the group, which has virtually set its own agenda for promoting HAW. However, through contact with other HAW groups, the group is aware that it has done things in common with other trusts and therefore is confident that it is on the right track.

There is no overall action plan for HAW within the trust. The group is currently working on a stress policy, and once this is completed, it will revisit the terms of reference to see how far the remit should go, as members believe that it is a good time to reassess the group's role within the trust and the direction its activities should take.

The work of the group is mainly focused on policy development. Once policies have been approved and passed by the board of directors, it is the responsibility of managers to implement policies. All managers are expected to abide by the policies. Training for managers is provided where the HAW group believes it to be necessary. For example, a training proposal has been submitted to the board for the management of stress, but no training is anticipated to accompany the new smoking policy.

Resources

The Health at Work group. The role of the HAW group is to promote healthy lifestyles within the organisation and to promote government directives and suggestions where they can. The group's main remit is to draft policy for approval by directors, and to make sure that these policies are then disseminated throughout the trust and result in tangible actions. The bulk of the group's focus has been spent on writing policies.

The HAW group now comprises representatives from a number of different trusts. The group reports to the director of HR and is thought to be quite powerful within the trust. It believes it has the clout needed to make action happen. The group meets every quarter and has existed for about eight years.

Financial resources. There is no specific budget dedicated to HAW activity within the trust. Most of the group's work has focused on producing policies and guidelines which do not require a financial resource, and in most cases, following up or implementing the policies does not require money. When money is required – for example for the HAW fair – in the past the group has written to the director of care services. The group is reasonably confident it can get the resources to do most things, but stresses that it could do a lot more to promote healthy lifestyles if it could be confident of financial resources.

Strategy planning

The HAW group has focused heavily on drafting policies, run a HAW fair, and tried to promote healthy eating and healthy activity within the trust. In most cases, the activity of the group has been directed by the group itself and

what it thinks will work, rather than consultation with staff groups. Many activities promoted by the HAW group have been generated from the personal interests of committee personnel.

Identifying the activities

The main focus of activity has been on:

- Healthy eating within the canteen
- Smoking cessation and the formulation of a no smoking policy
- HAW fair
- Policy on alcohol and substance misuse.

Feedback from a staff survey and input from the occupational health representative on the HAW group raised awareness that stress within the trust was an issue that should be addressed.

The staff survey also raised awareness that staff would be interested in organised physical activities, such as regular aerobics and yoga classes but, unfortunately, space restrictions and the geographical spread of employees has made this difficult to implement.

Feedback from various parts of the trust raised smoking as an issue – it is widely believed that most trusts have smoking policies when in fact they often do not. As a result of this, many buildings within the trust had developed their own local policies. In areas such as mental health and forensic services it was apparent that there was a need for centralised policy. On the back of the policy, smoking cessation programmes are available to staff who request them.

Communication strategies

Communication of HAW activities is difficult due to the size of the trust and its geographical spread – 1,300 employees based across a number of sites. The management line is one key method of communication, as all policies go to management and it is up to them to disseminate the information through team briefings.

The trust's staff newsletter, *Newslink*, which is issued every two months, is also a widely used channel for communicating initiatives. Where appropriate, email is used, although not everyone within the trust has access to electronic forms of communication. A poster campaign was used to advertise the HAW fair in 1998, which was two days of promoting HAW activity. The HAW fair demonstrated great interest in the concept of promoting employee health.

Examples of HAW activity

Smoking policy. Based on feedback indicating the need for a smoking policy within the trust, the HAW group drafted a policy. This was a long and contentious process, as there were different groups within the trust opposed to the development of a no smoking policy. The policy was then submitted to the directors' group for comment, then to the staff for consultation with union representatives. Once everyone had agreed the content of the policy, it was sent to the trust board for ratification. The policy was then sent to management, and it is a management function to make staff aware of the policy.

The HAW group recently issued a questionnaire to staff to find out staff attitudes to smoking, and comments on this will be used to review the policy. Most people seem to be aware of the policy and most don't seem to resent their colleagues going for smoking breaks, as they are keeping it under control. Smoking cessation programmes are available to those who want them. The biggest problems are for non-smoking staff working in psychiatric wards where patients chain-smoke. Unfortunately, it is impossible to deny patients in those wards the opportunity to smoke.

Alcohol and substance misuse. The process of consultation and review as described above was used to develop this policy. There is concern within the trust that the complete ban on alcohol is a bit draconian, and so the HAW group intends to run a survey to get feedback. The group is open to relaxing the policy if feedback suggests this is required.

Guidelines on healthy eating. The HAW group, under the guidance of the team's dietician, developed a healthy eating strategy to promote healthy food within the staff canteen, rather than junk food. As a result of these guidelines, there is a far greater choice of healthy eating on the menu; healthy options are clearly marked and healthy foods are no more expensive than less healthy options.

Stress management. The stress management policy is still at the draft stage. It has been approved by the directors, but yet to be approved by the trust board. The formation of this policy has followed a similar path

to other policies, although there has been input from a clinical psychologist, and the HAW group has consulted other organisations' stress policies. The group is surprised at how little information there is and how difficult it has been to gain access to other policies. It has taken two years to get this underway, mainly due to the contentious nature of the policy.

There is recognition that some areas of the trust are more stressful than others, and the policy will be piloted in these areas, before being rolled out to other groups. It is proposed that all managers will be sent on in-house training in how to recognise and deal with stress, and there will be a follow-up course six months later to monitor the effectiveness of the training, and whether there have been any measurable long-term benefits.

As one of the HAW members is from HR, it is anticipated that she will be able to provide an overview of the effectiveness of the policy (ie has there been less sickness in particular areas) without divulging confidential information.

Once managers have undergone training in recognition of stress, they may choose to implement action locally. A lot of the stress experienced over the past year has been the result of uncertainly over jobs, and there are still some people who do not know what is going to happen to them following the restructure of the trusts. The policy will refer local managers to occupational health, if necessary, for counselling. Alternatively, it may highlight that stress is being caused by the physical working environment, in which case action will be taken to rectify problems where possible.

The barriers

Money and communication are thought to be the main barriers to the successful implementation of the initiative. Additional resources would enable the group to implement more initiatives and to conduct more poster campaigns to raise awareness.

Another barrier is the proliferation of government initiatives – HAW in the NHS is just one of hundreds of initiatives that trusts are required to address. It becomes difficult for trusts to keep up with all the directives that come through, and the danger is that attempts to deal with directives are simply paying 'lip service'. The HAW group believe that trusts should be able to focus on one or two initiatives per year, be more focused and do them properly.

Impact on staff health

The HAW group has not issued a questionnaire to get formal feedback on what employees think of the initiative and how they have benefited – but it recognises that this would be a good idea. The group believes that HAW is just one of many initiatives that improves people's healthy lifestyles. The group would like to think it makes an impact on employee wellbeing, but admits that no clear measures are in place to determine the success of the endeavours. It is taken on trust that employees are aware of the initiatives but how far they have altered their lifestyles as a result of the programmes is not known. However, the group is confident that the initiatives are embedded into the culture of the trust. For example, healthy eating is embedded into the catering contract and it is a requirement of the caterers to abide by the healthy eating guidelines.

Unfortunately, it was not possible to speak to a group of staff in this particular trust to ascertain their views of the success or otherwise of the initiatives.

Lessons learnt

What went well?

Generally, the board is committed to promoting HAW in the NHS within this trust. The local implementer is confident that board members see the benefit of having a healthy workforce and HAW strategy, as they affect the efficiency of the trust, and influence such factors as sickness and absence levels, which ultimately represents financial savings.

A number of things are thought to have contributed to the success of implementing the initiative within the trust. The group believes that it is important to have policies in place for people to refer to and to give consistency across the organisation. Communication is the key, and is quite difficult in a community trust, due to the geographical spread of employees.

The compilation of the HAW group is also an essential success factor. A diverse, representative group is

definitely one of the keys to HAW success. It is important that the people on the HAW group have relevant specialist skills. The HAW group comprises a dietician, occupational health, clinical psychologist, health promotion from the local health authority, community liaison health visitor, union representatives and so on. The group should be a mix of management/non-management, community and hospital-based, clinicians and non-clinicians.

Things to improve

Ensure that there is easy access to facilities and services so that people do not have to make too much effort to follow a healthy lifestyle. This comes down to the availability of resources. Organisations need to find some way to provide these facilities, or on-site classes, without too much cost to the trust.

What would they have done differently?

The HAW group does not believe it would approach the initiative in a different way if it were to do it again. However, it would like to see fewer initiatives to enable more focus on particular issues. The group would like to see a centralised fund that HAW groups can access for improving amenities. Groups and trusts need to be aware that you do not see instant results from such initiatives, and there is a sense that the management may not want to support initiatives that take time to make changes in an organisation.

Case study 11 – Hull and East Riding Community Health NHS Trust

Background

The trust is a community trust formed from the merger in October 1999 of two neighbouring trusts. Following the transfer of district nurses and health visitors to PCTs in 2001, the trust employs about 2,700 staff.

Implementation process

Starting points

Originally, relevant workplace health activity was conducted by the health promotion team and by HR staff. With the need for additional financial resources, these staff prompted the board of directors to consider embedding the initiative more deeply in the trust. The directors discussed the HAW initiative and agreed that its implementation would be important for good practice. They agreed that it should have a fundamental impact on the processes and procedures within the trust that had not already been addressed by the HR and health promotion teams. The board believed that it was essential that the overall coordinator be at a high grade within the trust to emphasise the board's perception of the importance of the initiative. So the director of corporate development was charged with having overall responsibility for coordinating HAW in the trust.

Using the *Framework for Action*, the HAW group was able to map the work that had been conducted so far within the trust. Through liaison with the regional HAW coordinator the group gained more detailed information about how to implement the initiative in the trust, developed an action plan and assigned responsibilities to various management staff to oversee implementation of the HAW initiative. *Framework for Action* was used to direct the trust on good practice for different types of activities, and to evaluate the progress of the implementation of the initiative.

Through a regional health promotion group, which meets quarterly, many of the region's NHS trusts and other local organisations such as the health authority and colleges have been able to share expertise and discuss action plans. Representatives discuss their experiences, and support each other in running events and combined activities.

Resources

The director of corporate development selected employees from the trust to be included in a HAW steering committee. This committee included representatives from health promotion, occupational health and training and development teams, as well as the heads of nursing, mental health and communication. A project manager was selected from the HR team. A chairman representative was also selected from the staff side (trade union representative group).

The committee's main objective was identifying what action would need to be conducted within the trust to address HAW. It was decided by the steering group that the initiative could be integrated into various organisational processes and procedures through the inclusion of the initiative in business strategy and departmental action plans. Resourcing for the initiative is widespread across the organisation; all staff in the trust are expected to take responsibility for health promotion and the initiative is integrated into the work of many of the staff in different departments.

Due to the integrated nature of the initiative in the trust, the budgets for different departments can be used for HAW activities to support events. However, financial resourcing can be an issue, depending on timing and other priorities in the organisation, especially with budgets being diverted to priorities linked to organisational changes. Additional finance is available through the occupational health team, which is able to generate income from activities with external organisations.

The trust is working with local businesses and other government agencies. For example, the trust is implementing a zero tolerance campaign to address violence in the workplace. The local police and Crown Prosecution Service have been involved in roadshow activities and protocol design. The income generated by partnership working is used to fund further activities relating to HAW. Partnership working is part of the business plan for the trust and so the HAW initiative is closely linked to broader organisational strategy.

Strategy planning

The *Framework for Action* has been used for strategic planning for the implementation of more fundamental aspects of workplace health issues, such as auditing HR and health and safety policies. Internal experience of project management and health promotion strategies have also supported the strategic planning for implementation of processes.

Heads of relevant departments have been included in the HAW steering group, with an expectation that these managers will then include HAW in departmental planning and performance objectives. Regular communication is included in the process, with departmental heads reporting back to the steering group any issues that have been raised by staff. The coordinator includes the initiative in organisational planning through ensuring the inclusion of HAW as an agenda item at board meetings. The staff attitude survey is used to review and evaluate activities and also to identify alternative activities that could be implemented. The implementer believes that it is important that staff not only receive feedback from the survey but are also aware of the actions that are to be implemented as a result.

Identifying the activities

A survey was conducted in one of the former trusts in 1995 which aimed to identify the amount and type of pressure experienced by staff in the workplace. As a result of this survey, it was identified that change within the structure and focus of the organisation, due to mergers and future anticipated changes, were the main causes of stress or pressure.

The organisation set up a counselling service for staff, run by one of the nursing team, which was generally well used. Funding for the service was allocated from other internal budgets and allowed for the creation of a new post to coordinate the service. Some staff with counselling skills or Relate training also volunteered their time. However, some of the volunteers who supported the service have been unable to offer support more recently due to work pressures. This service is currently under review as there has also been some budget limitations, as a result of trust merger and reorganisation. A similar service may be offered by the OH team or outsourced in future.

The staff attitude survey has included questions linked to workplace health. The results of the survey are used as a benchmark to evaluate improvements resulting from the HAW initiative. The directors also have regular consultation sessions with staff in which they include questions about workplace health. So consultation with staff is an ongoing part of implementation, evaluation and review of the initiative.

Communication strategies

The head of communication is a member of the HAW steering group and so there is a significant input from this department in ensuring that the initiative is well publicised. Example communication methods include team briefing agenda items, staff magazines, newsletters, staff induction sessions, screening information, the intranet (including online newsletters), roadshows and workshops. There are monthly team briefings in the organisation, which include relevant information about HAW. There is also space available in the newsletter that is available to all staff within the organisation.

There is an intranet site which contains a large amount of information for staff, for example information on caring for older people and family care. The personnel policies and procedures are also available on the intranet site so that all staff are able to access the information with ease.

Linked to communication strategies, staff achievements are recognised by the trust. Staff are invited to attend a lunch with the chairman and members of the board. This conveys a positive message to staff and serves as an indirect form of communication about the activities of various departments and the work they are conducting in relation to this initiative.

Examples of HAW activity

Personnel policies have been reviewed in conjunction with staff-side representatives. Personnel policies and procedures are regularly reviewed, updated and benchmarked against external organisations for examples of best practice. For example, the trust has conducted a lot of work in relation to its disability policies, setting up a conference about disability and the workplace. The trust aims to have champions for disability in different parts of the trust, who others are able to approach for advice and support. The implementer approached the local health authority to gain funding and support for the initiative.

The training and development team have also implemented an employee development scheme which allows staff to attend courses that are not of a work-specific nature, such as flower arranging or languages. The aim of the scheme is for staff to benefit from personal development and feel that they are valued by the organisation. The scheme is linked to the local authority and colleges which offer a corporate discount to the NHS trust.

Staff have access to the trust's occupational health team for counselling and other related services. The occupational health team includes a consultant who is available to staff in other trusts in the area, including the local acute trust. The OH team has been consulting with the new PCT sites to assess the types of services they would require, including workplace health issues. Transport issues have been addressed by educating staff on how to ensure that they are acting in a responsible way towards the environment. Tai chi is arranged for staff at lunch-times at one of the trust's main sites, and the local school has gym facilities which are available for staff use outside of school hours.

The barriers

- In relation to partnership working or gaining resources from outside organisations, there can be a time delay due to bureaucratic processes in gaining commitment or funding for activities.
- Expertise, such as a nurse with post-traumatic stress disorder training, is lost when staff move to new jobs or workloads change and they are no longer able to provide a voluntary service.
- Merger of the trust and the advent of PCTs require the services to cover a much larger area. This makes events much more difficult to organise for all staff to have access and so ensure that, at a local level, staff are encouraged to follow healthy practices.

Impact on staff health

Activities are evaluated through analysis of the staff attitude survey. There is also attendance and feedback encouraged from training courses and other HR activities. The employee development scheme has been in place for three years and has been evaluated and reviewed based on the courses that are most popularly demanded and other courses that could be made available to staff. Some activities such as tai chi are more difficult to evaluate or assess. Attendance is assessed and appears to be successful.

Lessons learnt

What went well?

- One of the directors took overall responsibility for implementing the initiative and so was able to

introduce the initiative at a more fundamental level. This conveys the message to staff that the initiative is considered to be important at senior level, and that they are valued by their senior management team.
- The initiative has been implemented into a large variety of processes within the trust and in individual departments.
- Experts from within the trust have been able to offer their expertise and advice for various aspects of implementation, for example psychologists, counselling services and OH consultants.
- The health promotion team works within the trust and are very proactive in relation to good practice and publicising advice and information.
- There is a significant amount of partnership working which has increased the resource pool in the trust.
- Staff within the trust have a very good relationship with the staff-side representatives and so it has been easier to gain staff commitment to the initiative.
- The chief executive and chairman are also very supportive and view the initiative as a priority for the organisation to implement.

What went wrong and what would they have done differently?

- Although nothing has specifically gone wrong, involvement of the directors at an earlier stage would have moved the initiative forward more quickly in relation to addressing the more fundamental aspects of HAW, such as auditing of HR policies.
- A document could have been written which outlines all the services that are available to staff under the umbrella of HAW.

Case study 12 – Birmingham Children's Hospital NHS Trust

Background

The trust is a medium size acute trust which employs 2,500 staff, with the focus of work being of a specialist nature. The trust has been involved in workplace health activities for about ten years and was involved in the three-year Workplace Health study. This created much interest at board level as the then director of corporate development was involved in the study. This involvement has indirectly increased the support of the board at an early stage in the HAW implementation.

Implementation process

Starting points

The implementer has regional coordination capacity, and within the trust their position is based within human resources reporting directly to the director of HR. The implementer has been involved in workplace health promotion issues for some time and has also conducted research focusing on the impact of work on health specifically within the hospital. Based on their interest and expertise in this area, the implementer was identified as the best individual to fulfil the role of HAW implementer in this trust. The role was formally recognised more recently and has become a full-time responsibility for the implementer. The objectives of the post were identified jointly by the director of HR and the implementer and form the basis for performance appraisal, making the implementer accountable for the activities of the health promotion and staff support group.

A clinical psychologist was involved in the HAW group and focused it on stress and counselling for staff as main issues for improvement of employee health and wellbeing. The stress within the trust is thought to be made more acute by the specialist nature of the trust's clinical work. There has also been a relocation of the trust which has had a significant impact on potential stressors. Management of change within the trust has therefore had an impact on the implementation of HAW.

A lot of work was done by the trust in relation to workplace health in partnership with one of the local universities. The research involved stress indices and the measurement of stress within an organisation.

Resources

The HAW group included representatives from various different departments. The group was also supported by a clinical psychologist whose particular areas of interest are in stress management and counselling. The inclusion of a clinical psychologist in the resources available to the group was important due to the pressure that staff may be under caused by the specialist needs of the patients cared for in the hospital.

The directors of the trust have been very supportive of the initiative, due to the previous research conducted into workplace health. The work of the group is included as an agenda item at strategic management level. The implementer reports directly to a member of the board of directors and so has allowed the group to retain a high profile within the trust.

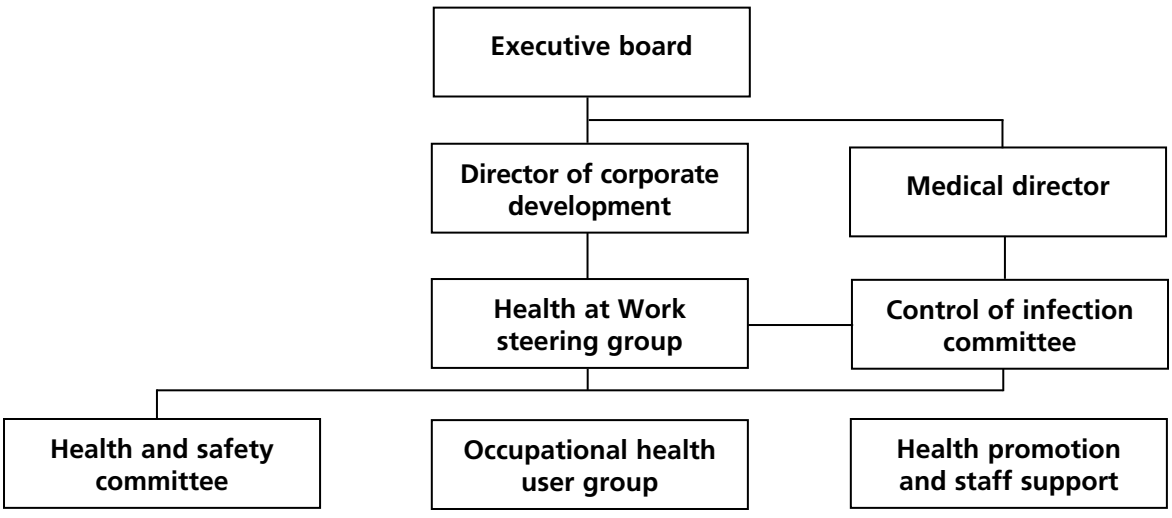
Experts include staff from the local university such as a professor who has been involved in partnership research with the trust and others in the city. Having this expertise and that of internal staff such as clinical psychologists, whose focus of work specifically links to stress, has been very beneficial for the trust. Likewise, the HAW implementer has conducted research specifically into organisational change and its impact on health. These sources of work have been beneficial for staff consultation processes.There are currently links to other trusts that can benefit from the HAW model in place, and these trusts could also help the trust financially through joint activities and mutual benefits.

Generally, financial resources are problematic as there has been no direct trust fund available for the work of the group. To gain more resources for funding activities, the group has sought to explore income generation schemes, including supporting the sale of a health awareness magazine, *Feelgood*, which is sold for £1 a copy in the trust. This magazine is available to all staff as well as patients and visitors and contains information about health promotion and lifestyle issues, collated by experts. The format and quality of the magazine is similar to health magazines found in the local newsagents and is currently available on a quarterly basis. The initiative for the sale and distribution of the magazine throughout the NHS was supported by the NHS Executive Communications Unit, and 20-40p from each copy is donated to the Health Promotion Fund.

One-off events are funded by other budgets within the trust, alongside voluntary support from external organisations, but the health promotion and staff support group recommends having its own budget for longer term activities.

Strategy planning

The HAW strategy was identified by the HAW steering group, chaired by the then director of corporate development. The strategy document included information about the background to the initiative; the benefits to the employer, staff and patients; the strategic aim; the key principles; the HAW objectives specific to the trust; the key priorities (components including health promotion and staff support, health and safety, occupational health, performance management, control of infection); and an early organisational structure for those involved in HAW implementation. (See diagram below.)



The responsibilities of the HAW implementer, action plan and strategy documents were all designed under the guidance of the director of human resources.

The trust identified the need to have a full-time position for a health promotion coordinator. The objectives for the post were identified as:

- To further develop the health promotion function within the trust, including improvements to staff health and wellbeing
- To contribute towards the human resources function, incorporating improvements in staff health and wellbeing at trust level
- To support the development of partnership working across all sectors and raise the profile of the trust within the multi-agency arena.

The trust is currently revamping the HAW strategy to update the focus of the group's work.

The action plan that has been designed outlines the outcome measures and standards of performance, the resources available and barriers to overcome, as well as short, medium and long-term actions and review processes.

In relation to the strategic planning process, the implementer believes that there is still a need to address staff commitment to the initiative. The next phase of the process is to communicate the initiative broadly to staff so that they are more aware of the investment that the trust is making for their health. Staff are consulted, but the HAW group would like more involvement from them and more feedback about how they want the initiative to be run within the trust.

Identifying the activities

The staff survey identified stressors that staff were exposed to and where the organisation was in relation to management of change. Using benchmark data, the trust was found to not be suffering significantly greater stressors than other trusts and organisations, which was a positive finding in light of the organisational change taking place.

However, using sickness absence figures and a stress index designed by a local university, several areas within the trust have been identified as suffering from greater stress levels than others, particularly clinical services staff. Several months after the move had been completed, the health of these staff was considered to have been affected more negatively by the trust relocation than other departments and units. There was an attempt to focus on improving the working conditions for these staff through support to tackle the stressors that might be affecting them and also through recommending lifestyle checks for these staff.

The sickness absence management statistics are used on an ongoing basis to support identification of other potential areas where staff may be suffering from stress-related ill health. However, it is acknowledged that these statistics are not indicative of stress hotspots, but patterns of higher levels of sickness absence are analysed. The context of the patterns then needs to be considered to assess whether there is an issue about illness induced by the working environment.

The remit of the group has been broadened recently due to the introduction of the Improving Working Lives (IWL) initiative. The IWL steering group covers broader activities such as implementing crèche facilities to improve staff work-life balance; there is a subcommittee focusing on this issue, alongside staff involvement and communication subcommittees. The IWL steering group is multidisciplinary in nature, chaired by a non-executive director, and supported by the director of human resources. The health promotion coordinator represents the interests of staff health and wellbeing on this group. It is envisaged that there will be cross-fertilisation of ideas between this and the HAW group.

Communication strategies

One-page survey fliers are sent to staff about different activities to gauge the level of interest. Not all communication processes reach all the staff in the trust, so the implementer tries different forms of communication such as email, internal post and noticeboards, particularly near the staff restaurant and in the restaurant itself. There are also display cabinets shared with the occupational health department and health and safety department (part of the clinical governance unit) which can be used for advertising HAW activities and key issues.

Activities such as flu vaccinations (supporting productivity) are viewed as staff health benefits as all staff have the opportunity to have the vaccination, not only those having a higher risk of exposure.

Examples of HAW activity

After consultation with staff, the issues they were most interested in included lifestyle, stress management and complementary therapy.

The HAW group has worked with local health clubs and gyms to offer staff corporate discounts, with a free trial coordinated by the trust. In addition to corporate rates, the trust is negotiating short-term membership for doctors and other staff who are 'rotating' in line with training or job requirements. The intention is that staff are encouraged to select a gym that is most convenient to them off-site and the different clubs recommended cover a large variety of needs. These include swimming, gym, yoga, aerobics and sports club facilities as well as health spas, beauty treatments and alternative therapy sessions such as aromatherapy and massage.

The HAW group is exploring the possibility of offering staff a self-assessment health survey which is sent to their home address and aims to identify lifestyle issues and individual stressors that may affect the individual's health. The results would be analysed by an external organisation and the individual given a personal health profile. The group is currently arranging for a representative from Weight Watchers to run weight management sessions with staff based on widespread staff interest. The potential for this activity is being assessed through staff consultation fliers distributed throughout the trust.

An external counselling service is also available that is located off-site and which staff are able to access through self-referral or referral via occupational health or the psychology department. In addition to this external facility, an internal staff support service operates, where a member of the clinical psychology team at the trust is involved in running an on-site counselling service. Her role also includes facilitation of debriefing sessions after critical incidents in the trust. The service is run predominately on a self-referral basis and includes workshops and training sessions for stress management and counselling skills. Referral to the service is confidential. The service also has links to psychiatric and mental health practices and so covers a wide range of services. The service is not overtly advertised within the trust to avoid creating a stigma about referral to the service. Periodically updated fliers detailing the staff support service are circulated to employees via payslips. The number of referrals to the service increased over the last year.

The barriers

National changes in policy guidelines affect the relevance of local policies, which need to be updated.

Facilities that are currently available at the main hospital site do not encourage staff to take exercise in the morning or at lunch-time; for example there are limited shower facilities.

The trust has a service level agreement with another NHS trust in the city for the provision of its occupational health services. On occasion, the constraints of such a service level agreement may be viewed as a barrier to the service being more proactive about some of the wider health issues and initiatives that are increasingly being seen as important to staff health and wellbeing. The main constraints are seen as capacity and costs associated with enhancing the service level agreement.

The trust moved site about three years ago and the space that is available at the new site, while being greater, has its own features that may have affected staff interaction across departments and units, so making communication processes more difficult. There are few areas for social interaction, which maybe considered a stressor. Physical space for activities has also been a barrier to implementing activities that require space, including exercise classes that would be well attended if available on site. When there has been space available, these activities have been fully booked or well attended. However, the lack of space has prompted the health promotion and staff support group to look at certain activities that can be conducted outside the trust and also partnership working with other organisations such as health clubs.

There also needs to be more support from staff within the trust, through taking responsibility for the initiative at an individual level.

Impact on staff health

Assessment of impact on staff is expected to be partly through sickness absence statistics, and the number of referrals to the on- and off-site counselling services. Activities that have been conducted on-site have been very popular, including exercise classes, which are quickly booked up. The HAW implementer acknowledged it is

important that the impact of the initiative and its various activities are assessed, but it is difficult to make this assessment too definitive beyond attendance at events. Using sickness absence records alone is not recommended as there are various factors influencing these statistics and it would not be a reliable measure of the success of the initiative.

The annual staff attitude survey and turnover statistics may offer good indications of staff wellbeing.

Lessons learned

What went well?

There has been an organised approach to implementation of the HAW initiative in the trust, with the director of human resources taking overall strategic responsibility while the implementer organised the more practical aspects of the initiative.

Partnership with local gyms and health clubs has attempted to address the lack of an on-site gym and health facilities for staff. A weekly weight control programme has proved particularly successful.

What went wrong?

Little funding was allocated specifically for HAW or health promotion activity, other than the more recent funding of a full-time health promotion coordinator.

Some services, such as on-site exercise classes, beauty treatments and massage sessions, have lacked follow through. This has principally been due to a staffing short-fall in partner organisations.

What would they have done differently?

The trust has been demonstrating a developmental approach to HAW activity, learning as they have been going along, so it is difficult to say that it would have done something dramatically differently.

Case study 13 – Anon.

Background

The health authority is a strategic planning organisation with responsibility for healthcare in the region. It has 200 employees. The authority is about to embark on a substantial programme of change management in terms of its function and the roles of its staff, as the Health Minister has announced that the number of health authorities in the region will be reduced by two-thirds.

The health authority considers its current remit to be leading change and promoting health at work in associated trusts. It is unlikely, however, that this will be its role in the future. The message from The *National Occupational Health Strategy* and the NHS *Modernisation Plan* indicates that initiatives aimed at promoting workplace health will be delivered at a primary care level, with health authorities providing a strategic steer and a performance management role. The current critical issue for the authority in terms of workplace health is to ensure that these functions devolve smoothly into primary care trusts.

This case study gives examples of the health authority's involvement in a HAW initiative in an acute care trust, and demonstrates how the authority is beginning to devolve its role for the promotion of health at work into the wider community.

Implementation process

Starting points

The health authority's view on health initiatives for its own staff is concerned more with prevention than intervention and so it does not promote HAW for its own employees, per se. It is the view that that there are enough existing vehicles to drive health improvement in health authorities without the need to follow a specific strategy. However, there are a number of employee health-related issues which the authority aims to address through the staff consultative committee and personnel policies.

Based on the axiom 'if you can maintain people's sense of wellbeing, you find they don't suffer as much physical ill health' the health authority has set up a 'leadership for

health' group. This group, including staff from shop floor to boardroom, is tasked by the chief executive to manage the transition planning stage for all authority staff during the forthcoming organisational change. Within this remit, the group will look at how employees in the organisation cope with change. The organisational development manager believes that a lot of ill health is a result of people's resistance or lack of capacity to deal with change. This approach considers every aspect of the organisation or a person's job as a potential enhancer or inhibitor of employee health. Consequently, the authority believes that good management practice, job design and preparing people for change are important to tackling potential risks to ill health and just as critical to promoting the health of staff as other, more specific, interventions focusing on workplace health.

> *'If you don't call it health at work, but instead you look at it as organisational development and good management standards, good communication and good care for staff so that they know what the purpose of their job is, they are involved in changing their roles, and that is the biggest contribution they can make for their health.'*

The bulk of the health authority's work on HAW has been done with trusts falling within their remit. The acute trust looked at here was classified a Health Promoting Hospital, as a result of its participation in a World Health Organization European project focusing on workplace health, started ten years ago.

The European project followed a 'settings' model as an approach to health in the workplace, looking at promoting health across a whole range of areas such as patient care, buildings, services and staff. The settings model was designed to help bridge the gap between the philosophy of health promotion and the reality of implementation.

The trust's chief executive at that time was keen to develop HAW alongside a portfolio of health promoting initiatives (for example, the promotion of green transport issues). The health authority's health promotion coordinator had previously worked in the trust and had been involved in the WHO project.

The HAW programme within the trust has now come to an end. The occupational health manager and quality manager both left the organisation, and some momentum carrying on the work has been lost. The hospital has gone through a merger and change of management. HAW initiatives do not appear to be top of the agenda in this time of flux.

Resources

Health at Work group. The authority's health promotion coordinator was seconded for two days a week to work with the trust on HAW. A condition was that the coordinator would be partnered with a trust employee who would act as a internal change agent. The trust's head of quality was nominated for this role. A HAW group was formed, comprising the authority's health promotion coordinator, the occupational health manager, the quality manager and other staff representatives. A staff steering group was also established to identify areas of concern within the trust, and possible initiatives. This group, which had representatives from wards and departments, gave direction to the HAW working group.

Financial resources. There was no separate budget for HAW activities. While the steering group could make proposals to the board for funding, none was actually given.

Reporting structures up to board level. Formal reporting structures were put in place, via the director of quality and development, up to the trust board. This was seen as an essential tool for ensuring that initiatives were given appropriate priority and backing at senior level.

Strategy planning

Difficulties were encountered getting the initiative incorporated into the strategy of the trust, although the enlistment of the trust's occupational health manager was recognised as a major breakthrough. The trust's newly appointed occupational health manager was very enthusiastic about HAW and helped to raise its profile within the trust by drawing on the HAW model.

The focus of the HAW group and the steering group was on addressing health issues which would benefit staff and patients alike. However, it would appear that a specific remit or terms of reference for the group were not established at the outset.

The health authority found that it was easier to get the commitment of trust board members to 'that which they know they have to do' rather than 'those which are

optional but equally desirable'. The authority was therefore challenged to illustrate the organisational benefits of pursuing HAW to the trust board.

Identifying the activities

The majority of initiatives implemented under HAW were based on staff feedback to the HAW group, via the steering group representatives. A specific health needs assessment within the trust was not undertaken. The need for action was often illustrated through issues raised by various trust policies. For example, the need for mutually supporting initiatives such as the clean environment policy was illustrated through discussion of the no smoking policy.

The no smoking policy had driven the trust's smoking problem underground and resulted in the environmental issue of huge piles of cigarette butts at the hospital entrance. The trust therefore recognised that it may not be possible to rigidly enforce a smoke-free environment, but could take remedial action to ensure a clean environment.

Communication strategies

The most effective form of communication was found to be word of mouth. The HAW group would transmit information to the steering group and the people in the steering group would take messages back to their colleagues. The hospital newsletter was also used to inform staff, with competitions being employed to encourage staff involvement.

Examples of HAW activity

Green travel plans. This initiative included car sharing schemes for staff. It also saw the trust working in partnership with local businesses to provide a shoppers' bus at lunch-time to get staff to the city centre to do their shopping, and discounted travel tickets for staff on public transport. This initiative has gained new energy due to site redevelopment.

Fast-track back treatment for nurses. This initiative not only recognised the risk of injury faced by nurses but also the need for prompt treatment to reduce extended absenteeism. The aim of the initiative was to allow nurses to take advantage of the trust's on-site facilities by enabling them to go directly for treatment, rather than have to be referred by their GP. This initiative initially met extreme resistance from doctors, who thought that nurses should go through the same process as patients.

Healthy eating initiative. The working party aimed to improve the nutritional value of food offered by the hospital to both employees and patients. A dietician was brought in and canteen food was improved and a nutrition policy established.

Further problems have been identified with ensuring that all staff have access to healthy food options. Night-shift workers, for example, have to rely on vending machines, which not only fail to provide healthy options but are often a long distance away from their place of work. This is still recognised as an issue within the trust, and one that is no closer to being addressed.

Smoking policy. The hospital was classified as a no smoking environment. Patients and visitors, however, used their own interpretations of what this meant and generally continued to smoke in the hospital grounds, particularly at the entrance to the building. The hospital staff had no method of policing and enforcing smoking restrictions. The trust recognises that this is a common problem in many hospitals.

The working group put forward a proposal for sheltered areas outside, away from main entrances, and designated ventilated smoking areas inside. This, it calculated, could be achieved at nominal cost. The proposal was presented to the board, but to date has not been implemented.

The barriers

Support at senior level

Initially, getting any form of initiative incorporated into the work of the hospital was difficult. The breakthrough came when the health promotion coordinator ensured the help of the hospital's occupational health manager, who managed to raise the profile of the initiative at senior level within the trust.

Lack of formal recognition for HAW responsibilities

Staff turnover was a key barrier to the successful implementation of initiatives. The HAW project within the trust ceased when key personnel left the organisation and, as their duties had not been formalised in their job descriptions, there was no formal method for ensuring that their responsibilities would continue with their successors.

Conflicting priorities

A major barrier to the successful implementation of HAW was the conflict with other priorities for resources. Acute hospitals are under tremendous pressure to deliver an increasing number of external measures, such as waiting lists. The HAW initiatives were regarded as an additional demand, adding to an already high workload, and one that would often 'drop off the end of a list'.

Organisational culture

The NHS itself was seen as a difficult environment in which to start new initiatives due to the culture of the organisation. It is believed that perhaps the only way to achieve real support for improvements to employee health and wellbeing is through a major culture change.

Interviewees were unsure about how to address this need for culture change. They saw the problem as essentially one of the organisation meeting the criteria of the initiative, without necessarily changing the culture that leads to health issues in the first instance. An organisation can often have a healthy working policy but still not have a culture of healthy working. To be part of the culture there has to be 'a meeting of minds' with staff at all levels fully understanding, supporting and living that culture.

Initiative overload

There are currently many different projects and initiatives going on in the NHS and employees believe that trusts are likely to be suffering from 'initiative overload'.

Impact on staff health

No formal assessment of the success of the various initiatives has been undertaken. Employee take-up of the initiatives under the green travel plans suggests that this has been a successful and popular scheme. The healthy eating campaign in the canteen has been relatively successful, although there are still outstanding issues regarding access to healthy options for staff working nights. The success of the smoking policy has been hindered by patients and visitors persisting in smoking, and the lack of support from senior level to provide sheltered and designated smoking areas within the hospital. It is expected that major site redevelopments will address this issue.

Lessons learnt

Getting staff involved

Staff involvement is essential to the success of initiatives. It ensures that initiatives are targeted appropriately, in line with what staff consider to be important. It also generates a sense of staff ownership of initiatives, which leads to greater acceptance to and cooperation with subsequent changes that took place. Communication was thought to be crucial to getting staff involved.

Commitment of individual champions

All interviewees spoke of the need for commitment from individuals to champion the cause and get results.

Need to get the basics right first

Many of the HAW initiatives put pressure on trusts to come up with innovative ideas. But many staff feel that trusts should be focusing on getting the basics right first:

> *'Staff still do not know what their occupational health rights are ... people still haven't got the basics such as child care and healthy food, why do they want something new?'*

Adapting policies to suit regional needs

A major barrier to the successful implementation of HAW is thought to be its 'national badge'. As the initiative was seen as a top-down exercise within the trust, employees did not feel as engaged as they should be. The solution is seen as greater scope for regional variation to address specific and local needs, within the broader remit of the initiative.

> *'Learn from the big corporations and multinationals that have got a lot of local control, thinking globally and acting locally. So in a sense, templates nationally are fine, but please let national organisations get on and shape these initiatives to meet local needs, otherwise you will end up with a lot of tick boxes being ticked and not a lot of change. If you let people go with this, they find a way of getting round difficulties.'*

The health authority is heeding this advice in its approach to devolving its responsibilities for HAW to primary care trusts and through new NHS Plus approaches. It is aiming to establish partnerships between different trusts with similar issues and encourage them to work together to find local solutions to the issues. An example of this regional approach is partnership work recently initiated with the local Chamber of Commerce.

Case study 14 – Walsall Hospitals

Background

The trust is a Health Promoting Hospital in a Health Action Zone, and employs approximately 3,500 staff over two sites. The occupational health department takes a central role in the HAW initiative and is linked to the local community trust and also more recently to primary care groups in the area.

The hospital has gained Health Promoting Hospital status and its philosophy is 'to provide an effective, caring service to all employees, taking into account the effects of their work on their health and their health on their work'. The hospital aims to focus on creating support for individuals, increasing staff awareness as well as making staff responsible for their own health and promoting good health practices to others.

Implementation process

Starting points

The trust's main health promotion effort is through the occupational health department. The board of directors therefore considered HAW as being included in the remit of the occupational health team. The four staff in the occupational health team have the HAW initiative integrated into their departmental objectives, as the remit is very similar to the Health Promoting Hospitals initiative.

The regional coordinator has an involvement, regularly attending meetings with the occupational health manager, which ensures that there is a strategic level of HAW work. The occupational health manager also speaks at regional conferences and is involved in the local health and work steering group which includes representatives from Unison, Citizens Advice Bureau, the health authority, local council, Training and Enterprise Council, and the Enterprise Agency.

Resources

The occupational health team has health promotion included in job descriptions and performance appraisals, so HAW is integrated into its working practices. However, the influence of health promotion is much wider in the trust, with staff in management positions having health promotion responsibility as part of their roles. Further, there are nurses on each ward or department who act as health promotion links at both sites in the trust. The work of the occupational health team can be viewed as a coordination role while all staff are involved in implementation. Health promotion can be very time consuming and the occupational health manager believes that there is a need for a full-time coordination position to encourage proactive working, as the occupational health team must still conduct reactive work in the trust.

Link workers meet with the occupational health team twice a year. The aim of the occupational health team is to set up awareness days and to design and deliver some training courses, while the link workers take on these activities on a smaller scale and over a longer period of time, maintaining the activities within the trust while the occupational health team concentrates on developing new activities.

The work of the occupational health department on health promotion has been adapted for use in private companies. This partnership working with other organisations has two main benefits for the trust: it is promoting the NHS trust as a role model organisation within the local area and it is also able to generate income as a consultant to these organisations. Other organisations such as Boots are able to sponsor the trust by offering free products to staff when promoting healthy skincare.

The hospital's board of directors has a responsibility to be actively involved in health promoting activities due to the demands of the Health Promoting Hospitals initiative, so directors are also supportive of HAW as the remits are closely linked. The HAW implementer feels that this support from the chief executive and directors is essential to the full success of the initiative as funding is more readily available from different departments as well as in securing a fund specifically for HAW activities. The trust's finance department is able to inform the occupational health manager about the funds from relevant budgets available for various activities. Finance is also available through the Health Promoting Hospitals funding.

Strategy planning

Due to their commitment in implementing the Health Promoting Hospitals initiative, the board of directors supported HAW when it was introduced. The board chose the occupational health department to take on the responsibility for the initiative. The occupational health manager reports to a board director about progress on both the Health Promoting Hospitals initiative and HAW.

Identifying the activities

The annual staff survey includes a section about HAW activities. A stress audit has also been conducted, the results of which are used to identify problem teams or areas and then target these groups for action. Staff are able to communicate ideas for health promoting activities through the staff negotiation committee, directly to occupational health or to their local link worker. A link worker has been identified in many departments across the two sites – they are the local representatives responsible for communicating issues to staff, providing advice and also liaising with occupational health about ideas or questions that the staff have.

The occupational health manager believes that it is important to increase staff awareness about various health issues so that they take more responsibility for their own health. However, it is equally important that staff receive support for any concerns they have – the occupational health team is also responsible for ensuring that this support is in place or that the support can be identified should staff need it. There needs to be follow-up designed as part of the development of awareness sessions. For example, after the smoking awareness training, there was a nicotine replacement therapy course offered to those who were planning to quit.

Communication strategies

Awareness posters are sited around the hospital so that staff, patients and visitors have access to them. The subject matter of the posters changes regularly, to reflect seasonal or other current topics of interest such as those addressed by the World Health Organization.

Comprehensive policies and procedures have been written and circulated to staff via the trust's intranet, for which the occupational health department is developing its own home page with links to external websites for additional information for staff. The intranet is actively used within the trust for dissemination of information and for contact between staff. For example, the directors are accessible to staff for questioning and keeping staff up to date about issues which may affect them, including national NHS updates and legislation.

There is a handbook available to all staff which has been funded by the Health Promoting Hospitals initiative; it is available in all wards and departments. The trust's HAW initiative has its own logo attached to all documentation so that staff are immediately aware of the contents of a document, poster or flier. During staff induction a training session is offered about different aspects of occupational health and the occupational risks that they may encounter. These include health and safety issues, such as contagious illnesses and risk assessment in the workplace.

Examples of HAW activity

Planned events include awareness weeks that are conducted on-site and involve displays, posters and lectures. Topics over the last year include active for life (physical exercise), Parkinson's disease, national swim week, sun awareness, and stroke. Follow-up support has included a no smoking patches voucher scheme to target those who are unable to collect patches from the occupational health department on the main site. This was implemented after a no smoking day, which included a smoking cessation training course that staff are encouraged to attend to promote smoking cessation to patients but also to understand the pressure and side effects that this may have on the patient's wellbeing. For smokers, a four-week nicotine replacement therapy course was also offered.

For healthy eating, staff were encouraged to try the healthy options available in the staff restaurant although other foods were still available to staff due to the physical nature of their jobs. There is now a healthy eating option available every lunch-time. For alcohol awareness, the implications of being drunk on duty were emphasised through a role play presentation. Awareness packs were also offered to staff to increase their understanding of the issues of alcohol abuse. Non-alcoholic cocktails were offered to attendees. However, delivery of these types of training courses can be difficult to maintain.

In addition to the awareness weeks, staff are given mandatory update training days about various health promotion and occupational health issues. They are also offered annual health checks at an open day.

The barriers

The occupational health manager feels that more may be done if there were increased resources, such as an individual responsible for proactive health promotion who was also able to take responsibility for external consulting to increase income generation. Presently, all the internal and external work is conducted by the current team,

which must also be responsible for the other occupational health responsibilities.

When staff leave the partnership organisations it can be difficult to develop new contacts within the organisation. So it is felt that there is some barrier to maintaining the partnership working due to the lower priority that some organisations have placed on promoting health for staff in the workplace.

Impact on staff health

Training sessions are evaluated through feedback forms offered to attendees. With regard to smoking cessation, the number of smokers in the trust who have not returned to smoking is being monitored by the occupational health department, although these figures are based on self 'confession'.

The impact of HAW within the trust is difficult to assess due to the close link between HAW and the Health Promoting Hospitals initiative. There are multiple initiatives that can be placed under both 'umbrellas'. The occupational health department used to have a reactive remit, but since the two initiatives have been in place its remit has become more proactive.

Lessons learnt

What went well?

Link workers increase the resources available to the occupational health department; this is an alternative to developing a HAW committee to increase potential resources.

What went wrong?

The occupational health manager does not feel that anything has necessarily gone wrong; however, the team is learning and improving the service that it offers based on feedback that they receive from staff.

What would they have done differently?

The trust should have involved staff at an earlier stage with a needs assessment that could have been used to focus resources and prioritise the subject matter of various training and awareness sessions. Staff consultation could have been conducted through focus groups to gain more feedback.

Case study 15 – Parkside Community Trust

Background

The organisation is a community trust covering multiple sites in an urban area, and employs approximately 1,900 staff. The trust is soon to undergo a significant organisational restructuring, as it will be broken down into several primary care trusts.

The trust has received a Health at Work category 3 award.

Implementation process

Starting points

In the early years of the initiative the trust had a very large HAW committee which included about 20 staff from many different parts of the trust. However, it was felt that little progress was made with such a large group and so the committee membership was reviewed. A working party was set up as part of this review process, which included eight staff, from human resources, occupational health, a dietician, and management staff from facilities, catering, training and operational management. The current HAW coordinator is the chair of this committee.

Committee members were asked what they and their staff would want from the HAW initiative. On the basis of these requirements, the coordinator identified the need for a part-time post to be created for the coordination of HAW activities within the occupational health department. The position had performance objectives and a job description which focused mainly on HAW activities. This position is referred to in this case study as the 'HAW implementer', while the working party committee chair (the occupational health manager) is referred to as the 'HAW coordinator'.

Resources

The HAW implementer had responsibility for the coordination of activities while being able to draw on the support of other staff and people outside the trust in setting up and running activities. Funding for this position was gained through OH although no specific budget for HAW activities was identified. Some money was available for one-off activities from the occupational health budget

(for example, for food at health fairs), and from other department budgets, such as HR and finance budgets. Commonly, there was no resource available other than the implementer, who then had to conduct some activities such as awareness training.

The focus of resourcing was mainly on gaining free time from other staff with expertise in the topic area being promoted and also on partnership working with other organisations. For example, commercial industries such as health shops were able to advertise their services through the health fairs and so were often willing to attend for this purpose.

Likewise, people offered support for activities such as physiotherapy or aromatherapy to practise the training that they had received. Police involvement in fairs aimed to raise staff and community awareness about policing issues that are objectives for the local constabulary, for example awareness about drug use in the local community.

Strategy planning

The activities that the trust planned to conduct were dependent on identifying the needs of staff. This included identifying changing needs, such as stress relief when the trust was placed under increased pressure. Part of the strategy planning process was influenced by the aim of the trust to gain a HAW award for its activity, as it was felt that having a target to achieve would be beneficial to implementation as well as communicating to staff what the trust is doing to address their health and welfare needs. To ensure that staff felt valued by the organisation was one of the aims of the HAW implementer, who had the main responsibility for developing the HAW strategy.

The HAW coordinator was expected to report to the trust directors each month to inform them of progress. This regular agenda item was beneficial in that funding could be negotiated from other departmental budgets. The coordinator also reported to the risk management committee.

More recently, with the introduction of the Improving Working Lives (IWL) initiative, the HAW coordinator has included this in the remit of the HAW group, due to potential lack of resources for chairing more than one group. The HAW initiative has been viewed as a closely linked or even as a precursor to the IWL initiative and so HAW strategy is evolving with the implementation of IWL. The increased funding and target setting required as part of IWL has been welcomed by the coordinator as it is felt that this will increase the emphasis placed on HAW.

Identifying the activities

To assess the health needs of staff, the OH team sent out a questionnaire asking staff what sorts of activities they would want to see introduced into the trust. The questionnaire was distributed attached to payslips. The results identified staff concerns about mental health, availability of counselling, opportunities for fitness, and health screening. The activities that have been arranged by the HAW implementer have followed these recommendations.

In line with national events, the implementer has also used the focus from national topics of interest, such as smoking cessation, to identify what the trust could do locally. Other events have been arranged on the basis of these national events.

To address some of the underlying causes of poor health among staff, the HAW coordinator and implementer also worked with the human resources team to audit policies and procedures to ensure that healthy environments were being actively encouraged, to assess sickness absence records and assessment of policies. They also worked with the health and safety team to assess good working practices to maximise the health of staff in the workplace.

Communication strategies

Communication was a time-consuming aspect of the initiative as there was no interconnecting email system or other electronic means of contacting all staff in the trust. A large proportion of time was therefore spent in administration, such as copying and mailing out posters to targeted people to advertise events. Occasionally, however, someone failed to display the posters in their local area and so some staff did not receive information about events.

One successful poster campaign was to promote awareness of violence in the workplace, advertised through 'signpost' posters around the trust, reminding people to demonstrate respect for each other. These posters were aimed at patients as well as staff.

Achievement of the HAW award was found to be indirectly beneficial to communicating the initiative in

the trust, through increasing the awareness of staff of activities being conducted for their benefit.

Examples of HAW activity

An in-depth lifestyle screening programme was also conducted, both for staff and those within the local community. Those coming forward for screening were assessed for health issues such as coronary risk factors, stress and mental health, exercise, male/female health, and back injuries. Where someone was identified with a difficulty, they were referred to a specialist for support, such as a physiotherapist or a counsellor, or to a fitness centre if there were lifestyle issues such as weight loss or gain. However, there were some problems with the implementation of the screening programme due to the cost involved in screening all staff.

The implementer arranged for staff to have access to stress awareness and stress relief classes. These classes were conducted by the implementer at various sites around the trust area. Exercise programmes were arranged through the gym to help staff with weight loss or rehabilitation, as identified through the lifestyle screening programme. These programmes were 'short and snazzy' programmes aimed to encourage staff to take more responsibility for their health as well as avoiding the possibility that the attendance at the exercise classes would dwindle over time. Stress relief activities included aromatherapy, Indian head massage, and reflexology.

Health fairs were identified as good opportunities to increase staff awareness of various health issues. These were arranged by the HAW implementer and included internal experts such as the dental team, and also partnership working with other organisations such as the police and fire services, which were able to give advice about fire hazards and personal safety training. The health fairs also aimed to increase awareness of issues such as drug and alcohol abuse, healthy eating and dieting, and good footwear.

A policy for limiting violence in the workplace was written, procedures put in place and training organised so that people knew what their responsibilities were, what action they could take and what support was available to them from the trust. There is a zero tolerance test or risk assessment in the community, especially for district nurses and for paramedics. Senior management were fully supportive of this policy. The trust is considering a helpline for people experiencing workplace violence.

The barriers

- It was difficult to implement health fairs and other activities due to the spread of staff across the trust area. The implementer had to travel to different sites to give awareness training to staff rather than conduct it at a central location.
- As the initiative is based on individuals offering support, changes in personnel can affect the enthusiasm and drive needed for implementation and limit the continuity of the initiative.
- The initiative is dependent on having the right people in post to arrange the activities. This is possibly due to the lack of financial funding allocated to the initiative, so the reliance is on the enthusiasm of the individuals involved. Those involved in the initiative need to have the right charisma and organisational skills to get the activities off the ground.
- Administration staff are more likely to attend activities than nursing staff, due to lack of resources on nursing wards. During lunch breaks, nursing staff also want to rest and sit down rather than walk round health promotion displays. The implementer found that it was difficult to arrange HAW activities for these staff due to the work demands placed on them.

Impact on staff health

The implementer felt that the initiative has raised the awareness of staff about health issues. The HAW initiative had increased staff awareness of what support can be offered to them by the trust, particularly occupational health. Staff contact with the department has increased for all sorts of health issues. The implementer has evaluated the health fairs through feedback questionnaires that have been sent both prior to and after the event. The implementer sent out 300 copies of a pre-health fair questionnaire to see what staff wanted from the fair, and received 800 back as staff had photocopied the questionnaire! This is reflective of staff interest in the activities conducted.

Lessons learnt

What went well?

- The trust gained the HAW award. This had given the trust something to achieve so was a driving force for the implementer and coordinator.

- The drugs and alcohol awareness sessions linked closely to priorities for the local police, and so working in partnership to raise awareness about these issues in the local community was beneficial to both agencies in achieving targets.
- Individual screening sessions allowed an in-depth discussion about health issues that staff would not be able to do at a health fair. This opportunity was well received by staff.

What went wrong?

Some posters that were sent out advertising events would not be displayed in the area intended as people had not taken the responsibility locally to help advertise the work of the HAW implementer. However, it was difficult for the implementer to advertise events due to the communication channels available in the trust.

What would they have done differently?

- Not used payslips for distribution – stapling surveys to 1,900 payslips left implementer with blisters!
- Although the trust has financed the position of the HAW implementer, a specific budget to be allocated to the implementer to help set up activities would have made the task easier. However, it was felt that the lack of budget actually added to the creativity of identifying what activities can be conducted with very limited resources.

Case study – Kent Ambulance Trust

Background

Kent Ambulance Trust coordinates ambulance services across Kent. It has 840 employees and is funded by the NHS. The trust has implemented several health initiatives in the past two years. Although it wouldn't necessarily put these under the heading of HAW, the implementation of many have been in line with the HAW *Framework for Action*.

Implementation process

Starting points

Examples of the many initiatives the trust has introduced can be grouped under four headings.

Employee welfare support. This includes:

- One of the first ambulance services to bring in a collective agreement on the working time directive
- A 'station listener', who is a trained operational member of staff, and a chaplain available at every station
- A contract with an open counselling service, which has been enhanced to include supervision of selection of station listeners and the provision of a specialist counsellor for post-traumatic stress
- Debt counselling support documentation
- Child support agency documentation and clinics
- An occupational health contract to provide welfare education and advice, in addition to health screening and flexibility for staff with specific domestic problems such as allowing an officer to temporarily work from home to help with childcare when their spouse was in hospital. The occupational health contract is currently being reviewed with a view to providing additional services to staff, such as early diagnosis and treatment of back conditions and other musculo-skeletal cases.

Health support. This includes:

- Fast tracking for physiotherapy and osteopathy treatment
- Zero tolerance regarding violence to staff on responses and training officers to diffuse conflict situations

- New policies for pregnant women risk assessments
- The introduction of easy load stretchers and trialing of other advancements in technology to help reduce potentially risky physical exertion such as lifting.

Environmental and community initiatives. These include:

- Use of duel fuel response cars (LP gas)
- Working with voluntary services such as the Red Cross and St John's Ambulance service to improve service delivery and pass on equipment and resources no longer needed
- A 'community responder' scheme for members of the public to act as 'reserves' to respond to emergencies
- Fund raising for and seconding staff to an air ambulance charity.

Operational support. This includes:

- The introduction of job share schemes taken up by women returnees and older members of staff who were finding it too stressful to be in full-time frontline duties and using these flexible options as a means of alleviating some of the pressure. Job share together with bank schemes provides staff with an option to retire with a pension and work on a part-time basis to supplement their pension
- Greater emphasis on redeployment of long-term sick staff rather than terminating their employment
- 'Stand down' time for operational staff who have had to attend particularly traumatic scenes
- A staged return to work scheme allowing people to build up from light duties rather than being required to return to fully operational duties immediately
- The introduction of a 'watch' scheme. This allows a team leader to work with all of his team members and significantly improves communication.

Resources

The trust has several different working groups looking at staff health. However, the terms of reference of each are not mutually exclusive. The various groups include the following.

The trust board. Through regular and formal updating from the chief executive the board is responsible for ensuring high standards of health, safety and welfare for employees and other persons affected by its undertaking, and providing a safe, high quality, cost-effective service.

The risk management committee. Chaired by the chief executive this sub-committee of the trust board meets at least quarterly. Its responsibilities includes trust-wide coordination and prioritisation of risk management issues, and fostering greater awareness of risk management throughout the organisation at all levels. This is chiefly the management of 'non-clinical' risk issues ('clinical' issues being managed by the clinical standards committee). The risk management strategy and policy is reviewed annually. Members include: chief executive, non-executive directors, director of human resources, director of operations, risk manager, A&E manager, personnel manager, quality standards manager, the risk and safety coordinator, fleet manager; and the 'South Coast Audit' representative.

Clinical standards committee. Chaired by the associate medical director, this group meets bi-monthly to consider the management of clinical issues. Members include the associate medical director, director of human resources, director of operations, non-executive directors, A&E consultant and managers, risk manager, quality standards manager, fleet manager, control manager, senior staff development officer, clinical audit officer.

Health and safety committee. Chaired by the risk and safety manager, this group meets quarterly. It has the responsibility for monitoring health and safety measures throughout the trust and provides a forum for consultation between union safety representatives and managers. Members include: risk and safety manager, A&E managers, fleet engineer, control manager, IT manager, patient transport manager.

Given that the membership of the three committees described above comprises a number of the same personnel, it can be necessary or expedient at times to call joint meetings of some or all committees.

The welfare committee. Chaired by the director of human resources (though currently a non-executive director is standing in) this group meets quarterly. Its main concern is staff welfare, in particular looking at long-term sick leave, stress management and surrounding issues. The group takes decisions on, for example, the counselling contract and occupational health services. The Improving Working Lives initiative is managed through a sub-committee of the welfare group. Members include: director of operations, personnel manager, benevolent fund representative, occupational health

nurse, station listeners, health and safety committee (staff-side) representatives, station chaplains and key staff members.

Station management groups. Every station has a station management group comprising local managers, supervisors and appointed representatives of each operational group (eg paramedics). This group meets every two months to discuss the operational running of the station, including the implementation of initiatives.

Health and safety managers forum. On a regular basis, health and safety managers meet with their counterparts from other services to discuss best practice, benchmark policies and procedures, and compare findings of equipment trials.

Joint consultative negotiating committee. This is a management-side, staff-side forum which meets to consult on issues affecting staff and to negotiate terms and conditions. As such, this is where policies such as the Working Time Directive are agreed by staff and management.

Sickness monitoring group. This group of senior managers and personnel managers meets on a monthly basis to consider long-term sickness cases. Participation in this group of managers from several areas facilitates cross-fertilisation of ideas and resourcing. A long-term sick person may, for example, be unable to return to front-line duties immediately, but a manager from a different area may be able use their skills to keep the employee in work.

Funding. All initiatives are funded by the health authority provided there is a good business case and in accordance with other priorities.

Identifying the activities

Initiatives usually result from a series of events, accidents or near misses or discussion groups highlighting a need. The trust also benchmarks practices with other organisations. It has recently, for example, written to a number of other services to ask how they manage meal breaks for operational response teams.

In addition to this, the trust monitors a number of measures such as absenteeism rates and duration, the number of early retirements and accident statistics, and staff views through an independent opinion survey.

Activities are also initiated in response to changes in legislation such as the Working Time Regulations and government performance targets such as responding to calls categorised as life threatening in eight minutes. Organisational goals and changes in performance targets often result in health initiatives as, throughout the organisation, there is a firm recognition that:

> *'If your staff are not being looked after and their welfare is not being considered then ultimately, directly or indirectly, it has to affect performance.'*

Board commitment. It is thought that the board demonstrates its commitment by sitting on committees and supporting the many initiatives. This is thought to be helped by the more 'open and listening' culture of the organisation since it was made a trust in 1994.

Communication strategies

Several methods are used to communicate with staff about initiatives and their progress. In addition to committee participants and managers feeding back to their colleagues, minutes are circulated and updates are given in a weekly staff bulletin.

Staff also have an opportunity to raise issues, make suggestions and voice their views and ideas to management. They can do this through their staff-side representative or using a 'hot line' (anonymity optional) which is a telephone line straight to senior management dedicated to the purpose of upward communication.

Examples of HAW activity

The trust is particularly proud of the introduction of a 'watch' scheme. This was mainly because it was initiated by staff for staff.

A group approached management with thoughts on how to change the way staff shift patterns were allocated. They presented to management an alternative approach based on a watch scheme with supporting arguments on how this would not only increase performance by facilitating greater team working and supervision of staff, but also improve their lives both in and out of work and raise their morale.

The scheme involves teams dividing into groups of four, each with a team leader, and rotating around four watches. This enables staff to forecast better their shifts and reduces reliance on overtime.

Implementation of the suggested scheme required the trust to recruit two additional staff. Following the staff presentation, management discussed the idea and financial implications with the director of finance and secured appropriate funding. The scheme was then piloted over a year. At an informal mid-term review, staff were asked for feedback after six months. The pilot's success was formally reviewed after a year using an internally designed evaluation questionnaire. The scheme has now been successfully introduced into two stations in the area.

Impact on staff health

The trust reports to have seen several positive outcomes of their attempts to improve health at work for their employees. The support systems in place have facilitated a speedier return to work in certain cases resulting in a reduction in long-term sickness absence in such circumstances. Though not formally tested, there is also a perceived increase in staff morale. An anecdotal account was an interview with a member of staff who had recently transferred from a neighbouring trust. When asked who had influenced him most in his work, the interviewee is reported to have answered:

> *'Nobody especially, but since I have been here I cannot believe the culture of this organisation in comparison to the one I have come from. I didn't know it was possible to be like this.'*

The barriers

The main barrier to successful implementation of HAW initiatives is thought to be people's attitudes. The point was made that sometimes HAW is not valued as much as it should be, as one interviewee said:

> *'Attitude is one of the main barriers to health at work; because it is not directly affecting output, it doesn't necessarily get the priority that it deserves.'*

This has a 'knock-on' effect and leads to other barriers:

- Cost – funding is received from the health authority and needs to be prioritised; HAW is rarely given a high priority as it is not perceived to have an immediate affect on performance
- External targets – the introduction of external standards (eg the 75% in eight minutes response rate) can similarly take away focus and resources from HAW initiatives
- Activity levels – the sheer volume of work and demand on time is reported to make it difficult for people to have an opportunity to be anything more than reactive when it comes to HAW
- New staff – an extension of the point made above, but felt worthy of specific mention, is the trust's recent recruitment initiative. Although in the long term this will lead to greater resources, in the short term it has added extra pressure to the more established members of staff who have had to induct, train and supervise new starters.

An additional major barrier to the HAW initiative was thought to be other competing initiatives. Interviewees felt that since the scheme was introduced it had lost importance as there had been many other similar initiatives launched afterwards which take over in importance and lead to conflicts of interest. As an interviewee said:

> *'You get Health at Work, then you get Working Together, then Improving Working Lives, then the HR Performance Management Framework and you don't know which one to prioritise because they all overlap with each other. Rather than it all being fragmented, it would be nice to see a ten-year plan that you could achieve over time, hopefully in some kind or structured and coordinated way – you need to have a cohesive approach to it, a long-term strategy rather than different initiatives coming on at different times.'*

Lessons learnt and tips

- It is better to try and have strategies in place to be proactive as well as reactive as this can give more time for planning, negotiation and piloting of initiatives. *'If a major accident happens, people will take notice and review policies, but it's still very reactive to some event at the time. We have strategies in place to do that, but we don't necessarily pre-empt events as well as we might.'*
- Staff involvement is essential to the successful instigation, design and implementation of initiatives. *'Don't always think that you (management) have the best ideas, involve staff in the process.'*

- Try to take a planned and coordinated approach to HAW. The interviewees commented that there were so many different ad hoc groups in their own organisation, that sometimes it was difficult not to confuse the remit of each group and that often they would find themselves discussing the same topics in different meetings. They recommend that people try to coordinate initiatives under one umbrella.
- 'Looking beneath the surface' was also recommended. The comment was made that managers should not just consider sickness figures and bottom line results, but try to investigate the underlying causes to understand HAW issues further.
- Training was also considered important for HAW. This is not only induction training but also update training in new practices and making sure that people continue to carry out their activities in a safe manner.