Royal College of Physicians
fom Faculty of Occupational Medicine

Implementing NICE public health guidance for the workplace: a national organisational audit of NHS trusts in England

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The Royal College of Physicians plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. It provides physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, it advises and works with government, the public, patients and other professions to improve health and healthcare.

Health and Work Development Unit

The Clinical Standards department's Health and Work Development Unit at the Royal College of Physicians aims to improve the health of the workforce through the delivery of national quality improvement projects. HWDU measures and raises standards, and reduces variability, of occupational health care through the development of evidence-based guidelines and conducting national clinical and organisational audits. HWDU also works to improve the implementation of NICE public health guidance for the workforce.

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- maximising people's opportunities to benefit from healthy and rewarding work while not putting themselves or others at unreasonable risk,
- elimination of preventable injury and illness caused or aggravated by work,
- access for everyone to advice from a competent occupational physician as part of comprehensive occupational health and safety services.

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Foreword

Dear colleagues,

The audit reported here shows how well trusts across England are implementing a range of NICE public health guidance relevant to staff health and wellbeing. Eighteen months on from the Boorman review, the report is a timely reminder of the important role that healthcare employers make to fostering wellbeing at work. Over 3.4 million days or an additional 14,900 FTEs could be released for patient care if all trusts could play their part in reducing absence by a third. Safeguarding the health and wellbeing of its own workforce is crucial if the NHS is to improve both the quality and efficiency of patient care.

It is heartening therefore that so many trusts have opted to take part in this new audit. Participants now have a baseline against which they can measure improvements in performance in future audit rounds together with information on areas that need to be tackled in order to do so.

This report provides a detailed picture which will enable healthcare employers to continue working toward being exemplars for employers across other sectors. It demonstrates both the value of workplace health to overall Public Health as well as the value that health employers place on their staff. It also demonstrates the value the NHS places on its staff. The wide variation in implementation, both between health promotion topics, and across trusts, is particularly informative while also being a cause for concern. Trusts can see from their local results, benchmarked against the national average, which areas to focus on.

We congratulate the Health and Work Development Unit, and participating NHS trusts, on their achievement. We encourage trust Chief Executive Officers to support their health and wellbeing leads, Human Resource departments and occupational health services as they make changes to raise standards further.

Professor Dame Carol Black
National Director of Health and Work

Clare Chapman
Director General of Workforce

Executive summary

This is the first national audit of implementation of National Institute for Health and Clinical Excellence (NICE) guidance for the workplace in NHS trusts in England. The audit questions reflect evidence-based guidance from NICE covering:

- Managing long-term sickness absence and incapacity for work (PH19)[1]
- Promoting physical activity in the workplace (PH13)[2]
- Promoting mental wellbeing through productive and healthy working conditions (PH22)[3]
- Workplace interventions to promote smoking cessation (PH5)[4]
- Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (CG43)[5]
- Promoting and creating built or natural environments that encourage and support physical activity (PH8).[6]

In preparing its guidance, NICE found improved productivity was associated with effective management of long-term sickness absence and with smoking cessation. In addition there is a growing body of evidence that workers with health issues, such as obesity and depression, are less productive.[7]

In 2009 Dr Steve Boorman led a review of the health of NHS staff. Dr Boorman found important associations between better staff health and wellbeing and patient outcomes including reduced MRSA rates, lower standardised mortality rates and better patient satisfaction.

Employers that implement the NICE workplace guidance tend to have a healthier and more productive workforce and better patient outcomes. This audit measures progress with implementation of the guidance and identifies opportunities to improve.

NHS trusts submitted their own data. These data were anonymised and analysed by the Health and Work Development Unit (HWDU). In addition to the national results, each participating trust received its own local confidential results.

The national results form a baseline relevant to both trusts that participated in the audit and those that were unable to. Local results will enable each participating trust to plan actions to fully implement the NICE guidance while comparing their current progress with other trusts.

[1] National Institute for Health and Clinical Excellence. *Management of long-term sickness and incapacity for work* (PH19). London: NICE, 2009.
[2] National Institute for Health and Clinical Excellence. *Promoting physical activity in the workplace* (PH13). London: NICE, 2008.
[3] National Institute for Health and Clinical Excellence. *Promoting mental wellbeing through productive and healthy working conditions* (PH22). London: NICE, 2009.
[4] National Institute for Health and Clinical Excellence. *Workplace interventions to promote smoking cessation* (PH5). London: NICE, 2007.
[5] National Institute for Health and Clinical Excellence. *Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children* (CG43). London: NICE, 2006.
[6] National Institute for Health and Clinical Excellence. *Promoting and creating built or natural environments that encourage and support physical activity* (PH8). London: NICE, 2008.
[7] Loeppke R, Taitel M, Haufle V, Parry T, Kessler R, Jinnett K. Health and productivity as a business strategy: a multiemployer study. *J Occup Environ Med* 2009;51:411–428.

Key findings and commentary

Participation

- 282 trusts in England participated in the audit. This comprised 91% of ambulance trusts, 73% of acute trusts, 67% of mental health trusts and 52% of primary care trusts.
- Participating trusts employ nearly 900,000 NHS staff.

Overall the participation rates were very encouraging and demonstrate trusts' commitment to improving staff health and wellbeing.

Board commitment

- 95% of trusts had a named board member (typically the human resources director) with responsibility for staff health and wellbeing.
- In two thirds of trusts staff health and wellbeing was a regular board agenda item. These trusts were much more likely to have taken actions to implement NICE workplace guidance compared with trusts where staff health and wellbeing was not regularly discussed by the board.
- 44% of trusts had an umbrella/over-arching strategy or policy for staff health and wellbeing. These trusts were more likely to have specific policies for obesity, physical activity and promoting mental wellbeing.

The results have shown convincingly the importance of senior leadership. Where boards are actively leading staff health and wellbeing programmes, action follows.

Staff engagement

- Trusts that had done relevant needs assessments were more likely to have taken actions recommended by NICE to address obesity, smoking, long-term sickness absence and mental wellbeing.
- Trusts that involved staff in planning and designing their approaches were more likely to have taken actions recommended by NICE to address obesity, smoking, long-term sickness absence and mental wellbeing.

Better staff engagement has been strongly associated with better staff health and wellbeing (and better patient outcomes). These results have shown that staff engagement is associated with better implementation of NICE guidance on health at work.

Obesity

- Obesity guidance was given the lowest priority by trusts and it was the issue on which the least action had been taken.
- Only 15% of trusts had a plan or policy to help reduce obesity amongst their staff.
- NICE recommends that NHS trusts promote healthy choices in restaurants, vending machines and shops. While 60% of trusts had achieved this in their staff restaurants, far fewer had achieved this in their shops (31%) and vending machines (32%) for staff and clients.
- NICE recommends evidence-based weight management programmes (i.e. that address activity, eating behaviour and weight reduction together). Such programmes were provided for staff by 31% of trusts.

Obesity is becoming more common. It can be a sensitive subject to address. Some trusts have engaged staff, taken action, and shown that implementation of the NICE obesity guidance is achievable.

Physical activity

- NICE recommends that employers help employees to be physically active during the working day. 32% of trusts had a plan or policy to encourage and support employees to be more physically active.
- Around half of trusts encouraged staff to walk or cycle to meetings, provided information about walking and cycling routes around the worksite or to and from work and encouraged staff to use stairs rather than lifts.
- Most trusts (82%) encouraged staff to use local leisure facilities and some provided these facilities on-site.

Trusts have begun to meet the challenge of encouraging their workforce to be physically active. However, there continues to be considerable scope to improve the implementation of evidence-based recommendations.

Smoking cessation

- 73% of trusts had a plan or policy to encourage and support employees to stop smoking and in 66% of trusts this had been formally approved by the board.
- Over 90% of trusts provided and publicised access to stop smoking support.

There was a high level of implementation of the smoking cessation guidance.

Long-term sickness absence

- All trusts had a policy for the management of long-term sickness absence.
- NICE recommends that employers make an initial enquiry into their employees' health in relation to their work early in a period of sickness absence. 95% of trusts required their managers to contact staff absent due to illness however the timescale for making contact was not always specified. Ambulance and mental health trusts were more likely to have a short trigger (2 weeks) than acute and primary care trusts.
- Virtually all managers were required to make appropriate enquires that have been shown to support an earlier return to work and to agree a return to work plan with the employee.
- Over 90% of trusts routinely identify staff who are on long-term sickness using a central system and monitor trust trends. However only 33% of trusts record absence in real time (eg through ESR self-service).
- Only 19% of trusts monitor the timeliness of all components of the occupational health care pathway: time from start of absence to referral; time from receipt of referral to appointment with OH clinician; and time from appointment to issue of a report to the referring manager.

Long-term absence accounts for the majority of days NHS staff are absent due to illness. The audit results suggest that not all trusts have fully implemented evidence-based sickness absence management practices.

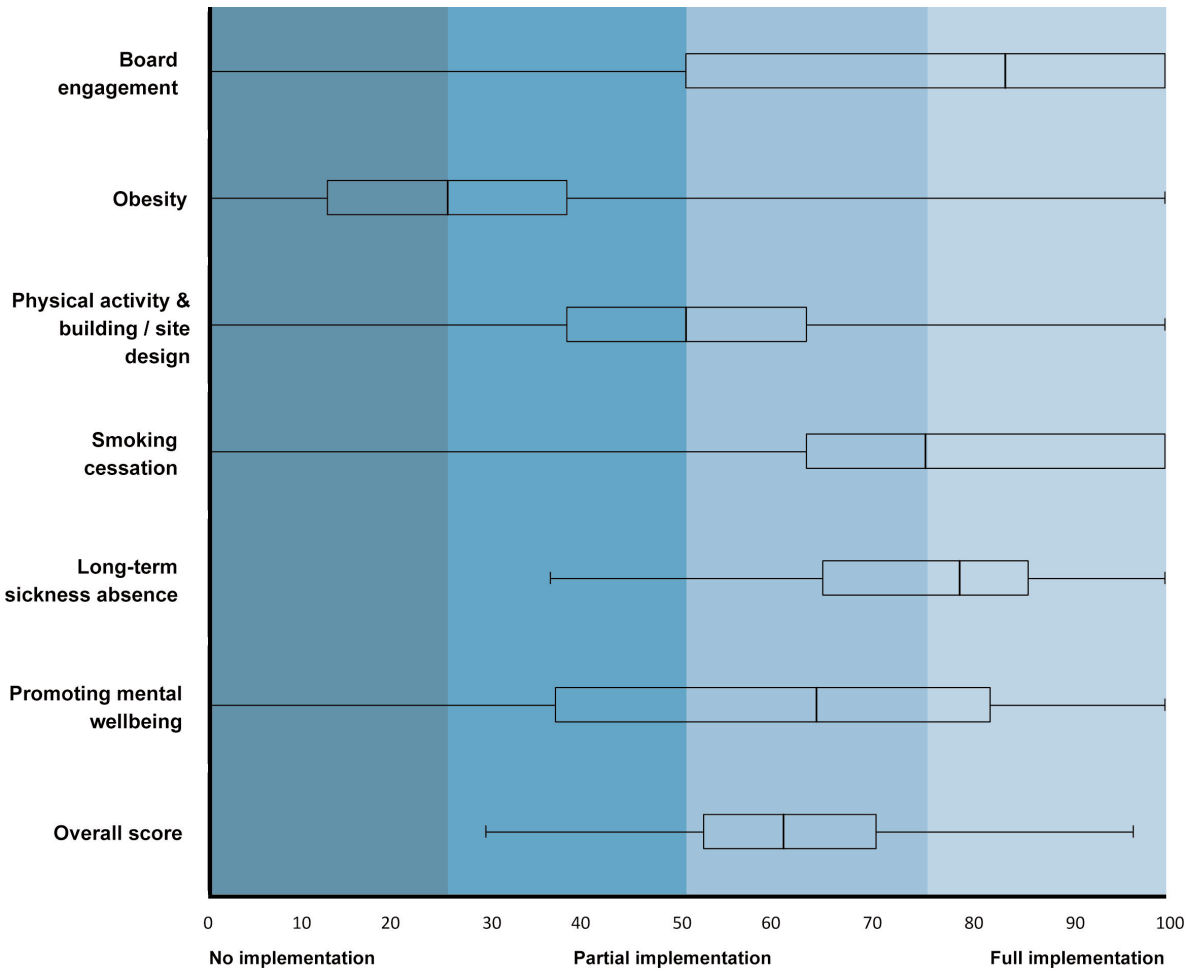
Mental wellbeing

- 46% of trusts had a plan or policy to promote the mental wellbeing of their staff and in 37% of trusts this had been approved by the board.
- NICE recommends that employers strengthen the role of managers in promoting the mental wellbeing of employees through supportive leadership styles and management practices. 63% of trusts provided training for line managers on how to promote and protect employee mental wellbeing. 60% of trusts provided training to ensure line managers are able to identify and respond with sensitivity to employees' emotional concerns and symptoms of mental health problems.

Mental health problems are the most common health issue reported by staff. Many trusts had implemented the recommendations to promote mental wellbeing but there is scope for further improvement.

Summary score

We have created a summary score for each trust. This is derived from 39 standards divided into six domains. Five of the domains match a guidance topic and the sixth is an overarching board engagement domain. The figure below shows the national picture. Individual trusts have their own scores superimposed on the figure.



A box and whisker plot is used to show the distribution of data points for a given measurement. The central box is bounded by the 25th and 75th percentiles (the interquartile range) and represents where the middle 50% of all data points lie. The line running through the centre of the box represents the median (50th percentile) of the data. The whiskers are used to show the spread of the data outside of the lower and upper quartiles. All observed values are within this range.

All trusts should be aiming to fully implement the guidance and reach 100% compliance.

Conclusions

Trusts have successfully completed the first round of audit of the implementation of NICE public health guidance relevant to the workplace. The guidance is formed of recommendations that are effective and cost effective. To achieve the maximum improvement in the health of staff the guidance should be fully implemented.

We found trusts that prioritised health and wellbeing at a high level within the organisation made more progress with implementation of the guidance than trusts that didn't take staff health and wellbeing to board level.

We found variation across England. The results show that some trusts have successfully implemented many aspects of the six sets of evidence-based guidance but also that more action can still be taken to improve the health and wellbeing of staff. This audit will enable trusts to identify and take the actions needed to achieve full implementation of the guidance.

Trusts need to optimise performance and productivity. It is essential that staff health is continually addressed by trust boards. Not only do staff costs account for 60% of the NHS budget but better staff health is associated with better outcomes for their patients.

Next steps

Trusts

We recommend that trusts consider their own results in light of the NICE guidance and in comparison with the national results.

We recommend that trusts engage with staff and their representatives to assess needs, plan actions, report progress and measure impact.

Health and Work Development Unit

We will hold a stakeholder launch on 6 May 2011. We will invite audit participants and trust health and wellbeing leads. This event will brief attendees on the key findings of the audit. Top performing trusts will present how they have successfully implemented the guidance and what allowed them to achieve this.

We will hold regional workshops and focus groups in 2011/ 2012. These events will give participants a chance to review the NICE guidance on health and work and the specific recommendations for change. Participants will be able to share their experiences of using the audit to change practice, barriers to such change and how these can be overcome.

We will repeat data collection in two years' time so that trusts can measure their progress and to give a new national picture of employer commitment to NHS staff health and wellbeing.

Introduction

Background

Work is an integral part of everyday life for about half the population, others will work at some time in the future and others have worked in the past. Work affects our health and our health affects our work. Where health is managed effectively at work it will improve and contribute to greater wellbeing, greater effectiveness and greater productivity.

In her report *Working for a healthier tomorrow* Dame Carol Black described the wider social benefits of work, writing: 'For most people, their work is a key determinant of self-worth, family esteem, identity and standing within the community, besides, of course, material progress and a means of social participation and fulfilment.'[8,9]

But Dame Carol also highlighted the £100 billion cost of ill health in our workplaces due to 175 million working days lost to sickness absence each year, 2.6 million people not working and receiving benefits because of a health issue and other factors. She noted the impact of specific health issues in people of working age including obesity, smoking, reduced mental wellbeing and physical inactivity.

The NHS is the UK's largest employer and employs 1.2 million people in England alone. Its constitution commits the NHS to 'provide support and opportunities for staff to maintain their health, well-being and safety'.[10]

In 2009 Dr Steve Boorman led a review of the health of NHS staff.[11] He found that 10.3 million working days were lost in the NHS in England each year, equivalent to 45,000 whole time staff at a direct cost of £1.7 billion. Dr Boorman found important associations between better staff health and wellbeing and important patient outcomes including reduced MRSA rates and lower standardised mortality rates. He concluded 'Organisations that work with their staff to provide healthy and safe work combined with a caring environment perform better, and, importantly, by promoting the health of their workers rather than risking damage, they deliver reliably.'

Dr Boorman emphasised the need for the NHS to be an exemplar employer. He recommended NHS trusts should provide effective and proactive interventions and called for a strengthening of the evidence base.

The recommendations in Dr Boorman's report were accepted. Implementation was included in the NHS Operating Framework for 2010–11 and again for 2011–12. The recommendations received further support in the Coalition Government's White Paper *Equity and Excellence: Liberating the NHS*.

[8] HM Government. *Working for a healthier tomorrow. Review of the health of Britain's working age population.* London: TSO, 2008.
[9] HM Government. *Working for a healthier tomorrow. Review of the health of Britain's working age population.* London: TSO, 2008
[10] Department of Health. *The NHS Constitution for England.* Crown copyright, 2009.
(http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093419).
[11] Department of Health. *NHS Health and Well-being. Final Report.* Crown copyright, 2009.
(http://www.nhshealthandwellbeing.org/FinalReport.html)

Dame Carol Black called for improvements to the evidence base for health at work. In her report she commented that the Health and Work Development Unit had 'made a good start in synthesising the evidence base, but this work needs to be given a higher profile and accelerated.'

The evidence for health at work has been improving. An important contribution to this growing evidence has come from the work of the National Institute for Health and Clinical Excellence (NICE). In 2006 NICE recommended specific workplace interventions for the first time (in the clinical guideline on the management of obesity). In 2007 the first guideline wholly focused on work interventions (for smoking cessation) was published by NICE. The guideline was developed by the Public Health team and further guidance on work and health followed in 2008 and 2009.

NICE has now prepared a portfolio of workplace guidance that addresses important health issues for NHS staff. Population data show the importance of these health issues.

In some cases there have been encouraging trends. In the last decade there has been a trend towards more adults meeting recommended levels of physical activity.[12] Over the period 2003 to 2009 the proportion of NHS staff who reported in the annual staff survey they had suffered from work-related stress in the preceding year reduced from 39% to 28%.[13] Between 1993 and 2009 the proportion of men and women who were current smokers declined overall to 24% and 20% respectively. Despite these improvements a significant proportion of adults remain with these health issues and in some groups the trend has not been present, for example, there has been no significant change in the proportion of male smokers aged 25–34.

In contrast obesity has become an increasing concern. Between 1993 and 2009 the proportion of the adult population that were obese increased from 13% of men in 1993 to 22% in 2009 and from 16% of women in 1993 to 24% in 2009.[14]

These public health issues are equally relevant to NHS staff. The NHS has been striving to create smoke-free work environments for more than twenty five years.[15] In 2009 the Healthy Weight Healthy Lives One Year On report suggested up to 700,000 NHS staff were overweight or obese. Last year the NHS launched a challenge to increase physical activity among staff before the 2012 Olympics.[16]

It might be assumed that many NHS staff are by necessity physically active during the working day. For some staff this is certainly the case. However there is little evidence that nurses and doctors walk substantial distances during a shift; at least not to the extent that this significantly raises heart rate or reaches a level that might mean other physical activity was unnecessary.[17,18,19] A very recent report found that nurses' energy expenditure equated to a light intensity level.[20]

[12] The NHS Information Centre for health and social care. *Health Survey for England 2009 Trend Tables.* London, The Health and Social Care Information Centre, 2010.
[13] Preece R. Work-related stress: case definitions, prevalence and the NHS national surveys. *Occupational Medicine* 2011;61(2):136.
[14] The NHS Information Centre for health and social care. *Health Survey for England 2009 Trend Tables.* London, The Health and Social Care Information Centre, 2010.
[15] Health Service Circular. *Health Services Management: promoting non-smoking on hospital premises.* London, NHS Executive, 1985.
[16] Cross-Government Obesity Unit. *Healthy Weight,Healthy Lives One Year On.* London, HM Government, 2009.
[17] Welton M, Decker M, Adam J, Zone-Smith L. How far do nurses walk? *Med Surg Nursing* 2006;15(4):213–6.
[18] Atkinson J, Goody RB, Walker CA. Walking at work: a pedometer study assessing the activity levels of doctors. *Scott Med J* 2005;50(2):73–4.
[19] Cuthill JA, Fitzpatrick K, Glen J. Anaesthesia – a sedentary specialty? Accelerometer assessment of the activity level of anaesthetists while at work. *Anaesthesia* 2008;63(3):279–83.
[20] Chen J, Davis LS, Davis KG, Pan W, Daraiseh NM. Physiological and behavioural response patterns at work among hospital nurses. *Journal of Nursing Management* 2011;19:57–68.

The benefits of improved health are not limited to NHS staff. In preparing its guidance NICE found improved productivity was associated with effective management of long-term sickness absence and with smoking cessation. In addition there is a growing body of evidence that workers with health issues, such as obesity and depression, are less productive.[21]

Employers that implement the NICE workplace guidance tend to have a healthier and more productive workforce and better patient outcomes. This audit measures progress with implementation of the guidance and identifies opportunities to improve.

Standards used in the audit – NICE guidance

NICE has prepared six sets of guidance that are directly aimed at workplaces:

- Managing long-term sickness absence and incapacity for work (PH19)[22]
- Promoting physical activity in the workplace (PH13)[23]
- Promoting mental wellbeing through productive and healthy working conditions (PH22)[24]
- Workplace interventions to promote smoking cessation (PH5)[25]
- Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (CG43)[26]
- Promoting and creating built or natural environments that encourage and support physical activity (PH8).[27]

NICE has a clear methodology for preparing guidance[28] based on best available evidence drawn from a range of disciplines. Wherever possible, recommendations are based on studies of any design that consider the outcome of an intervention. Inclusion and exclusion criteria for the evidence reviews are clearly stated for all NICE guidance. The scope of the review is also subject to consultation. Occasionally experts are called upon to offer insights into emerging interventions. The cost effectiveness of interventions is also considered so that final recommendations reflect evidence of both effectiveness and cost effectiveness. The processes are transparent and scrutiny by stakeholders is actively sought at several stages during the development of guidance. The guidance process is independent of Government and other interests.

In preparing this audit all the six sets of NICE guidance for the workplace were included. The scope of the guidance on obesity (CG43) and creating environments to promote physical activity (PH8) extended

[21] Loeppke R, Taitel M, Haufle V, Parry T, Kessler R, Jinnett K. Health and productivity as a business strategy: a multiemployer study. *J Occup Environ Med* 2009;51:411–428.
[22] National Institute for Health and Clinical Excellence. *Management of long-term sickness and incapacity for work* (PH19). London: NICE, 2009.
[23] National Institute for Health and Clinical Excellence. *Promoting physical activity in the workplace* (PH13). London: NICE, 2008.
[24] National Institute for Health and Clinical Excellence. *Promoting mental wellbeing through productive and healthy working conditions* (PH22). London: NICE, 2009.
[25] National Institute for Health and Clinical Excellence. *Workplace interventions to promote smoking cessation* (PH5). London: NICE, 2007.
[26] National Institute for Health and Clinical Excellence. *Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children* (CG43). London: NICE, 2006.
[27] National Institute for Health and Clinical Excellence. *Promoting and creating built or natural environments that encourage and support physical activity* (PH8). London: NICE, 2008.
[28] National Institute for Health and Clinical Excellence. *Methods for development of NICE public health guidance.* London; NICE, 2011 (http://www.nice.org.uk/media/FB9/59/PHMethodsManual2006.pdf).

beyond the workplace. Only those sections of the guidance that related to the workplace were included in the audit.

Employers implementing workplace guidance can be confident that their actions will bring health benefits to their workers and give value for money.

Scope

The audit involved all NHS trusts in England with an overall aim of improving staff health and wellbeing. The Special and Strategic Health Authorities were not included.

Organisational audit

A major strength of this audit has been translation of the robust audit methodology used by clinicians into a non-clinical setting, bringing clinical rigour to organisation assessment. The first national audit of this kind, it allows trusts to benchmark their results against the national average for this year, to compare progress with similar trusts and set a path towards full implementation. All the NICE recommendations are evidence-based actions that bring tangible benefits. Only full implementation will deliver the maximum benefits to staff and the trust.

Aims

The aim of the audit was to measure the extent and quality of the implementation of the relevant NICE workplace guidance by NHS trusts in England.

Target audience

This report has been written for the following audiences:
- Trust's board member with responsibility for health and work
- Senior member of staff leading on the Boorman recommendations
- HR director
- Public health lead
- Occupational Health lead
- Audit/Governance lead

How to use this report

We present descriptive statistics throughout this report without inference (p-values or confidence intervals). The interpretation of results rests as far as possible with audit participants, who are best placed to understand their meaning in the local context and to formulate quality improvement strategies as a result.

Method

Audit development group

The audit process, including design of the audit tool, was overseen by the Health and Work Development Unit (HWDU) Audit Development Group. The Group includes experts in HR, Public Health, NHS Health and Wellbeing and Occupational Health. Full group membership details can be found on page iv.

Tool design

In designing the audit tool, all recommendations relating to the employer from the following pieces of guidance were considered for inclusion:

- Managing long-term sickness absence and incapacity for work (PH19)[29]
- Promoting physical activity in the workplace (PH13)[30]
- Promoting mental wellbeing through productive and healthy working conditions (PH22)[31]
- Workplace interventions to promote smoking cessation (PH5)[32]
- Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (CG43)[33]
- Promoting and creating built or natural environments that encourage and support physical activity (PH8).[34]

A number of factors were considered before a recommendation was included in the audit tool:

- the ease with which it could be posed as a question
- the likelihood of the question producing a meaningful and useable response
- how specific the question could be made to ensure consistency in interpretation by respondents
- the length of the audit questionnaire and time it would take to complete.

We also asked questions to put the recommendations into context and to review the quality of implementation, as well as the quantity. These aren't drawn directly from the guidance but reflect best practice implementation of the recommendations in the guidance.

[29] National Institute for Health and Clinical Excellence. *Management of long-term sickness and incapacity for work* (PH19). London: NICE, 2009.
[30] National Institute for Health and Clinical Excellence. *Promoting physical activity in the workplace* (PH13). London: NICE, 2008.
[31] National Institute for Health and Clinical Excellence. *Promoting mental wellbeing through productive and healthy working conditions* (PH22). London: NICE, 2009.
[32] National Institute for Health and Clinical Excellence. *Workplace interventions to promote smoking cessation* (PH5). London: NICE, 2007.
[33] National Institute for Health and Clinical Excellence. *Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children* (CG43). London: NICE, 2006.
[34] National Institute for Health and Clinical Excellence. *Promoting and creating built or natural environments that encourage and support physical activity* (PH8). London: NICE, 2008.

Recruitment

All NHS trusts in England were eligible to take part. The HWDU wrote to chief executives asking them to nominate their Health and Wellbeing Lead, preferably at board level. The Health and Wellbeing leads were then contacted by email, letter and telephone inviting them to register their trust and to submit data. Where trusts did not respond, or registered but did not submit data, HWDU sent through all the information necessary to participate to the directors of human resources and the trust chief executive's office. A full list of participating trusts can be found in Appendix 2.

Webtool

The HWDU commissioned the development of a secure, web-based tool to collect trusts' data. Data were entered via password protected accounts containing the audit questions and full helpnotes. A problem with data saving was encountered during data collection. This issue did not affect the quality of the data collected but we would like to thank participants for their patience while we worked to fix the problem.

Data collection and entry

All data were entered through a specially designed audit website which was open from 3 October 2010 until 25 January 2011. Access to each trust's data was password protected for confidentiality. For each dataset submitted, the webtool routed the data collector through the questions, making available only the applicable answers, and responses were validated prior to completion. Helpnotes and definitions were provided, as were free text 'comment boxes', to enable the data collector to provide any clarifications. The audit tool can be found in Appendix 3 and the helpnotes in Appendix 4.

The HWDU ran an audit helpdesk for participants throughout the data collection period. We contacted audit participants by email, post and telephone at intervals throughout the data collection period to encourage them to participate and offer support in using the webtool.

More than one data collector could enter data for any one trust – the usernames and passwords were specific to each trust, rather than individuals.

Trusts that wanted to enter more than one data set (for example where they had two major hospitals on different sites with separate policies) were able to do so.

Pilot

The audit tool, webtool and helpnotes were piloted in June 2010. The audit tool was revised in light of the data analysis and feedback from participants.

Data analysis

Descriptive statistics are presented as N (%) in this report. When no denominator is given, the stated percentage is based on all 282 participants. For any questions with fewer than 282 responses, the numerator and denominator are both given.

The interpretation of results rests as far as possible with audit participants, who are best placed to understand their meaning in the local context and to formulate quality improvement strategies as a result. The role of central analysis is to produce valid, reliable and high-quality local and national statistics through extensive checking and data cleaning.

Statistical analysis was carried out by the medical statistician at the Royal College of Physicians using Stata version 11. Results were interpreted by the Audit Development Group and the project team.

Presentation of results

The national report shows the pooled, anonymised results from all participating trusts in 2010/2011.

Confidential trust-specific reports are provided to participants with trust level information presented alongside the national data.

Summary score

Overall performance is assessed using a summary score. This is derived from 39 standards divided into six domains. Five domains match a guidance topic and the sixth is an overarching board engagement domain. Full details of how each score is calculated can be found in Appendix 5.

Limitations of information

This audit uses self reported data. We are reliant on trusts entering data that accurately reflect their policies and practices. For some questions on policy we included an 'in development' option to allow participating trusts to demonstrate that they were taking action.

Results

How to interpret your results

Each participating trust has received its own results for comparison with the national results. These data only provide part of the picture. We advise that they are considered in conjunction with the following factors:

- The local results should be interpreted by each trust itself, taking into account knowledge of its own processes.
- This audit measures only some activities that contribute to staff health and wellbeing. However, these are the activities recommended in NICE guidance and are the evidence-based actions that should be fully implemented to effectively and cost-effectively contribute to staff health and wellbeing.
- The report is a tool for reviewing and planning actions to promote staff health and wellbeing taken by each trust.

Trust participation and demographics

282 NHS trusts participated including 122 acute trusts, 41 mental health and care trusts and 109 primary care trusts. This represents 63% of eligible trusts.

Trust type	Total	Participating trusts	Headcount
Acute	167	122 (73%)	573,854
Ambulance	11	10 (91%)	35,489
Care	2	2 (100%)	5,400
Mental health	58	39 (67%)	121,579
Primary care	210	108 (51%)	128,506
Other	1	1 (100%)	4,151
Total	449	282 (63%)	868,979

Participating trusts employ 868,979 staff which is 71% of all NHS staff in England.[35]

In acute trusts most staff worked on the main site whereas in other trusts most staff did not work on a main site.

Trust board engagement

95% of trusts had a named board member with responsibility for staff health and wellbeing but a small number (15), mainly primary care trusts, did not.

[35]NHS Information Centre. Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England – December 2010, Provisional, Experimental Statistics. The Health and Social Care Information Centre, London ,2010. (http://www.ic.nhs.uk)

In about two thirds of trusts it was the workforce/human resources director who held this responsibility but in some cases the responsibility was held by other executive and non-executive directors.

Trust board engagement	Total holding responsibility
HR/Workforce director	173
Nursing director	15
Chief Executive	10
Operations director	9
Medical director	2
Finance director	1
Other executive board member	38
Non-executive board member	19

Almost all boards received regular reports on staff sickness absence. Only two acute trusts and five primary care trusts did not. 87% of boards received reports more frequently than twice per annum.

In two thirds of trusts health and wellbeing was a regular board agenda item. Of these about half of the boards considered health and wellbeing more frequently than twice per annum and about half considered this once or twice per annum.

Trusts where health and wellbeing was a regular board agenda item were much more likely to have taken actions to implement NICE guidance for the workplace .

Part 1: Organisational arrangements

Policy

44% of trusts had an umbrella/over-arching strategy or policy for staff health and wellbeing and a further 47% were developing one. Trusts with an umbrella/overarching strategy or policy were more likely to have staff health and wellbeing as a regular board agenda item and more likely to have specific policies for obesity, physical activity and promoting mental wellbeing.

All trusts had at least one policy in place or in development that was specific to one of the health issues explored in the audit.

Needs Assessment

Trusts reported whether they had done health needs assessments in the preceding three years.

Only 29% of trusts had done a needs assessment for obesity management and only 17% had done this assessment using a formal process.

Half the trusts had done a needs assessment for smoking cessation but only one third had done this using a formal process. 80% of ambulance trusts had not done a smoking cessation needs assessment.

39% of trusts had done a needs assessment for increasing physical activity but only 20% had done this assessment using a formal process. 48% of primary care trusts had done a needs assessment whereas only 32% of acute trusts had done this.

Most trusts (74%) had done a needs assessment for long-term sickness absence management and most 61% had done this assessment using a formal process.

Most trusts (61%) had done a needs assessment for promoting mental wellbeing and many (42%) had done this assessment using a formal process. A needs assessment for promoting staff mental wellbeing had more commonly been done by mental health trusts (85%) than other trusts.

1.6 Within the last three years, has the trust done a needs assessment to inform an organisational approach to:	National (282 trusts)	
	Yes	%
1.6.1 Obesity	81	29
1.6.2 Smoking	141	50
1.6.3 Physical activity	110	39
1.6.4 Long-term sickness absence	208	74
1.6.5 Promoting mental wellbeing	174	62

Trusts that had done relevant needs assessments were more likely to have taken actions recommended by NICE to address obesity, smoking, long-term sickness absence and mental wellbeing (see the relevant following sections).

Workplace health priorities

72% of trusts prioritised workplace health improvement topics. Promoting mental wellbeing was most commonly top priority and most commonly amongst the top three priorities. Reducing obesity was the least likely to be the top priority and amongst the top three priorities.

1.7.1 What are your trust's top 3 health promotion topics for staff?	Priority (Trusts)		
	1st	2nd	3rd
Obesity	17	21	43
Smoking	45	56	54
Physical activity	33	74	59
Mental wellbeing	107	53	32
Other	8	9	10

Involving staff

Trusts frequently involved staff in planning and designing their approach to long-term sickness absence (72%), promoting mental wellbeing (69%), smoking cessation (64%), promoting physical activity (58%) and less frequently building design (46%). However, only about one third of trusts involved staff in planning and designing their approach to obesity management.

1.8 Has the trust involved staff in planning and designing and organisational approach to:	National (282 trusts)	
	Yes	%
Obesity	94	33
Smoking cessation	180	64
Promoting physical activity	163	58
Building site design	131	46
Long-term sickness absence	202	72
Promoting mental wellbeing	194	69

Trusts that involved staff in planning and designing their approaches to public health issues were more likely to have taken actions recommended by NICE to address obesity, smoking, long-term sickness absence and mental wellbeing (see the relevant following sections and the summary table below).

	National (282 trusts)				
	1.6 Within the last three years, has the trust done a needs assessment to inform an organisational approach to:	1.8 Has the trust involved staff in planning and designing an organisational approach to:	Does the trust have an organisation-wide plan or policy?	Has the plan/policy been signed off by the board?	Does the plan/policy address the different needs of different staff groups?
Obesity	81 (29%)	94 (33%)	42 (15%)	25/42 (60%)	22/42 (52%)
Smoking	141 (50%)	180 (64%)	207 (73%)	185/207 (89%)	117/207 (57%)
Promoting physical activity	110 (39%)	163 (58%)	89 (32%)	58/89 (65%)	55/89 (62%)
Long-term sickness absence	208 (74%)	202 (72%)	282 (100%)	NA	NA
Promoting mental wellbeing	174 (62%)	194 (69%)	129 (46%)	104/129 (81%)	76/129 (59%)

Part 2: Obesity

The audit explored trusts' implementation of the NICE guidance on the management of overweight and obesity in the workplace (CG43).

Only 15% of all trusts had a plan or policy to help reduce obesity amongst its staff and only in 9% of all trusts had this been formally approved by the board. Another 31% were developing a plan or policy.

In 53% (25/42) of the trusts where a plan or policy was in place the needs of different staff were addressed.

Only 13 trusts measured uptake of any programmes by different staff groups such as by grade, gender or ethnicity. In 11 trusts the programme was adjusted if there were clear differentials in uptake.

Healthy food choices

NICE recommends NHS trusts actively promote healthy choices in restaurants, hospitality, vending machines and shops. Trusts reported variability in the promotion of healthy food choices. About half the trusts promoted healthy food choices in their hospitality and 61% promoted these in the staff restaurant. A considerable number of trusts had met the challenge of promoting healthy choices from vending machines (32%) and shops for staff and clients (31%).

2.2 Does the trust actively promote healthy food choices, for example using signs, pricing and positioning of products to encourage healthy choices in:	National (282 trusts)	
	Yes	%
Vending machines	90	32
Shops for staff and clients	86	31
Hospitality	142	50
Staff restaurant	173	61

Weight management

Only 31% of trusts offered overweight and obese staff multi-component interventions that addressed physical activity, eating behaviour and weight reduction together. In most cases these were led by someone trained in obesity management. Only one ambulance trust offered intervention for obesity.

	National (282 trusts)	
	Number	%
2.3 Does the trust offer overweight and obese staff multicomponent interventions that address all three?	86	31
2.3.1 If yes, is the person providing the programme trained in obesity management?	64/86	74

Trusts were far more likely to offer multi-component interventions if they had performed a needs assessment for obesity and had involved staff in planning and designing their approach to obesity management.

Part 3: Physical activity and building/ site design

Physical activity

The audit explored trusts' implementation of the NICE guidance on promoting physical activity in the workplace (PH13 and PH8).

32% of trusts had a plan or policy to encourage and support employees to be more physically active and in 21% of all trusts this had been formally approved by the board. Another 41% were developing a plan or policy. In 62% (55/89) of the trusts where a plan or policy was in place this addressed the needs of different staff.

27 trusts measured uptake of programmes by different staff groups such as by grade, gender or ethnicity and in almost all of these trusts (25/27) the programme was adjusted if there were clear differentials in uptake.

Cycle parking

NICE recommends (CG43) that NHS trusts provide secure cycle parking for staff. Nearly all trusts (90%) provide safe and secure cycle parking. Only about one third of trusts provide safe and secure cycle parking for more than fifty bicycles. Not surprisingly, as the trust headcount increases the quantity of safe and secure cycle parking also increases.

Building design

75% of trusts (116/155) with campus sites (where two or more related buildings are set together in the grounds of a defined site) confirmed that all parts of their sites were linked by appropriate walking and cycling routes.

72% of trusts (112/156) that had new workplaces built (or in the planning stages) since 2006 confirmed a system was in place to ensure that these were linked to existing walking and cycling networks.

NICE recommends staircases are clearly signposted, attractive to use and positioned to encourage people to use them. Three quarters of trusts made sure staircases were designed and positioned to encourage people to use them but one quarter did not. While 55% of trusts made sure that most of their staircases were clearly signposted and attractive to use, only a further 30% of trusts made sure that this was true for all staircases. 6% of trusts reported that few or no staircases were clearly signposted and attractive to use.

Promoting activity

NICE recommends employers help employees to be physically active during the working day. About half of the trusts encouraged staff to be physically active during the working day by encouraging staff to walk or cycle to external meetings, to use the stairs rather than lifts, and by providing information about walking and cycling routes to and from work and around the worksite. More trusts (61%) encouraged staff to take short walks during work breaks and use local leisure facilities (82%).

3.5 Does the trust help staff to be physically active during the working day by:	National (282 trusts)	
	Number	%
Encouraging staff to walk or cycle to external meetings	149	53
Encouraging staff to use the stairs rather than lifts e.g. by putting up signs at strategic points and distributing written information	134	48
Providing information about walking and cycling routes to and from work	147	52
Providing information about walking and cycling routes around the worksite	142	50
Encouraging staff to take short walks during work breaks e.g. providing information about lunchtime walks	173	61
Encouraging staff to use local leisure facilities	231	82
Encouraging staff to set goals on how far they walk and cycle and monitor the distances they cover	103	37

Primary care trusts were more likely than acute and mental health trusts to provide information on walking and cycling and more likely to encourage staff to use the stairs, take walks during work breaks and set goals for activity.

Trusts used a wide range of mechanisms to set and measure goals for increased physical activity. The table below provides some examples of the most commonly received.

3.5.1 If yes, how do you set and monitor that goals are being achieved?
'Initiatives such as pedometer challenges that include target numbers of steps or distance outside or inside capturing movement during the day and /or whilst using a treadmill.'
'Our wellbeing centre … is our main focus for activities. We monitor usage of the centre and the number of persons meeting personal goals set by 1 to 1 sessions with the fitness instructors.'
'We encourage staff to make pledges and informally monitor and publicise articles on people's progress and will shortly be introducing a pedometer challenge to encourage departmental competition.'
'Staff feedback.'
'Staff survey.'
'Through responses and participation in competitions and initiatives.'

Most trusts offered a bike purchase scheme and discounted membership fees for local leisure facilities. Some trusts provided on-site facilities for sports and leisure including a gym (21%), squash or tennis courts (10%) and a swimming pool (6%).

3.6 Does the trust provide:	National (282 trusts) Number	%
On-site gym	59	21
On-site swimming pool	16	6
On-site squash or tennis courts	28	10
Reduced membership fees for local leisure facilities (e.g. subsidised by trust or negotiated with facility)	237	84
Bike purchase scheme	222	79

A gym was provided on-site by 28% of acute trusts and 41% of mental health trusts. 19% of acute trusts have on-site squash or tennis courts but only 3% (5/160) of other trusts.

Part 4: Smoking cessation

The audit explored trusts' implementation of the NICE guidance on smoking cessation in the workplace (PH5).

NICE recommends employers develop a smoking cessation policy in collaboration with staff and their representatives. 73% of trusts had a plan or policy to encourage and support employees to stop smoking and in 66% of all trusts this had been formally approved by the board. Another 15% of trusts were developing a plan or policy.

In 57% (117/207) of the trusts where a plan or policy was in place this addressed the needs of different staff.

17% of trusts measured uptake of programmes by different staff groups such as by grade, gender or ethnicity and in most of these trusts the programme was adjusted if there were clear differentials in uptake.

Cessation support

Almost all trusts provided access to stop smoking support (either on-site or through arrangements with another local service) and publicised this for their staff. Nearly all publicised where, when and how to access these services and the type of help available.

	National (282 trusts) Number	%
4.2 Does the trust publicise smoking cessation services for staff?	264	94
4.2.1 If yes to 4.2, does this publicity include:		
Where services are available	258/264	98
How to access these services	262/264	99
The type of help available	256/264	97
When services are available	236/264	89
4.3 Does the trust provide access to stop smoking support (either on-site or through arrangements with another local service)?	268	95

NICE recommends employers allow staff to attend smoking cessation services during working hours without loss of pay. Around one third of acute, mental health and primary care trusts and 70% of ambulance trusts did not allow this.

	National (282 trusts)	
	Number	%
4.4 Does the trust policy allow staff to attend smoking cessation services during working hours without loss of pay?	179	63

Trusts were more likely to allow staff to attend smoking cessation services during working hours without loss of pay if they had performed a needs assessment for smoking cessation and had involved staff in planning and designing their approach to smoking cessation management.

Part 5: Long-term sickness absence

The audit explored trusts' implementation of the NICE guidance on the management of long-term sickness absence (PH19).

All trusts had a policy for the management of long-term sickness absence. In only two trusts, both in primary care, were employees absent due to illness not required to inform their manager on the first day of absence.

Initial enquiries

NICE recommends that employers make an initial enquiry early in a period of sickness absence into their employee's health in relation to their work.

In 95% of trusts managers were required to contact staff whose sickness absence continued beyond a week or so for an initial enquiry to discuss their health and work. The time by which managers should have contacted absentees is specified by 81% of trusts, while in 40 trusts managers were required to contact absentees but no time was specified.

Where trusts specified a time limit for managers to make an initial enquiry, this was within two weeks in 42% (112/268) of trusts and within four weeks in a further 42% of trusts. 60% (6/10) of ambulance trusts and 59%(23/39) of mental health trusts required their managers to contact staff within two weeks whereas this was only required by 40% (45/113) of acute trusts and 34% (35/103) of primary care trusts.

In the initial enquiry almost all trusts required managers to explore the reasons for sickness absence (263/268), when the staff member thinks that he/she will be back at work (259/268), the potential need for a referral to OH (257/268), the options for returning to work and what, if any, action is required to prepare for this (248/268) and any perceived (or actual) barriers to returning to work (including the need for workplace adjustments) (241/268). In most trusts managers were also required to explore whether the staff member was receiving appropriate treatment (225/268).

	National (282 trusts)	
	Number	%
5.1.2 Does the policy require managers to contact staff whose sickness absence continues beyond a week or so, for an initial enquiry to discuss their health and work?	268	95
5.1.2.1 Does the policy give a trigger for when this should be done?		
Yes at 2 weeks (or less)	112/268	42
Yes by 3 weeks	15/268	6
Yes by 4 weeks	97/268	36
Yes by 5 weeks	1/268	0.4
Yes by 6 weeks	1/268	0.4
Yes, later than 6 weeks	2/268	1
No	40/268	15

5.1.2.2 Does the policy (or accompanying guidance) ask managers to explore in this initial enquiry:	National (282 trusts)	
	Number	%
The reasons for sickness absence	263/268	98
Whether the staff member has received appropriate treatment	225/268	84
When the staff member thinks that he/she will be back at work	259/268	97
Any perceived (or actual) barriers to returning to work (including the need for workplace adjustments)	241/268	90
The potential need for a referral to OH	257/268	96
The options for returning to work and what, if any, action is required to prepare for this	248/268	9

Planning a return to work

In almost all trusts a policy required the development of a return to work plan, agreed between the manager and the employee, that included consideration of a gradual return to the original job by increasing the hours and days worked over a period of time, a return to some of the duties of the original job and a move to another job within the trust (on a temporary or permanent basis).

	National (282 trusts)	
	Number	%
5.1.3 Does the policy require development of a return to work plan agreed between the manager and the employee?	274	97
5.1.3.1 If yes, does the policy specify that managers must consider, with the employee (taking account of any OH advice), the need for:		
A gradual return to the original job by increasing the hours and days worked over a period of time	273/274	99
A return to some of the duties of the original job	272/274	99
A move to another job within the organisation (on a temporary or permanent basis)	269/274	98

Case management

NICE recommends employers consider identifying a case manager to co-ordinate support for employees absent due to illness.

64% of trusts reported they use case managers for the more complex cases of long-term sickness absence. The identity of case managers varied between and within trusts with many trusts having more than one staff group doing case management.

In most trusts the case managers undertook almost all the specific activities that might be associated with this role. In almost all trusts case managers co-ordinated any required assessments, initiated formal interventions and prompted and tracked actions. However, in 20% (36/181) of trusts they didn't monitor absence data in real time, in 10% (19/181) they didn't timetable actions to eliminate delays between milestones and in 11% (20/181) they didn't provide periodic reports to stakeholders.

	National (282 trusts)	
	Number	%
5.2 Does the trust use case managers for the more complex cases of long-term sickness absence?	181	64
5.2.2 Does the case manager:		
Monitor absence data in real time	145/181	80
Co-ordinate any required assessments	177/181	98
Timetable actions to eliminate delays between milestones	162/181	90
Initiate formal interventions	175/181	97
Prompt and track actions	172/181	95
Provide periodic reports to stakeholders	161/181	89

Absence data management

About one third of trusts fully recorded absence data in real time and a further 27% did this in part. 39% of trusts did not record absence data in real time.

5.3 Does the trust record absence data in real time (e.g. through ESR self-service)?	National (282 trusts)	
	Number	%
Yes fully	94	33
Yes partially	77	27
No	111	39

Almost all trusts (96%) routinely identified staff who were on long-term sickness absence using a central system.

95% of trusts monitored the trend in long-term sickness absence. In most cases this was reported to HR, to line manages, to divisional/directorate managers and to the trust board.

Measuring occupational health timeliness

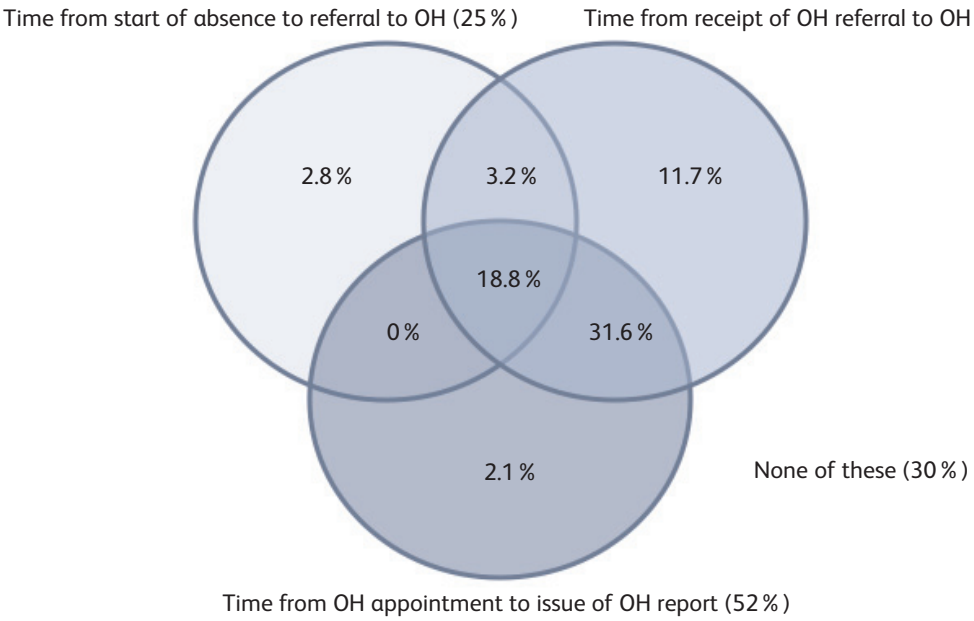
Only 19% of trusts monitor all components of the occupational health referral pathway:: time from start of absence to referral; time from receipt of referral to appointment with OH clinician; and time from appointment to issue of a report to the referring manager.

Only 25% of trusts routinely collected and reported data on the time from start of absence to referral to occupational health. [Delay in referral has also been identified as a potential issue in the HWDU's National Depression Audit.[36]]

Over half of trusts routinely collected and reported data on the time from receipt of the occupational health referral to the appointment (65%) and the time from the appointment to issue of the report (52%).

Where measures were reported it was usually to HR. Only a very small number of trusts reported the timeliness of OH reviews and reports to the board.

5.6 Does the trust routinely collect and report on the following data?



Specific interventions

NICE recommends employers consider a number of specific interventions to help absent employees resume work.

74% of trusts provided education/training events or programmes on physical and mental coping strategies and resilience for their staff. Mental health trusts provided this less commonly than all other types of trusts.

76% of trusts provided physiotherapy for their staff. Mental health trusts provided this less commonly than all other types of trusts.

[36] Health and Work Development Unit. *Depression detection and management of staff on long-term sickness absence – Occupational health practice in the NHS in England: A national clinical audit – round 2*. London: RCP, 2010.

89% of trusts provided psychological therapies for their staff. These were provided by a mix of practitioners.

	National (282 trusts)	
5.7 Does the trust provide:	**Number**	**%**
5.7.3 Psychological therapies for its staff	252	89
5.7.3.1 If yes, are these provided by:		
Qualified psychologists	146/252	58
Counsellors trained in CBT approach	217/252	86
OH staff trained in CBT approach	89/252	35
Other staff trained in CBT approach	48/252	19

Staff seeking psychological therapies may be vulnerable. 12% (29/282) of trusts were not able to immediately confirm the credentials of all practitioners providing psychological interventions for their staff. However, all trusts with internal provision of psychological therapies were able to immediately confirm this.

Almost all trusts provided training for managers on how to manage long-term sickness absence. In one third of trusts this training was considered mandatory for all managers.

Trusts that had done a needs assessment on long-term sickness absence were more likely to provide education/ training events or programmes on physical and mental coping strategies/resilience for their staff and training on how to manage long-term sickness absence for their managers.

Trusts that had involved staff in planning and designing the organisational approach to long-term sickness absence management were more likely to provide physiotherapy services and provide psychological therapies.

Part 6: Mental wellbeing

The audit explored trusts' implementation of the NICE guidance on the promotion of mental wellbeing in the workplace (PH22).

About half of trusts (46%) had a plan or policy to promote the mental wellbeing of their staff and in 37% of trusts this had been formally approved by the board. Another 38% of trusts were developing a plan or policy.

In 59% (76/129) of the trusts where a plan or policy was in place this addressed the needs of different staff groups.

45 trusts measured uptake of programmes by different staff groups such as by grade, gender or ethnicity and in most of these trusts the programme was adjusted if there were clear differentials in uptake.

Monitoring mental wellbeing

72% of trusts had systems for monitoring the mental wellbeing of employees. They used a range of systems.

6.2.1 How do you monitor the mental wellbeing of employees?
'Reviewing the results from the annual staff survey'
'Absence related to stress and mental ill health is monitored as part of the absence policy (through the electronic staff record)'
'Monitoring the uptake of the employee assistance programme and/ or counseling service'
'Monitoring attending on wellbeing training courses'
'Bullying and harassment monitoring'
'HSE Management Standards Risk Assessment'

Only one trust did not formally review the findings of the annual NHS staff survey. Only four trusts did not develop an action plan based on the NHS staff survey findings.

Training managers to promote mental wellbeing

NICE recommends employers strengthen the role of line managers in promoting the mental wellbeing of employees through supportive leadership style and management practices.

63% of trusts provided training for line managers on how to promote and protect employee mental wellbeing. In 12% of all trusts this was mandatory for all line managers.

60% of trusts provided training to ensure line managers are able to identify and respond with sensitivity to employees' emotional concerns and symptoms of mental health problems. In 13% of all trusts this was mandatory for all line managers.

90% of trusts provided training to ensure that line managers understand when it is necessary to refer an employee to occupational health services or other sources of help and support. In only 28% of all trusts was this mandatory for all line managers.

	National (282 trusts)	
	Number	%
6.5 Does the trust provide training for line managers on how to promote and protect employee mental wellbeing?	178	63
6.5.1 If yes, is this training mandatory for all line managers?	33/178	19
6.6 Does the trust provide training to ensure line managers are able to identify and respond with sensitivity to employees' emotional concerns, and symptoms of mental health problems?	168	60
6.6.1 If yes, is this training mandatory for all line managers?	38/168	23
6.7 Does the trust provide training to ensure that line managers understand when it is necessary to refer an employee to occupational health services or other sources of help and support?	253	90
6.7.1 If yes, is this training mandatory for all line managers?	79/253	31

Trusts that had done a needs assessment and had involved staff in planning and designing the organisational approach for promoting mental wellbeing were more likely to provide training for line managers on how to promote and protect employee mental wellbeing and on how to identify and respond with sensitivity to employees' emotional concerns.

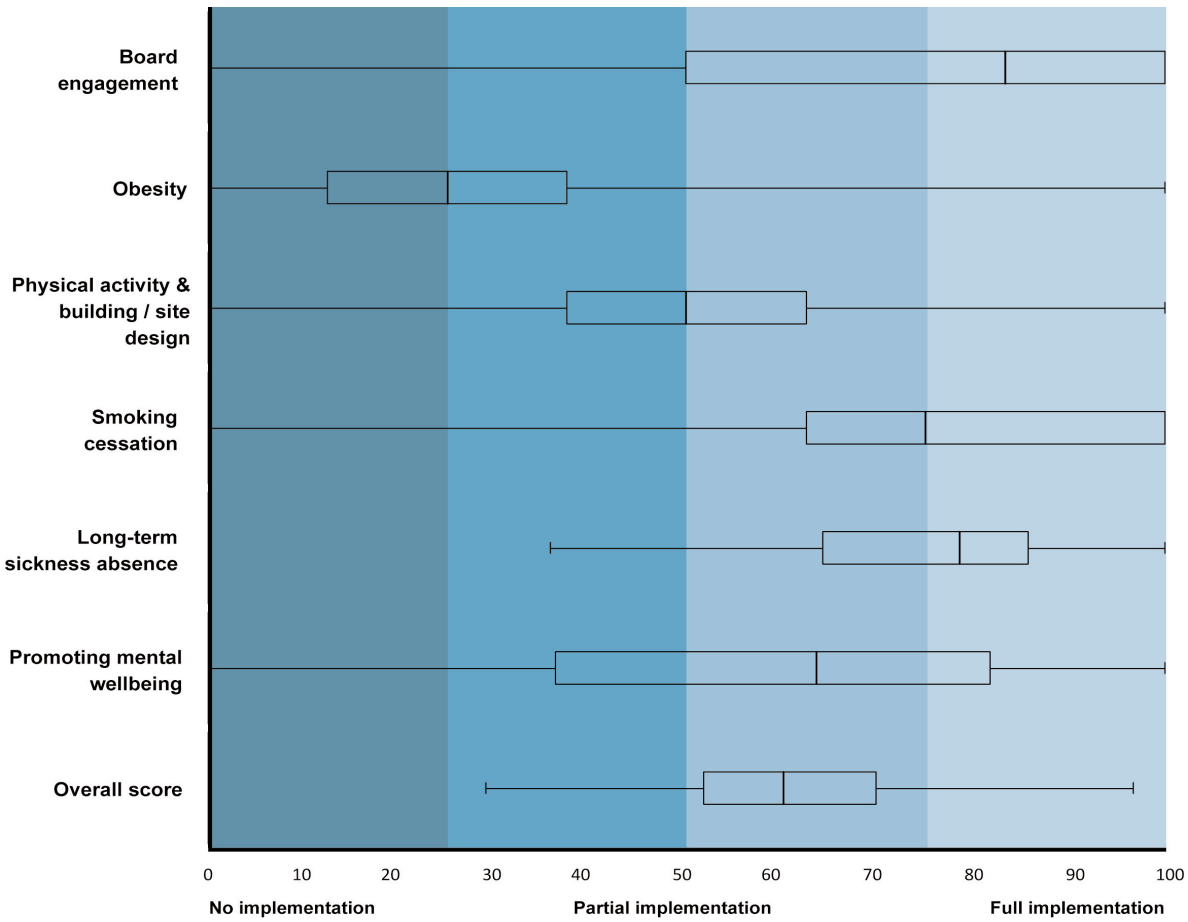
Summary score

We have created a summary score for each trust. This is derived from 39 standards divided into six domains. Five domains match a guidance topic and the sixth is an overarching board engagement domain. The table and figure below show the national picture. Individual trusts have their own scores superimposed on the figure.

Full details on the methodology can be found in Appendix 5. The average score by trust type can be found in Appendix 6. We have excluded trust types where the numbers that participated are too small to maintain anonymity of results.

All trusts should be aiming to fully implement the guidance and reach 100% compliance.

A box and whisker plot is used to show the distribution of data points for a given measurement. The central box is bounded by the 25th and 75th percentiles (the interquartile range) and represents where the middle 50% of all data points lie. The line running through the centre of the box represents the median (50th percentile) of the data. The whiskers are used to show the spread of the data outside of the lower and upper quartiles. All observed values are within this range.



Domain	National median (IQR)
Board engagement	83.3 (50, 100)
Obesity (NICE CG43)	25 (12.5, 37.5)
Physical activity (NICE PH13) and building site design (NICE PH8)	50 (37.5, 62.5)
Smoking cessation	75 (62.5, 100)
Long-term sickness absence	78.6 (64.3, 85.7)
Promoting mental wellbeing	63.6 (36.4, 81.2)
Overall summary score	60.2 (52.1, 69.8)

Conclusions

Trusts have successfully completed the first round of audit of the implementation of NICE public health guidance relevant to the workplace. The guidance is formed of recommendations that are effective and cost effective. To achieve maximum improvement in the health of staff the guidance should be fully implemented.

We found that trusts that prioritised health and wellbeing at a high level within the organisation made more progress with implementation of the guidance than trusts that didn't take staff health and wellbeing to board level.

We found variation across England. The results show that some trusts have successfully implemented many recommendations from the six sets of evidence-based guidance but also that more action can still be taken to improve the health and wellbeing of staff. This audit will enable trusts to identify and take the actions needed to achieve full implementation of the guidance.

Trusts need to optimise performance and productivity. It is essential that staff health is continually addressed by trust boards. Not only do staff costs account for 60% of the NHS budget but better staff health is associated with better outcomes for their patients.

Next steps

Trusts

We recommend that trusts consider their own results in light of the NICE guidance and in comparison with the national results.

We recommend that trusts engage with staff and their representatives to assess needs, plan actions, report progress and measure impact.

HWDU

We will hold a stakeholder launch on 6 May 2011. We will invite audit participants and trust health and wellbeing leads. This event will brief attendees on the key findings of the audit. Top performing trusts will present how they have successfully implemented the guidance and what allowed them to achieve this.

We will hold regional workshops and focus groups in 2011/2012. These events will give participants a chance to review the NICE guidance on health and work and the specific recommendations for change. Participants will be able to share their experiences of using the audit to change practice, barriers to such change and how these can be overcome.

We will repeat data collection in two years' time so that trusts can measure their progress and to give a new national picture of employer commitment to NHS staff health and wellbeing.

Abbreviations

AoMRC: Academy of Medical Royal Colleges

IQR: Inter-quartile range

HWDU: Health and Work Development Unit

NICE: National Institute of Clinical Excellence

RCP: Royal College of Physicians

Appendix 1 National audit data

Part 1: Organisational data		National (282 trusts) N (%)
1.1	Please select the main type of care this trust provides	
	Acute	122 (43)
	Ambulance	10 (4)
	Care	2 (1)
	Mental health	39 (14)
	Primary care	108 (38)
	Other	1 (0.4)
1.2	What is the trust's total headcount?	
	Total	868979
	Median (IQR)	2537 (1200, 4151)
1.2.1	Approximately what proportion of the trust's headcount works on the main site?	
	25 % or less	96 (34)
	26 % – 50 %	32 (11)
	51 % – 75 %	43 (15)
	76 % – 100 %	111 (39)
1.3	Does the trust have a named board member with responsibility for staff health and wellbeing?	267 (95)
1.3.1	If yes, is this board member:	
	Executive: Medical director	2/267 (1)
	Executive: Nursing director	15/267 (6)
	Executive: HR/Workforce director	173/267 (65)
	Executive: Finance director	1/267 (0.4)
	Executive: Estates director	0/267 (0)
	Executive: Operations director	9/267 (3)
	Chief executive	10/267 (4)
	Other executive board member	38/267 (14)
	Non-executive board member	19/267 (7)
1.4	Is staff sickness absence reported regularly to the Board	275 (98)
1.4.1	If yes, at what intervals?	
	Annual	17/275 (6)
	6 monthly	20/275 (7)
	More frequently than 6 monthly	238/275 (87)
1.5	Is staff health and wellbeing a regular Board agenda item?	187 (66)
1.5.1	If yes, at what intervals?	
	Annual	60/187 (32)
	6 monthly	41/187 (22)
	More frequently than 6 monthly	86/187 (46)

continued

Part 1: Organisational data – *continued*		National (282 trusts) N (%)
1.6	Within the last three years, has the trust done a needs assessment to inform an organisational approach to:	
1.6.1	Obesity	81 (29)
1.6.1.1	If yes, did you go through a formal process?	48/81 (59)
1.6.2	Smoking	141 (50)
1.6.2.1	If yes, did you go through a formal process?	92/141 (65)
1.6.3	Physical activity	110 (39)
1.6.3.1	If yes, did you go through a formal process?	57/110 (52)
1.6.4	Long-term sickness absence	208 (74)
1.6.4.1	If yes, did you go through a formal process?	171/208 (82)
1.6.5	Promoting mental wellbeing	174 (62)
1.6.5.1	If yes, did you go through a formal process?	118/174 (68)
1.7	Does the trust prioritise health promotion topics for staff?	202 (72)
1.7.1	If yes, what are your trust's top 3 health promotion topics for staff?	
	Obesity	
	1	17
	2	21
	3	43
	Smoking	
	1	45
	2	56
	3	54
	Physical activity	
	1	33
	2	74
	3	59
	Mental wellbeing	
	1	107
	2	53
	3	32
	Other	
	1	8
	2	9
	3	10

continued

Part 1: Organisational data – *continued*		National (282 trusts) N (%)
1.8	Has the trust involved staff in planning and designing an organisational approach to:	
	Obesity	94 (33)
	Smoking cessation	180 (64)
	Promoting physical activity	163 (58)
	Building site design	131 (46)
	Long-term sickness absence	202 (72)
	Promoting mental wellbeing	194 (69)
	Total number of areas	
	0	30 (11)
	1	29 (10)
	2	32 (11)
	3	37 (13)
	4	54 (19)
	5	56 (19)
	6	44 (16)
1.9	Does the trust have an umbrella/over-arching strategy or policy for staff health and wellbeing?	
	Yes	125 (44)
	No, strategy/policy in development but incomplete	133 (47)
	No	24 (9)

Part 2: Obesity		National (282 trusts) N (%)
2.1	Does the trust have an organisation-wide plan or policy to help reduce obesity amongst its staff?	
	Yes	42 (15)
	No, strategy/policy in development but incomplete	86 (31)
	No	154 (55)
	If yes:	
2.1.1	Has the obesity plan/policy been signed off by the board?	25/42 (60)
2.1.2	Does the obesity plan/policy address the different needs of different staff groups?	22/45 (52)
2.1.3	Does the trust measure uptake of any programmes in the plan/policy by different staff groups such as grade, gender or ethnicity?	13/42 (31)
2.1.3.1	If yes, does the trust adjust the programme where there are clear differentials in uptake?	11/13 (85)

continued

Part 2: Obesity – *continued*		National (282 trusts) N (%)
2.2	Does the trust actively promote healthy food choices, for example using signs, pricing and positioning of products to encourage healthy choices in:	
	Vending machines	90 (32)
	Shops for staff and clients	86 (31)
	Hospitality	142 (50)
	Staff restaurant	173 (61)
2.3	To be effective interventions for obesity need to include the three components of activity, eating behaviour and weight reduction together. Does the trust offer overweight and obese staff multicomponent interventions that address all three? (please confirm this with the person delivering the programme)	86 (31)
2.3.1	If yes, is the person providing the programme trained in obesity management?	
	Yes	64/86 (74)
	No	12/86 (14)
	Don't know	10/86 (12)

Part 3: Physical activity		National (282 trusts) N (%)
3.1	Does the trust have an organisation-wide plan or policy to encourage and support employees to be more physically active?	
	Yes	89 (32)
	No, strategy/policy in development but incomplete	115 (41)
	No	78 (28)
	If yes:	
3.1.1	Has the physical activity plan/policy been signed off by the board?	58/89 (65)
3.1.2	Does the physical activity plan/policy address the different needs of different staff groups?	55/89 (82)
3.1.3	Does the trust measure uptake of any programmes in the plan/policy by different staff groups such as grade, gender or ethnicity?	27/89 (30)
3.1.3.1	If yes, does the trust adjust the programme where there are clear differentials in uptake?	25/27 (93)
3.2	Does the trust provide safe and secure cycle parking for staff?	254 (90)
3.2.1	If yes, approximately how many bikes can it accommodate?	
	Up to 25	112/254 (44)
	26–50	53/254 (21)
	51–100	50/254 (20)
	101 or more	39/254 (15)
3.3	Are all parts of a campus site (two or more related buildings set together in the grounds of a defined site) linked by appropriate walking and cycling routes?	
	Yes	116 (41)
	No	39 (14)
	Not applicable	137 (45)

continued

Part 3: Physical activity – *continued*		National (282 trusts) N (%)
3.4	For any new workplaces built (or in the planning stages) since 2006, does the trust have a system in place to ensure that they are linked to existing walking and cycling networks?	
	Yes	112 (40)
	No	44 (16)
	Not applicable	126 (45)
3.5	Does the trust help staff to be physically active during the working day by:	
	Encouraging staff to walk or cycle to external meetings	149 (53)
	Encouraging staff to use the stairs rather than lifts e.g. by putting up signs at strategic points and distributing written information	134 (48)
	Providing information about walking and cycling routes to and from work	147 (52)
	Providing information about walking and cycling routes around the worksite	142 (50)
	Encouraging staff to take short walks during work breaks e.g. providing information about lunchtime walks	173 (61)
	Encouraging staff to use local leisure facilities	231 (82)
	Encouraging staff to set goals on how far they walk and cycle and monitor the distances they cover	103 (37)
3.6	Does the trust provide:	
	On-site gym	59 (21)
	On-site swimming pool	16 (6)
	On-site squash or tennis courts	28 (10)
	Reduced membership fees for local leisure facilities (e.g. subsidised by trust or negotiated with facility)	237 (84)
	Bike purchase scheme	222 (79)
	Other	114 (40)
3.7	During building design or refurbishment does the trust ensure staircases are designed and positioned to encourage people to use them?	213 (76)
3.8	Are staircases clearly signposted and attractive to use (e.g. well-lit and well-decorated)?	
	All	85 (30)
	Most	154 (55)
	Approximately half	26 (9)
	Few	15 (5)
	None	2 (1)

Part 4: Smoking cessation		National (282 trusts) N (%)
4.1	Does the trust have an organisation-wide plan or policy to encourage and support employees to be more physically active?	
	Yes	207 (73)
	No, strategy/policy in development but incomplete	43 (15)
	No	32 (11)
	If yes:	

continued

Part 4: Smoking cessation – *continued*		National (282 trusts) N (%)
4.1.1	Has this smoking cessation plan/policy been signed off by the board?	185/207 (89)
4.1.2	Does the plan/policy address the different needs of different staff groups?	117/207 (57)
4.1.3	Does the trust measure uptake of any programmes in the plan/policy by different staff groups such as grade, gender or ethnicity?	48/207 (23)
4.1.3.1	If yes, does the trust adjust the programme where there are clear differentials in uptake?	32/48 (67)
4.2	Does the trust publicise smoking cessation services for staff?	264 (94)
4.2.1	If yes, does this publicity include:	
	Where services are available	258/264 (98)
	How to access these services	262/264 (99)
	The type of help available	256/264 (97)
	When services are available	236/264 (89)
4.3	Does the trust provide access to stop smoking support (either on-site or through arrangements with another local service)?	268 (95)
4.4	Does the trust policy allow staff to attend smoking cessation services during working hours without loss of pay?	179 (63)

Part 5: Long-term sickness absence		National (282 trusts) N (%)
5.1	Does the trust have an organisation-wide plan or policy to encourage and support employees to be more physically active?	
	Yes	282 (100)
	No, strategy/policy in development but incomplete	0 (0)
	No	0 (0)
	If yes:	
5.1.1	Does the policy require employees absent due to illness to inform their manager on the first day of absence?	280/282 (99)
5.1.2	Does the policy require managers to contact staff whose sickness absence continues beyond a week or so, for an initial enquiry to discuss their health and work?	268/282 (95)
	If yes:	
5.1.2.1	Does the policy give a trigger for when this should be done?	
	Yes at 2 weeks (or less)	112/268 (42)
	Yes by 3 weeks	15/268 (6)
	Yes by 4 weeks	97/268 (36)
	Yes by 5 weeks	1/268 (0.4)
	Yes by 6 weeks	1/268 (0.4)
	Yes, later than 6 weeks	2/268 (1)
	No	40/268 (15)

continued

Part 5: Long-term sickness absence – *continued*		National (282 trusts) N (%)
5.1.2.2	Does the policy (or accompanying guidance) ask managers to explore in this initial enquiry:	
	The reasons for sickness absence	263/268 (98)
	Whether the staff member has received appropriate treatment	225/268 (84)
	When the staff member thinks that he/she will be back at work	259/268 (97)
	Any perceived (or actual) barriers to returning to work (including the need for workplace adjustments)	241/268 (90)
	The potential need for a referral to OH	257/268 (96)
	The options for returning to work and what, if any, action is required to prepare for this	248/268 (93)
5.1.3	Does the policy require development of a return to work plan agreed between the manager and the employee ?	274/282 (97)
5.1.3.1	If yes, does the policy specify that managers must consider, with the employee (taking account of any OH advice), the need for:	
	A gradual return to the original job by increasing the hours and days worked over a period of time	273/274 (99.6)
	A return to some of the duties of the original job	272/274 (99)
	A move to another job within the organisation (on a temporary or permanent basis)	269/274 (98)
5.2	Does the trust use case managers for the more complex cases of long-term sickness absence?	181 (64)
	If yes:	
5.2.1	What is the background of the case managers?	
	Occupational Health	72/181 (40)
	Human Resources	145/181 (80)
	Line management	123/181 (68)
	Other	3/181 (2)
5.2.2	Does the case manager:	
	Monitor absence data in real time	145/181 (80)
	Co-ordinate any required assessments	177/181 (98)
	Timetable actions to eliminate delays between milestones	162/181 (90)
	Initiate formal interventions	175/181 (97)
	Prompt and track actions	172/181 (95)
	Provide periodic reports to stakeholders	161/181 (89)
5.3	Does the trust record absence data in real time (e.g. through ESR self-service)?	
	Yes fully	94 (33)
	Yes partially	77 (27)
	No	111 (39)
5.4	Does the trust routinely identify staff who are on long-term sick using a central system (e.g. by interrogating ESR and running reports at regular intervals)?	272 (96)
5.5	Does the trust monitor trust trends in long-term sickness absence?	267 (95)

continued

Part 5: Long-term sickness absence – *continued*		National (282 trusts) N (%)
5.5.1	If yes, who is long-term sickness absence information reported to:	
	HR	255/267 (96)
	Line manager	241/267 (90)
	Divisional/ directorate manager	246/267 (92)
	Trust board	245/267 (92)
	Other	54/267 (20)
5.6	Does the trust's OH provider routinely collect and report on the following data?	
5.6.1	Time from start of absence to referral to OH	70 (25)
5.6.1.1	If yes, who is this information reported to?	
	HR	60/70 (86)
	Trust Board	8/70 (11)
	Other	16/70 (23)
5.6.2	Time from receipt of OH referral to OH appointment	184 (65)
5.6.2.1	If yes, who is this information reported to?	
	HR	147/184 (80)
	Trust Board	29/184 (16)
	Other	39/184 (21)
5.6.3	Time from OH appointment to issue of OH report	148 (52)
5.6.3.1	If yes, who is this information reported to?	
	HR	115/148 (78)
	Trust Board	20/148 (14)
	Other	30/148 (20)
5.7	Does the trust provide:	
5.7.1	Education/ training events or programmes on physical and mental coping strategies/resilience for its staff	208 (74)
5.7.2	Physiotherapy for its staff	215 (76)
5.7.3	Psychological therapies for its staff	252 (89)
5.7.3.1	If yes, are these provided by:	
	Qualified psychologists	146/252 (58)
	Counsellors trained in CBT approach	217/252 (86)
	OH staff trained in CBT approach	89/252 (35)
	Other staff trained in CBT approach	48/252 (19)
	Other	33/252 (13)
5.7.3.2	Does the trust verify the credentials of all practitioners providing psychological interventions for its staff (including outsourced provision)?	223/252 (88)
5.8	Does the trust provide training for managers on how to manage staff on long-term sick (either as stand alone training or part of a broader sickness absence training)?	274 (97)
5.8.1	If yes, is this training mandatory for all managers?	90/274 (33)

continued

Part 6: Mental wellbeing		National (282 trusts) N (%)
6.1	Does the trust have an organisation-wide plan or policy to encourage and support employees to be more physically active?	
	Yes	129 (46)
	No, strategy/policy in development but incomplete	108 (38)
	No	45 (16)
	If yes:	
6.1.1	Has the plan/policy to promote mental wellbeing been signed off by the board?	104/129 (81)
6.1.2	Does this plan/policy integrate the promotion of mental wellbeing into all policies and practices concerned with managing people, including those related to employment rights and working conditions?	82/129 (64)
6.1.3	Does the plan/policy address the different needs of different staff groups, and include measures to maximise the opportunity for all employees to participate?	76/129 (59)
6.1.4	Does the trust measure uptake of any programmes in the plan/policy by different staff groups such as by grade, gender or ethnicity?	45/129 (35)
6.1.4.1	If yes, does the trust adjust the programme where there are clear differentials in uptake?	31/45 (69)
6.2	Does the trust have systems for monitoring the mental wellbeing of employees?	203 (72)
6.3	Does the trust formally review the findings of the annual NHS staff survey?	281 (99.7)
6.4	Does the trust develop an action plan based on the NHS staff survey findings?	278 (99)
6.5	Does the trust provide training for line managers on how to promote and protect employee mental wellbeing?	178 (63)
6.5.1	If yes, is this training mandatory for all line managers?	33/178 (19)
6.6	Does the trust provide training to ensure line managers are able to identify and respond with sensitivity to employees' emotional concerns, and symptoms of mental health problems?	168 (60)
6.6.1	If yes, is this training mandatory for all line managers?	38/168 (23)
6.7	Does the trust provide training to ensure that line managers understand when it is necessary to refer an employee to occupational health services or other sources of help and support?	253 (90)
6.7.1	If yes, is this training mandatory for all line managers?	79/253 (31)

Appendix 2 Participating trusts

The following trusts submitted data into the audit:

2gether NHS Foundation Trust
Airedale NHS Trust
Alder Hey Children's NHS Foundation Trust
Ashford & St Peter's Hospital NHS Trust
Ashton, Leigh & Wigan Community Health Care
Avon and Wiltshire Mental Health Partnership NHS Trust
Barking Havering and Redbridge University Hospitals NHS Trust
Barnet & Chase Farm Hospitals NHS Trust
Barnet, Enfield and Haringey Mental Health NHS Trust
Barnsley Hospital NHS Foundation Trust
Barts and the London NHS Trust
Basildon and Thurrock University Hospital NHS Foundation Trust
Basingstoke and North Hampshire NHS Foundation Trust
Bedford Hospital NHS Trust
Birmingham and Solihull Mental Health NHS Foundation Trust
Birmingham Women's NHS Foundation Trust
Bradford District Care Trust
Bradford Teaching Hospitals NHS Foundation Trust
Buckinghamshire Hospitals NHS Trust
Burton Hospitals NHS Foundation Trust
Calderdale & Huddersfield NHS Foundation Trust
Calderstones Partnership NHS Foundation Trust
Camden and Islington NHS Foundation Trust
Central and Eastern Cheshire Primary Care Trust
Central Essex Community Services
Central London Community Healthcare
Central Manchester University Hospitals NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
Cheshire East Community Health
Chesterfield Royal Hospital NHS Foundation Trust
Clatterbridge Centre for Oncology NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
Commissioning Support for London
Countess of Chester Hospital NHS Foundation Trust
County Durham & Darlington NHS Foundation Trust
Coventry & Warwickshire Partnership NHS Trust
Dartford & Gravesham NHS Trust
Derby Hospitals NHS Foundation Trust
Derbyshire Community Health Services
Derbyshire County Primary Care Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
Dorset HealthCare NHS Foundation Trust
Ealing Hospital NHS Trust
East and North Hertfordshire NHS Trust
East Cheshire NHS Trust
East Kent Hospitals University NHS Foundation Trust
East London NHS Foundation Trust
East Midlands Ambulance Service NHS Trust
East of England Ambulance Service NHS Trust
Epsom and St Helier University Hospitals NHS Trust
Frimley Park Hospital NHS Foundation Trust
Gateshead Health NHS Foundation Trust
George Eliot Hospital NHS Trust
Gloucestershire Hospitals NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Trust
Great Western Ambulance Service NHS Trust
Greater Manchester West Mental Health NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Hampshire Partnership NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Hereford Hospitals NHS Trust
Hertfordshire Partnership NHS Foundation Trust
Hillingdon Hospital NHS Trust
Hinchingbrooke Health Care NHS Trust
Imperial College Healthcare NHS Trust
Ipswich Hospital NHS Trust
Isle of Wight NHS Primary Care Trust
Kent & Medway NHS & Social Care Partnership Trust
King's College Hospital NHS Foundation Trust
Kingston Hospital NHS Trust
Lancashire Care NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Leeds Partnerships NHS Foundation Trust
Leicestershire Partnership NHS Trust
Lewisham Healthcare Trust
Lincolnshire Partnership NHS Foundation Trust

Liverpool Heart and Chest Hospital NHS Trust
Liverpool Primary Care Trust
London Ambulance Service NHS Trust
Luton and Dunstable Hospital NHS Foundation Trust
Maidstone and Tunbridge Wells NHS Trust
Manchester Mental Health & Social Care Trust
Medway Community Healthcare
Medway NHS Foundation Trust
Mersey Care NHS Trust
Mid Cheshire Hospitals NHS Foundation Trust
Mid Staffordshire NHS Foundation Trust
Mid-Essex Hospital Services NHS Trust
Newham University Hospital NHS Trust
NHS Barking and Dagenham
NHS Bath & North East Somerset
NHS Bedfordshire
NHS Berkshire West
NHS Berkshire West – Community Health
NHS Birmingham East and North
NHS Blackburn with Darwen
NHS Blackpool
NHS Bolton
NHS Bradford and Airedale
NHS Bromley
NHS Calderdale
NHS Cambridgeshire
NHS Camden
NHS Camden – Provider Services
NHS Central Lancashire
NHS Cornwall and Isles of Scilly
NHS County Durham
NHS Coventry
NHS Croydon
NHS Darlington
NHS Devon
NHS Devon Provider Services
NHS Doncaster
NHS Dorset
NHS Dudley
NHS Ealing
NHS Eastern and Coastal Kent
NHS Gloucestershire
NHS Haringey
NHS Hartlepool
NHS Hull
NHS Islington
NHS Islington – Provider Services
NHS Kingston
NHS Kirklees
NHS Leicester City
NHS Leicestershire County and Rutland
NHS Lincolnshire
NHS Liverpool – Community Health
NHS Luton
NHS Luton – Community Services
NHS Medway
NHS Mid Essex
NHS Middlesbrough
NHS Milton Keynes
NHS Norfolk – Norfolk Community Health & Care
NHS North East Essex
NHS North Lancashire
NHS North Lancashire – Provider Services
NHS North Lincolnshire
NHS North of Tyne – Newcastle Primary Care Trust
NHS North of Tyne – North Tyneside Primary Care Trust
NHS North Staffordshire
NHS North Staffordshire – Community Health
NHS Nottingham City
NHS Nottinghamshire County
NHS Oldham
NHS Peterborough
NHS Redbridge
NHS Richmond
NHS Richmond – Community Health Services
NHS Rotherham
NHS Salford
NHS Sefton
NHS Sheffield
NHS Sheffield- Provider Services
NHS Somerset
NHS Somerset Community Care
NHS South East Essex
NHS South of Tyne – Gateshead Primary Care Trust
NHS South of Tyne – South Tyneside Primary Care Trust
NHS South of Tyne —- Sunderland Teaching Primary Care Trust
NHS South West Essex Community Services
NHS Stockton-on-Tees
NHS Stoke on Trent
NHS Surrey – Community Health Services
NHS Swindon
NHS Tower Hamlets
NHS Trafford
NHS Walsall
NHS Waltham Forest

NHS Warwickshire
NHS Western Cheshire
NHS Western Cheshire – Community Care
NHS Wiltshire
NHS Wiltshire – Community Health Services
Norfolk and Norwich University Hospitals NHS Foundation Trust
Norfolk and Waveney Mental Health NHS Foundation Trust
North Bristol NHS Trust
North Cumbria University Hospitals NHS Trust
North East Ambulance Service NHS Trust
North Essex Partnership NHS Foundation Trust
North Staffordshire Combined Healthcare NHS Trust
North Tees & Hartlepool NHS Foundation Trust
North West Ambulance Service NHS Trust
Northampton General Hospital NHS Trust
Northern Devon Healthcare NHS Trust
Northumberland, Tyne and Wear NHS Trust
Northumbria Healthcare NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Nottinghamshire Community Health
Nottinghamshire Healthcare NHS Trust
Oxford Radcliffe Hospitals NHS Trust
Oxfordshire Learning Disability NHS Trust/Ridgeway Partnership
Oxleas NHS Foundation Trust
Papworth Hospital NHS Foundation Trust
Peterborough & Stamford Hospitals NHS Foundation Trust
Plymouth Hospitals NHS Trust
Poole Hospital NHS Foundation Trust
Portsmouth Hospitals NHS Trust
Royal Bolton Hospital NHS Foundation Trust
Royal Free Hampstead NHS Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Royal National Hospital for Rheumatic Diseases NHS Foundation Trust
Royal Surrey County Hospital NHS Trust
Royal United Hospital Bath NHS Trust
Salford Royal NHS Foundation Trust
Salisbury NHS Foundation Trust
Sandwell & West Birmingham Hospitals NHS Trust
Sandwell Mental Health and Social Care NHS Foundation Trust
Sandwell Primary Care Trust
Scarborough and North East Yorks Healthcare NHS Trust
Sheffield Children's NHS Foundation Trust
Sheffield Health and Social Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
Shropshire County Primary Care TrustTrust – Community Services
Shropshire County Primary Care Trust
Solent Healthcare
South Birmingham Community Health
South Central Ambulance Service NHS Trust
South Devon Healthcare NHS Foundation Trust
South East Coast Ambulance Service NHS Trust
South Essex Partnership University NHS Foundation Trust
South London & Maudsley NHS Foundation Trust
South Staffordshire Primary Care Trust
South Tees Hospitals NHS Foundation Trust
South Tyneside NHS Foundation Trust
South West London & St Georges Mental HealthHealth NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Southampton City Primary Care Trust
Southend University Hospital NHS Foundation Trust
St George's Healthcare NHS Trust
St Helens & Knowsley Teaching Hospitals NHS Trust
Stockport NHS Foundation Trust
Stoke on Trent Community Health Services
Surrey & Borders Partnership NHS Foundation Trust
Surrey & Sussex Healthcare NHS Trust
Sussex Community NHS Trust
Sussex Partnership NHS Foundation Trust
Tameside Hospital NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
The Christie NHS Foundation Trust
The Leeds Teaching Hospitals NHS Trust
The Mid Yorkshire Hospitals NHS Trust
The Newcastle upon Tyne Hospitals NHS Foundation Trust
The North West London Hospitals NHS Trust
The Pennine Acute Hospitals NHS Trust
The Queen Elizabeth Hospital King's Lynn NHS Trust
The Queen Victoria Hospital NHS Foundation Trust
The Rotherham NHS Foundation Trust
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
The Royal Orthopaedic Hospitals NHS Foundation Trust
The Walton Centre NHS Foundation Trust
Trafford Healthcare NHS Trust

Trafford Provider Services
United Lincolnshire Hospitals NHS Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
University Hospitals Coventry & Warwickshire NHS Trust
University Hospitals of Leicester NHS Trust
Walsall Hospitals NHS Trust
Warrington & Halton Hospitals NHS Foundation Trust
West London Mental Health NHS Trust
West Middlesex University Hospital NHS Trust
West Midlands Ambulance Service NHS Trust
West Suffolk Hospital NHS Trust
Western Sussex Hospitals NHS Trust
Weston Area Health NHS Trust
Whipps Cross University Hospital NHS Trust
Whittington Hospital NHS Trust
Wirral University Teaching Hospital NHS Foundation Trust
Wolverhampton City PrimaryPrimary Care Trust – Provider Services
Wolverhampton City Primary Care Trust
Wrightington, Wigan & Leigh NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
York Hospitals NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

Appendix 3 Audit tool

National Organisational Audit of the implementation of NICE Public Health guidance for the workplace by NHS trusts

Please answer all questions.

Please complete this questionnaire for your main site only. **This form may be used internally for data collection. Data can only be submitted for analysis online at https://audit.rcplondon.ac.uk/hwdu**. The deadline for entering data on the data collection tool is 17 December 2010.

If you are from a trust which shares facilities and management functions with other trusts, you must still complete a separate questionnaire for each trust (regardless of whether your answers are the same for each trust).

Trust name: _____

Site name (if auditing more than 1 site belonging to this trust): _____

Instructions for completion:

1. Please cross the boxes as appropriate (☒ or ⊗).
2. Please refer to the accompanying help booklet.
3. Data can only be submitted to HWDU via the webtool at https://audit.rcplondon.ac.uk/hwdu.
4. The help desk can be contacted on 020 3075 1585 or hwdu@rcplondon.ac.uk.

PART ONE: ORGANISATIONAL DATA

1.1 Please select the main type of care this trust provides (tick one only):

- ◯ Acute
- ◯ Ambulance
- ◯ Care
- ◯ Mental health
- ◯ Primary care
- ◯ Other (please specify):

1.2 What is the trust's total headcount?

1.2.1 Approximately what proportion of the trust's headcount works on the main site?

- ◯ 25 % or less
- ◯ 26 % –50 %
- ◯ 51 % –75 %
- ◯ 76 % –100 %

1.3 Does the trust have a named board member with responsibility for staff health and wellbeing?

◯ Yes ◯ No

1.3.1 If yes, is this board member: (tick one only)

- ◯ Executive: Medical director
- ◯ Executive: Nursing director
- ◯ Executive: HR/Workforce director
- ◯ Executive: Finance director

◯ Executive: Estates director
◯ Executive: Operations director
◯ Chief executive
◯ Other executive board member
◯ Non- executive board member

1.4 Is staff sickness absence reported regularly to the Board? ◯ Yes ◯ No

1.4.1 If yes, at what intervals?
◯ Annual
◯ 6 monthly
◯ More frequently than 6 monthly

1.5 Is staff health and wellbeing a regular Board agenda item? ◯ Yes ◯ No

1.5.1 If yes, at what intervals?
◯ Annual
◯ 6 monthly
◯ More frequently than 6 monthly

1.6 Within the last three years, has the trust done a needs assessment to inform an organisational approach to:

1.6.1 Obesity	◯ Yes ◯ No
1.6.1.1 If yes, did you go through a formal process?	◯ Yes ◯ No
1.6.2 Smoking	◯ Yes ◯ No
1.6.2.1 If yes, did you go through a formal process?	◯ Yes ◯ No
1.6.3 Physical activity	◯ Yes ◯ No
1.6.3.1 If yes, did you go through a formal process?	◯ Yes ◯ No
1.6.4 Long-term sickness absence	◯ Yes ◯ No
1.6.4.1 If yes, did you go through a formal process?	◯ Yes ◯ No
1.6.5 Promoting mental wellbeing	◯ Yes ◯ No
1.6.5.1 If yes, did you go through a formal process?	◯ Yes ◯ No

1.7 What are your trust's top 3 highest health promotion topics for staff? Please select 1 for highest priority and 3 for the third highest priority

❑ Obesity
❑ Smoking
❑ Physical activity
❑ Mental wellbeing
❑ Other health promotion topic (please specify) [ ]
❑ No one topic prioritised above any other

1.8 Has the trust involved staff in planning and designing an organisational approach to:

Obesity	◯ Yes ◯ No
Smoking cessation	◯ Yes ◯ No
Promoting physical activity	◯ Yes ◯ No
Building site design	◯ Yes ◯ No
Long-term sickness absence	◯ Yes ◯ No
Promoting mental wellbeing	◯ Yes ◯ No

1.9 Does the trust have an umbrella/over-arching strategy or policy for staff health and wellbeing?

◯ Yes
◯ No, strategy/policy in development but incomplete
◯ No

PART TWO: OBESITY (NICE CG43)

2.1 Does the trust have an organisation-wide plan or policy to reduce obesity amongst its staff?

- ◯ Yes
- ◯ No, strategy/policy in development but incomplete
- ◯ No

If yes:

2.1.1 Has the obesity plan/policy been signed off by the board? ◯ Yes ◯ No

2.1.2 Does the obesity plan/policy address the different needs of different staff groups? ◯ Yes ◯ No

2.1.3 Does the trust measure uptake of any programmes in the plan/policy by different staff groups such as by grade, gender or ethnicity? ◯ Yes ◯ No

2.1.3.1 If yes, does the trust adjust the programme where there are clear differentials in uptake? ◯ Yes ◯ No

2.2 Does the trust actively promote healthy food choices, for example using signs, pricing and positioning of products to encourage healthy choices in:

- Vending machines ◯ Yes ◯ No
- Shops for staff and clients ◯ Yes ◯ No
- Hospitality ◯ Yes ◯ No
- Staff restaurant ◯ Yes ◯ No

2.3 To be effective interventions for obesity need to include the three components of activity, eating behaviour and weight reduction together. Does the trust offer overweight and obese staff multicomponent interventions that address all three? (please confirm this with the person delivering the programme) ◯ Yes ◯ No

2.3.1 If yes, is the person providing the programme trained in obesity management?

- ◯ Yes
- ◯ No
- ◯ Don't know

PART THREE: PHYSICAL ACTIVITY (NICE PH13) AND BUILDING/SITE DESIGN (NICE PH8)

3.1 Does the trust have an organisation-wide plan or policy to encourage and support employees to be more physically active?

- ◯ Yes
- ◯ No, strategy/policy in development but incomplete
- ◯ No

If yes:

3.1.1 Has the physical activity plan/policy been signed off by the board? ◯ Yes ◯ No

3.1.2 Does the physical activity plan/policy address the different needs of different staff groups? ◯ Yes ◯ No

3.1.3 Does the trust measure uptake of any programmes in the plan/policy by different staff groups such as grade, gender or ethnicity? ◯ Yes ◯ No

3.1.3.1 If yes, does the trust adjust the programme where there are clear differentials in uptake? ◯ Yes ◯ No

3.2 Does the trust provide safe and secure cycle parking for staff? ◯ Yes ◯ No

3.2.1 If yes, approximately how many bikes can it accommodate?
- ◯ Up to 25
- ◯ 26–50
- ◯ 51–100
- ◯ 101 or more

3.3 Are all parts of a campus site (two or more related buildings set together in the grounds of a defined site) linked by appropriate walking and cycling routes?
- ◯ Yes
- ◯ No
- ◯ Not applicable

3.4 For any new workplaces built (or in the planning stages) since 2006, does the trust have a system in place to ensure that they are linked to existing walking and cycling networks?
- ◯ Yes
- ◯ No
- ◯ Not applicable

3.5 Does the trust help staff to be physically active during the working day by:

Encouraging staff to walk or cycle to external meetings	◯ Yes ◯ No
Encouraging staff to use the stairs rather than lifts e.g. by putting up signs at strategic points and distributing written information	◯ Yes ◯ No
Providing information about walking and cycling routes to and from work	◯ Yes ◯ No
Providing information about walking and cycling routes around the worksite	◯ Yes ◯ No
Encouraging staff to take short walks during work breaks e.g. providing information about lunchtime walks	◯ Yes ◯ No
Encouraging staff to use local leisure facilities	◯ Yes ◯ No
Encouraging staff to set goals on how far they walk and cycle and monitor the distances they cover	◯ Yes ◯ No

3.5.1 How do you set and monitor that goals are being achieved?

3.6 Does the trust provide:

On-site gym	◯ Yes ◯ No
On-site swimming pool	◯ Yes ◯ No
On-site squash or tennis courts	◯ Yes ◯ No
Reduced membership fees for local leisure facilities (e.g. subsidised by trust or negotiated with facility)	◯ Yes ◯ No
Bike purchase scheme	◯ Yes ◯ No

Other onsite facilities or incentive schemes to encourage physical activity (please describe)

3.7 During building design or refurbishment does the trust ensure staircases are designed and positioned to encourage people to use them? ◯ Yes ◯ No

3.8 Are staircases clearly signposted and attractive to use (e.g. well-lit and well-decorated)?
◯ All
◯ Most
◯ Approximately half
◯ Few
◯ None

PART FOUR: SMOKING CESSATION (NICE PH5)

4.1 Does the trust have an organisation-wide plan or policy to encourage and support employees to stop smoking?
◯ Yes
◯ No, strategy/policy in development but incomplete
◯ No

If yes:

4.1.1 Has this smoking cessation plan/policy been signed off by the board? ◯ Yes ◯ No

4.1.2 Does the plan/policy address the different needs of different staff groups? ◯ Yes ◯ No

4.1.3 Does the trust measure uptake of any programmes in the plan/policy by different staff groups such as grade, gender or ethnicity? ◯ Yes ◯ No

4.1.3.1 If yes, does the trust adjust the programme where there are clear differentials in uptake? ◯ Yes ◯ No

4.2 Does the trust publicise smoking cessation services for staff? ◯ Yes ◯ No

4.2.1 If yes, does this publicity include:

Where services are available ◯ Yes ◯ No

How to access these services ◯ Yes ◯ No

The type of help available ◯ Yes ◯ No

When services are available ◯ Yes ◯ No

4.3 Does the trust provide access to stop smoking support (either on-site or through arrangements with another local service)? ◯ Yes ◯ No

4.4 Does the trust policy allow staff to attend smoking cessation services during working hours without loss of pay? ◯ Yes ◯ No

PART FIVE: LONG-TERM SICKNESS ABSENCE (NICE PH19)

These questions relate to the organisation and the actions of managers (not the actions of occupational health specialists)

5.1 Does the trust have an organisation-wide policy for the management of long-term sickness absence (either as a stand alone policy or addressed explicitly within an absence policy)?

- ◯ Yes **(please answer all remaining questions)**
- ◯ No, strategy/policy in development but incomplete **(please skip to question 5.1)**
- ◯ No **(please skip to question 5.1)**

If yes:

5.1.1 Does the policy require employees absent due to illness to inform their manager on the first day of absence? ◯ Yes ◯ No

5.1.2 Does the policy require managers to contact staff whose sickness absence continues beyond a week or so, for an initial enquiry to discuss their health and work? ◯ Yes ◯ No

If yes:

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

- ◯ yes at 2 weeks (or less)
- ◯ yes by 3 weeks
- ◯ yes by 4 weeks
- ◯ yes by 5 weeks
- ◯ yes by 6 weeks
- ◯ yes, later than 6 weeks
- ◯ no

5.1.2.2 Does the policy (or accompanying guidance) ask managers to explore in this initial enquiry:

The reasons for sickness absence	◯ Yes ◯ No
Whether the staff member has received appropriate treatment	◯ Yes ◯ No
When the staff member thinks that he/she will be back at work	◯ Yes ◯ No
Any perceived (or actual) barriers to returning to work (including the need for workplace adjustments)	◯ Yes ◯ No
The potential need for a referral to OH	◯ Yes ◯ No
The options for returning to work and what, if any, action is required to prepare for this	◯ Yes ◯ No

5.1.3 Does the policy require development of a return to work plan agreed between the manager and the employee? ◯ Yes ◯ No

5.1.3.1 If yes, does the policy specify that managers must consider, with the employee (taking account of any OH advice), the need for:

A gradual return to the original job by increasing the hours and days worked over a period of time	◯ Yes ◯ No
A return to some of the duties of the original job	◯ Yes ◯ No
A move to another job within the organisation (on a temporary or permanent basis)	◯ Yes ◯ No

For more complex cases of long-term sickness absence, NICE guidance recommends the appointment of a case manager. This person co-ordinates any assessments and rehabilitation so that actions are done appropriately and on time. Please read the help notes for more details before answering the questions below.

5.2 Does the trust use case managers for the more complex cases of long-term sickness absence? ◯ Yes ◯ No

If yes:

5.2.1 What is the background of the case managers?

- Occupational Health ◯ Yes ◯ No
- Human Resources ◯ Yes ◯ No
- Line management ◯ Yes ◯ No
- Other (please specify): _____

5.2.2 Does the case manager:

- Monitor absence data in real time ◯ Yes ◯ No
- Co-ordinate any required assessments ◯ Yes ◯ No
- Timetable actions to eliminate delays between milestones ◯ Yes ◯ No
- Initiate formal interventions ◯ Yes ◯ No
- Prompt and track actions ◯ Yes ◯ No
- Provide periodic reports to stakeholders ◯ Yes ◯ No

5.3 Does the trust record absence data in real time (e.g. through ESR self-service)? ◯ Yes fully ◯ Yes partially ◯ No

5.4 Does the trust routinely identify staff who are on long-term sick using a central system (e.g. by interrogating ESR and running reports at regular intervals)? ◯ Yes ◯ No

5.5 Does the trust monitor trust trends in long-term sickness absence? ◯ Yes ◯ No

5.5.1 If yes, who is long-term sickness absence information reported to:

- HR ◯ Yes ◯ No
- Line manager ◯ Yes ◯ No
- Divisional/ directorate manager ◯ Yes ◯ No
- Trust board ◯ Yes ◯ No
- Other (please specify) _____

5.6 Does the trust's OH provider routinely collect and report on the following data?

- Time from start of absence to referral to OH ◯ Yes ◯ No
- Time from receipt of OH referral to OH appointment ◯ Yes ◯ No
- Time from OH appointment to issue of OH report ◯ Yes ◯ No

5.6.1 If any of the above data is routinely collected, who is this information reported to?

- HR ◯ Yes ◯ No
- Trust board ◯ Yes ◯ No
- Other (please specify): _____

5.7 Does the trust provide:

- 5.7.1 Education/ training events or programmes on physical and mental coping strategies/resilience for its staff ◯ Yes ◯ No
- 5.7.2 Physiotherapy for its staff ◯ Yes ◯ No
- 5.7.3 Psychological therapies for its staff ◯ Yes ◯ No
  - 5.7.3.1 If yes, are these provided by:
    - Qualified psychologists ◯ Yes ◯ No
    - Counsellors trained in CBT approach ◯ Yes ◯ No
    - OH staff trained in CBT approach ◯ Yes ◯ No
    - Other staff trained in CBT ◯ Yes ◯ No
    - Other
  - 5.7.3.2 Does the trust verify the credentials of all practitioners providing psychological interventions for its staff (including outsourced provision)? ◯ Yes ◯ No

5.8 Does the trust provide training for managers on how to manage staff on long-term sick (either as stand alone training or part of a broader sickness absence training)? ◯ Yes ◯ No

- 5.8.1 If yes, is this training mandatory for all managers? ◯ Yes ◯ No

PART SIX: PROMOTING MENTAL WELLBEING (NICE PH22)

6.1 Does the trust have an organisation-wide plan/ policy to promoting mental wellbeing amongst its staff?

◯ Yes
◯ No, strategy/policy in development but incomplete
◯ No

If yes:

- 6.1.1 Has the plan/policy to promote mental wellbeing been signed off by the board? ◯ Yes ◯ No
- 6.1.2 Does this plan/policy integrate the promotion of mental wellbeing into all policies and practices concerned with managing people, including those related to employment rights and working conditions? ◯ Yes ◯ No
- 6.1.3 Does the plan/policy address the different needs of different staff groups, and include measures to maximise the opportunity for all employees to participate? ◯ Yes ◯ No
- 6.1.4 Does the trust measure uptake of any programmes in the plan/policy by different staff groups such as by grade, gender or ethnicity? ◯ Yes ◯ No
  - 6.1.4.1 If yes, does the trust adjust the programme where there are clear differentials in uptake? ◯ Yes ◯ No

NICE (and other national) guidance expects trusts to adopt a structured approach to promoting employees' mental wellbeing and managing risks.

6.2	Does the trust have systems for monitoring the mental wellbeing of employees?	◯ Yes ◯ No
	6.2.1 How do you monitor mental wellbeing of staff?	
6.3	Does the trust formally review the findings of the annual NHS staff survey?	◯ Yes ◯ No
6.4	Does the trust develop an action plan based on the NHS staff survey findings?	◯ Yes ◯ No
6.5	Does the trust provide training for line managers on how to promote and protect employee mental wellbeing?	◯ Yes ◯ No
	6.5.1 If yes, is this training mandatory for all line managers?	◯ Yes ◯ No
6.6	Does the trust provide training to ensure line managers are able to identify and respond with sensitivity to employees' emotional concerns, and symptoms of mental health problems?	◯ Yes ◯ No
	6.6.1 If yes, is this training mandatory for all line managers?	◯ Yes ◯ No
6.7	Does the trust provide training to ensure that line managers understand when it is necessary to refer an employee to occupational health services or other sources of help and support?	◯ Yes ◯ No
	6.7.1 If yes, is this training mandatory for all line managers?	◯ Yes ◯ No

Appendix 4 Instructions and helpnotes

Implementing NICE public health guidance for the workplace: a national organisational audit of NHS trusts in England

INSTRUCTIONS AND HELP NOTES FOR DATA COLLECTION

These help notes contain all the information needed to participate in the audit. Please read the helpnotes carefully before commencing data collection and data submission onto the online audit tool. **If you have any queries please contact the audit helpdesk for advice either by email to hwdu@rcplondon.ac.uk or by phone on 020 3075 1585 (Monday – Friday, 10:00am–4:00pm).**

Acknowledgements

The Health and Work Development Unit (HWDU) Audit Development Group would like to thank all those involved in developing and piloting the audit tool,, and colleagues for their help and advice. The audit has been funded by the Faculty of Occupational Medicine and the Academy of Medical Royal Colleges.

Introduction

The HWDU aims to drive forward improvements in staff health and wellbeing both within the NHS and more widely. This national comparative audit aims to:

- measure the extent, and quality, of the implementation of the relevant NICE public health guidance by NHS trusts in England
- enable NHS trusts to benchmark the quality of their implementation of NICE public health guidance against evidence-based standards
- enable NHS trusts to demonstrate variation in practice
- facilitate change through the delivery of high quality useful data, and provide a basis for identifying change in the quality of guideline implementation
- provide a forum for sharing experience and good practice.

Sources of information

This document contains an introduction to the audit and steps for collecting and submitting data (pages 1–4) followed by help notes on the audit questions (pages 5–24). You may also refer to:

- PDF version of the audit tool
- Webtool userguide
- Quick-start guide to data collection
- Introductory letter to colleagues who will be involved in data collection

These documents can all be downloaded from the webtool.

How has this audit been designed?

This is an organisational audit. The objective of this audit is to gather data that reflect the organisation's progress with, and quality of, implementation by NHS trusts of NICE public health guidance.

The HWDU team, project lead and multi-disciplinary audit development group have developed a bespoke project methodology and audit tool based directly on the recommendations for employers in the following sets of NICE public health guidance:

- Managing long-term sickness absence and incapacity for work (PH19)
- Promoting physical activity in the workplace (PH13)
- Promoting mental wellbeing through productive and healthy working conditions (PH22)
- Workplace interventions to promote smoking cessation (PH5)
- Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (CG43)
- Promoting and creating built or natural environments that encourage and support physical activity (PH8).

Data will be submitted via a secure, web-based data collection tool which validates data. Following national data collection, HWDU will clean and analyse the data and participants will receive individual reports which compare their data with the guidance and national average data. These reports should be used locally to stimulate planned, informed, positive change to support staff health and productivity.

Who is eligible to take part?

All NHS trusts in England are eligible and encouraged to participate; HWDU is aiming for 100% participation and a truly national dataset.

Trust webtool user names

All trusts will receive an individual trust usernameusername for the webtool. It is important that each trust submits at least one response.

Step-by-step to data collection

- Please log in to the online audit tool to activate your account.
- The following materials are available to download from the webtool.
  - A webtool user guide
  - A PDF copy of the audit tool
  - A introductory letter which can be sent to colleagues who may need to be involved in the audit
  - Audit instructions and helpnotes for data collection (this document).
- Who will be involved?
  - Trust lead coordinating participation – we recommend that this is the board member with responsibility for health and work or a senior member of staff with responsibility for staff health and work. The audit lead will co-ordinate the trust's audit submission.

- HR department
- OH department
- Estates/ facilities department
- Finance department

You may also find you require support from fewer/other departments.

- Please review the documents listed above and then circulate the introductory letter to any colleagues that may be involved in data collection. This letter provides an overview of the aims of the audit and covers which pieces of guidance are being audited.
- A meeting should be held between all colleagues who will contribute data to review the audit tool and help notes. You may find that you are able to complete the entire form in this meeting, or your colleagues may need to take some questions away with them to follow up. We suggest that this meeting take place by the middle of November to allow adequate follow-up time for checking accuracy. You can either enter the data that you have collected directly onto the webtool, or onto a paper copy of the tool and then transfer it onto the webtool once complete.
- For detailed instructions on using the webtool, please download the webtool user guide (available from the audit homepage once you log in). You do not need to complete all questions at once. You can save a partially completed submission and resume it in a different session. We strongly encourage saving your data regularly.
- Once you have finalised your data on the web tool you should 'commit' the entry. HWDU will only then have access to your data for analysis. Please contact HWDU if you have any queries during or after data submission.
- You should keep a secure, local record of the data you have entered. You can export the data into Excel. We may need to contact you for further information whilst we are cleaning and analysing your data.

How should I collect data for a trust with multiple sites?

If your trust has multiple sites, a small number of questions on the audit tool will relate to an individual site rather than to the organisation as a whole. Please answer the audit for your main site in the first instance. You may choose to collect more than one dataset if your trust is split across more than one site. You should contact the help desk to let us know that you would like to do this. You can then add a new record to your webtool account for each additional site. You should ensure that a comment is added to each record identifying the site; it is important that these sites belong to the same trust.

How should I collect data if my organisation is a member of a partnership?

Please complete the audit tool for each trust. If your trust has the same policies as partner organisations you will still need to enter data for each individual trust.

How can I access the online audit tool and how do I use it?

- The online audit tool is accessed at https://audit.rcplondon.ac.uk/hwdu. If you have any difficulty getting started please contact the helpdesk and we will talk you through the process.

- Follow the links through to the page *Organisational Audit: Implementation of NICE Public Health guidance relating to health and work* and select 'add a new record', you can then work through the audit tool. Please make sure you save your data regularly.
- For detailed instructions on using the webtool please download the webtool user guide.
- Online help is available at the right hand side of the screen next to each question by clicking on the '?' icon. You are also able to enter any comments as you work through the tool- please click on the pencil icon.
- Once you have completed the audit, please click on the 'commit' button. This will lock your data and indicate to us that you have finalised your submission.. Once a case is 'committed' it is automatically submitted to HWDU and can no longer be edited.
- You can open and save your results as often as you would like on the tool.
- Your raw data can be exported into spreadsheet format for additional, local analysis.
- Please note that the HWDU does not have capacity to accept audit data on paper; all data should be submitted via the online audit tool.
- Data collection closes on 17 December. Data cleaning and analysis will then commence.

How are data confidentiality and security ensured?

Data will be submitted to the HWDU via the online audit tool which is hosted on a secure server. Trusts will be provided with a username and password as described above. These usernames and passwords are sent only to the registered audit contacts for each trust. Under no circumstances should site codes or passwords be passed on to others outside the organisation, however please share this information within your organisation where appropriate. If a user believes that their password has been compromised they should inform the HWDU immediately. Users will only be able to see data in records from their own organisation. If a user detects what he or she believes is a breach of security or confidentiality then it is their responsibility not to disseminate the information obtained and to report the event to the HWDU immediately.

Data protection and information governance

The HWDU processes the contact details held for the purpose of managing this audit in line with the data protection act. The HWDU operates under the Royal College of Physicians' Clinical Standards Department information governance policy, which is available at www.rcplondon.ac.uk.

How does the audit ensure the quality of the data collected?

Each trust's designated lead will take overall responsibility for the data submitted to the audit.

When is the data collection open?

The webtool is open from 13th October to 17th December 2010. Your data must be committed by 5pm on 17th December 2010.

How do I contact the help desk?

The help desk is open 10am to 4pm Monday-Friday. It can be contacted by email to hwdu@rcplondon.ac.uk or phone to 020 3075 1585.

How will the results be disseminated?

A generic report will be publicly available describing the national picture. Each trust will be provided with a confidential report detailing their results in comparison to the national results. Participation lists and the audit data will be available to CQC. There will be an opportunity for trusts to notify us if they DO NOT want us to share this information. HWDU will publish a list of participating trusts in the public report of national average results.

HELP NOTES

Part 1: Organisational data

Question number	Question text	Extract from NICE guidance (full version)	Help notes
1.1	Please select the main type of care this trust provides (tick one only): • Acute • Ambulance • Care • Mental health • Primary care • Other (please specify):		Tick the appropriate type of care. If you provide a combination of care please tick the primary type of care provided by this trust. Use 'other' only for a type of care not listed.
1.2	What is the trust's total headcount?		This is the total headcount at the time the audit is completed, not the whole time equivalent. It is important to record accurate information for the first part of this question; please check with your Human Resources Department if you are unsure.
1.2.1	Approximately what proportion of the trust's headcount works on the main site? • 25% or less • 26%–50% • 51%–75% • 76%–100%		This should be an approximation only. There is no need to give precise proportions.

continued

Part 1: Organisational data – *continued*

Question number	Question text	Extract from NICE guidance (full version)	Help notes
1.3	Does the trust have a named board member with responsibility for staff health and wellbeing?		In his recent report on NHS Staff Health and Wellbeing, Dr Boorman recommended that an individual board member in every NHS organisation should be identified with responsibility for this. Implementation of his recommendations is included in the Coalition Government White Paper on health.
1.3.1	If yes, is this board member (tick one only): • Executive: Medical director • Executive: Nursing director • Executive: HR/Workforce director • Executive: Finance director • Executive: Estates director • Executive: Operations director • Chief executive • Other executive board member • Non-executive board member		
1.4	Is staff sickness absence reported regularly to the Board?		For the purposes of the audit, 'regularly' is defined as at least annually.
1.4.1	If yes, at what intervals? • Annual • 6 monthly • More frequently than 6 monthly		
1.5	Is staff health and wellbeing a regular Board agenda item?		Staff health and wellbeing should be included in the main board's work plan. Where implementation is delegated to a sub-committee or other group the board should receive regular reports from that group. For the purposes of the audit regular is defined as at least annually. The board's review should include a broad aspect of staff health and wellbeing and not just sickness absence.
1.5.1	If yes, at what intervals? • Annual • 6 monthly • More frequently than 6 monthly		

continued

Part 1: Organisational data – *continued*

Question number	Question text	Extract from NICE guidance (full version)	Help notes
1.6	Within the last three years, has the trust done a needs assessment to inform an organisational approach to: 1.6.1 Obesity 1.6.1.1 If yes, did you go through a formal process? 1.6.1.2 Smoking 1.6.2.1 If yes, did you go through a formal process? 1.6.3 Physical activity 1.6.3.1 If yes, did you go through a formal process? 1.6.4 Long-term sickness absence 1.6.4.1 If yes, did you go through a formal process? 1.6.5 Promoting mental wellbeing 1.6.5.1 If yes, did you go through a formal process?		Needs assessment here means a method for reviewing the health issues facing your workforce, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. To answer yes, the needs assessment needs to have been completed within the past three years. Formal process here means that the needs assessment has been signed off by the Board or an equivalent senior HR Board.
1.7	Does the trust prioritise health promotion topics for staff? 1.7.1 If yes, what are your trust's top 3 health promotion topics for staff? Please select 1 for highest priority, 2 for the second highest priority and 3 for the third highest priority • Obesity • Smoking • Physical activity • Mental wellbeing • Other health promotion topic (please specify)		
1.8	Has the trust involved staff in planning and designing an organisational approach to • Obesity • Smoking cessation • Promoting physical activity • Building site design • Long-term sickness absence • Promoting mental wellbeing		Involvement of staff may have occurred through open meetings with staff, staff representatives on planning committees, questionnaires providing opportunities for staff to put forward suggestions, etc.
1.9	Does the trust have an umbrella/ over-arching strategy or policy for staff health and wellbeing?		You should only answer 'No, strategy/ policy in development but incomplete' if you are well under way in developing this policy. For example, meetings may have been held and a draft may be in circulation or under consultation.

continued

Part 2: Obesity (NICE CG43)			
Question number	**Question text**	**Extract from NICE guidance (full version)**	**Help notes**
2.1	Does the trust have an organisation-wide plan or policy to help reduce obesity amongst its staff?	An organisation's policies and incentive schemes can help to create a culture that supports healthy eating and physical exercise. Action will have an impact, not only on the health of the workforce but also in savings to industry. That is why all workplaces, particularly large organisations, should address the prevention and management of obesity.	The programme should address the prevention and management of obesity – it may be a stand alone programme or it may be part of a larger programme that addresses staff health and wellbeing. To answer yes to this question the programme must explicitly address obesity. You should only answer 'No, strategy/ policy in development but incomplete' if you are well under way in developing this policy. For example, meetings may have been held and a draft may be in circulation or under consultation.
2.1.1	If yes: has the obesity plan/policy been signed off by the board?		To answer 'yes' the plan must have been signed off by the board.
2.1.2	Does the obesity plan/policy address the different needs of different staff groups?		To answer 'yes', the plan/policy must be explicit in its approach to address the needs of different staff groups.
2.1.3	Does the trust measure uptake of any programmes in the plan/policy by different staff groups such as by grade, gender or ethnicity?		
2.1.3.1	If yes, does the trust adjust the programme where there are clear differentials in uptake?		
2.2	Does the trust actively promote healthy food choices, for example using signs, pricing and positioning of products to encourage healthy choices in: • Vending machines • Shops for staff and clients • Hospitality • Staff restaurant	In their role as employers, NHS organisations should set an example in developing public health policies to prevent and manage obesity by following existing guidance and (in England) the local obesity strategy. In particular on-site catering should promote healthy food and drink choices (for example by signs, posters, pricing and positioning of products).	This applies to both in-house and contracted catering services for staff. Examples of ways to promote healthy food choices include signs, posters, pricing and positioning of products.

continued

Part 2: Obesity (NICE CG43) – *continued*

Question number	Question text	Extract from NICE guidance (full version)	Help notes
2.3	To be effective interventions for obesity need to include the three components of activity, eating behaviour and weight reduction together. Does the trust offer overweight and obese staff multicomponent interventions that address all three? (Please confirm this with the person delivering the programme?)	Multicomponent interventions are the treatment of choice. Weight management programmes should include behaviour change strategies to increase people's physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person's diet and reduce energy intake.	Effective interventions for obesity address issues together including the three components of activity, eating behaviour, and weight reduction. To answer yes to this question you should offer obesity services that address all of these together. If you are unsure whether the programme that you offer addresses all three of these issues, please confirm this with the person/organisation running the programme.
2.3.1	If yes, is the person providing the programme trained in obesity management?		Staff who advise people on diet, weight and activity need appropriate training, experience and enthusiasm to motivate people to change. Some will need general training (for example, in health promotion), while those who provide interventions for obesity (such as dietary treatment and physical training) will need more specialised training. The evidence suggests that the type of professional who provides the advice is not critical as long as they have appropriate training and experience, are enthusiastic and able to motivate, and are able to provide long-term support. Training will need to address barriers to professionals providing support and advice, particularly concerns about the effectiveness of interventions, people's receptiveness and ability to change and the impact of advice on relationships with patients.

continued

Part 3: Physical activity (NICE PH13) and building/site design (NICE PH8)			
Question number	**Question text**	**Extract from NICE guidance (full version)**	**Help notes**
3.1	Does the trust have an organisation-wide plan or policy to encourage and support employees to be more physically active?	Develop an organisation-wide plan or policy to encourage and support employees to be more physically active. This should: • include measures to maximise the opportunity for all employees to participate • be based on consultation with staff and should ensure they are involved in planning and design, as well as monitoring activities, on an ongoing basis • be supported by management and have dedicated resources • set organisational goals and be linked to other relevant internal policies (for example, on alcohol, smoking, occupational health and safety, flexible working or travel) • link to relevant national and local policies (for example, on health or transport).	The plan/policy should address the promotion of physical activity – it may be a stand alone plan/policy or it may be part of a larger programme that addresses staff health and wellbeing. To tick yes to this question the programme must explicitly address increasing physical activity. Use 'No, strategy/policy in development but incomplete' if you are well under way in developing this policy. For example, meetings may have been held and a draft may be in circulation or under consultation.
3.1.1	If yes, has the physical activity plan/policy been signed off by the board?		To answer 'yes' the plan must have been signed off by the Board.
3.1.2	Does the physical activity plan/ policy address the different needs of different staff groups?		To answer 'yes', the plan/ policy must be explicit in its approach to address the needs of different staff groups.
3.1.3	Does the trust measure uptake of any programmes in the plan/policy by different staff groups such as grade, gender or ethnicity?		
3.1.3.1	If yes, does the trust adjust the programme where there are clear differentials in uptake?		
3.2	Does the trust provide safe and secure cycle parking for staff?	Encourage employees to walk, cycle or use another mode of transport involving physical activity to travel part or all of the way to and from work (for example, by developing a travel plan).	This facility may be in one place (such as a bicycle shed) or several facilities may be around the site (e.g. cycle racks). The cycle parking does not have to be purpose built but must be safe and secure and recognised for this use. (The question relates to security of the bicycles. The safety and security of staff is very important and should always be considered but is not addressed here.)
3.2.1	If yes, approximately how many bikes can it accommodate? • Up to 25 • 26–50 • 51–100 • 101 or more		

continued

Part 3: Physical activity (NICE PH13) and building/site design (NICE PH8) – *continued*			
Question number	**Question text**	**Extract from NICE guidance (full version)**	**Help notes**
3.3	Are all parts of a campus site (two or more related buildings set together in the grounds of a defined site) linked by appropriate walking and cycling routes?	Those involved with campus sites, including hospitals and universities, should ensure different parts of the site are linked by appropriate walking and cycling routes.	Campuses comprise two or more related buildings set together in the grounds of a defined site.
3.4	For any new workplaces built (or in the planning stages) since 2006, does the trust have a system in place to ensure that they are linked to existing walking and cycling networks?	Ensure new workplaces are linked to walking and cycling networks. Where possible, these links should improve the existing walking and cycling infrastructure by creating new, through routes (and not just links to the new facility).	To answer this question you may need to ask your head of works/estates. We are asking about buildings since 2006 because this is the year that the relevant NICE guidance was published.
3.5	Does the trust help employees to be physically active during the working day by: • encouraging staff to walk or cycling to external meetings • encouraging staff to use the stairs rather than lifts e.g. by putting up signs at strategic points and distributing written information • providing information about walking and cycling routes to and from work • providing information about walking and cycling routes around the worksite • encouraging staff to take short walks during work breaks e.g. providing information about lunchtime walks • encouraging staff to use local leisure facilities • encouraging staff to set goals on how far they walk and cycle and monitor the distances they cover	Encourage employees to walk, cycle or use another mode of transport involving physical activity to travel part or all of the way to and from work (for example, by developing a travel plan). Help employees to be physically active during the working day by: • where possible, encouraging them to move around more at work (for example, by walking to external meetings) • putting up signs at strategic points and distributing written information to encourage them to use the stairs rather than lifts if they can • providing information about walking and cycling routes and encouraging them to take short walks during work breaks • encouraging them to set goals on how far they walk and cycle and to monitor the distances they cover.	

continued

Part 3: Physical activity (NICE PH13) and building/site design (NICE PH8) – *continued*			
Question number	**Question text**	**Extract from NICE guidance (full version)**	**Help notes**
3.5.1	How do you set and monitor that goals are being achieved?		
3.6	Does the trust provide: • on-site gym • on-site swimming pool • on-site squash or tennis courts • reduced membership fees for local leisure facilities (e.g. subsidised by trust or negotiated with facility) • bike purchase scheme • other onsite facilities or incentive schemes to encourage physical activity (please describe)		
3.7	During building design or refurbishment does the trust ensure staircases are designed and positioned to encourage people to use them?	During building design or refurbishment, ensure staircases are designed and positioned to encourage people to use them.	To answer this question you may need to ask your director of works/estates. There is specific building guidance on aspects of staircase design that encourage use.
3.8	Are all staircases clearly signposted and attractive to use (e.g. well-lit and well-decorated)? • All • Most • Approximately half • Few • None	Ensure staircases are clearly signposted and are attractive to use. For example, they should be well-lit and well-decorated.	This question relates to staircases in normal use and not those reserved for emergency escape. To answer this question you may need to ask your director of works/estates. There is specific building guidance on aspects of staircase design that encourage use.

continued

Part 4: Smoking cessation (NICE PH5)

Question number	Question text	Extract from NICE guidance (full version)	Help notes
4.1	Does the trust have an organisation-wide plan or policy to encourage and support employees to stop smoking?	Develop a smoking cessation policy in collaboration with staff and their representatives as one element of an overall smoke free workplace policy.	The smoking cessation policy should have been developed in collaboration with staff and their representatives as part of an overall smoke free workplace policy. The policy should address the need for staff to stop smoking. The policy may be a stand alone policy or it may be part of a larger programme that addresses staff health and wellbeing. You should only answer 'No, strategy/policy in development but incomplete' if you are well under way in developing this policy. For example, meetings may have been held and a draft may be in circulation or under consultation.
4.1.1	If yes, has this smoking cessation plan/policy been signed off by the board?		To answer 'yes' the plan must have been signed off by the board.
4.1.2	Does the plan/policy address the different needs of different staff groups?		To answer 'yes', the plan/ policy must be explicit in its approach to address the needs of different staff groups.
4.1.3	Does the trust measure uptake of any programmes in the plan or policy by different staff groups such as grade, gender or ethnicity?		
4.1.3.1	If yes: does the trust adjust the programme where there are clear differentials in uptake?		
4.2	Does the trust publicise smoking cessation services for staff?	Publicise the interventions identified in this guidance and make information on local stop smoking support services widely available at work. This information should include details on the type of help available, when and where, and how to access the services.	These services might be publicised through leaflets, posters, the intranet, at induction training, etc.
4.2.1	If yes, does this publicity include: • where services are available • how to access these services • the type of help available • when services are available		

continued

Part 4: Smoking cessation (NICE PH5) – *continued*			
Question number	**Question text**	**Extract from NICE guidance (full version)**	**Help notes**
4.3	Does the trust provide access to stop smoking support (either on-site or through arrange-ments with another local service)?	Be responsive to individual needs and preferences. Where feasible, and where there is sufficient demand, provide on-site stop smoking support.	These smoking cessation services should be available at times and venue(s) that mean staff can easily get to them and make use of them. They should be provided for all staff and at no cost to them.
4.4	Does the trust policy allow staff to attend smoking cessation services during working hours without loss of pay?	Allow staff to attend smoking cessation services during working hours without loss of pay.	

Part 5: Long-term sickness absence (NICE PH19)			
Question number	**Question text**	**Extract from NICE guidance (full version)**	**Help notes**
These questions relate to the organisation and the actions of managers (not the actions of occupational health specialists)			
5.1	Does the trust have an organisation-wide policy for the management of long-term sickness absence (either as a stand alone policy or addressed explicitly within an absence policy)? **(If yes, please answer all remaining questions) (f no, please skip to question 5.2)**		
5.1.1	Does the policy require employees absent due to illness to inform their manager on the first day of absence?		
5.1.2	Does the policy require managers to contact staff whose sickness absence continues beyond a week or so, for an initial enquiry to discuss their health and work?	Different types of employer (such as large, small or public and private organisations) are likely to have different policies and practices on sickness absence, which means the criteria and trigger points for intervening may differ. For example, the number of days of sickness absence before a sickness absence policy is triggered may vary. Consequently, employers implementing the recommendations may need to consider adjusting their employment contracts and/or organisational policies.	This question is about action that managers take themselves. It is not about the content of an occupational health consultation. This question deliberately gives a non-specific timeframe i.e. 'a week or so' to recognise the variation of trust policies (and associated trigger points) and individual circumstances.

continued

Part 5: Long-term sickness absence (NICE PH19) – *continued*

Question number	Question text	Extract from NICE guidance (full version)	Help notes
5.1.2.1	If yes, does the policy give a trigger for when this should be done? • Yes at 2 weeks (or less) • Yes by 3 weeks of absence • Yes by 4 weeks of absence • Yes by 5 weeks of absence • Yes by 6 weeks of absence • Yes, later than 6 weeks absence • No	Within 12 weeks (ideally between 2 and 6 weeks) of a person starting sickness absence (or following recurring episodes of short- or long-term sickness absence) ensure that initial enquiries are undertaken in conjunction with the employee.	This question is asking about a trigger for the manager to talk with their staff member. You must answer no to this question if the only trigger in your policy is for making a referral to OH.
5.1.2.2	Does the policy (or accompanying guidance) ask managers to explore in this initial enquiry: • The reasons for sickness absence • Whether the staff member has received appropriate treatment • When the staff member thinks that he or she will be back at work • Any perceived (or actual) barriers to returning to work (including the need for workplace adjustments) • The potential need for a referral to OH • The options for returning to work and what, if any, action is required to prepare for this	The aim is to: • determine the reason for the sickness and the prognosis for returning to work (that is, how likely it is that the staff member will return to work) and if they have any perceived (or actual) barriers to returning to work (including the need for workplace adjustments). • decide on the options for returning to work and jointly agree what, if any, action is required to prepare for this.	This question is about the conversation between a manager and their employee during the initial enquiry above. It is not about the content of an occupational health consultation.
5.1.3	Does the policy require development of a return to work plan agreed between the manager and the employee?		This return to wok plan may include advice from OH but must be developed and agreed between the manager and the employee.
5.1.3.1	If yes, does the policy specify that managers must consider, with the employee (taking account of any OH advice) the need for: • A gradual return to the original job by increasing the hours and days worked over a period of time • A return to some of the duties of the original job • A move to another job within the organisation (on a temporary or permanent basis)	If action is required consider identifying: • whether or not a detailed assessment is needed to determine what interventions and services are required and to develop a return-to-work plan • whether or not a case worker/s is needed to coordinate a detailed assessment, deliver any proposed interventions or produce a return-to-work plan. • If necessary, appoint a case worker/s.	

continued

Part 5: Long-term sickness absence (NICE PH19) – *continued*

Question number	Question text	Extract from NICE guidance (full version)	Help notes
For more complex cases of long-term sickness absence, NICE guidance recommends the appointment of a case manager. This person co-ordinates any assessments and rehabilitation so that actions are done appropriately and on time. (Please read the help notes for more details before answering the questions below).			
5.2	Does the trust use case managers for the more complex cases of long-term sickness?	[Case managers] may need: • Training in communication skills • Access to supervision and consultation with more skilled professionals • Access to sources of employment, health and safety advice and discrimination law. Attendance management is a continuous process. It is a planned activity determined by policy and practice. Case management is one part of attendance management. It is a collaborative process of assessment, planning, facilitation and advocacy to help prepare actions so they are done appropriately and on time. The fundamental role of a case worker is to co-ordinate any required assessments and manage a rehabilitation plan to help a worker resume effective work, and so restoring their income and safeguarding their employment.	Attendance management is a continuous process. It is a planned activity determined by policy and practice. Case management is one part of attendance management. It is a collaborative process of assessment, planning, facilitation and advocacy to help prepare for these (which actions?) actions so they are done appropriately and on time. The fundamental role of a case worker is to co-ordinate any required assessments and manage a rehabilitation plan to help a worker resume effective work, and so restoring their income and safeguarding their employment.
		A case manager will: • Monitor absence data in real time • Co-ordinate any required assessments • Prompt and track actions • Timetable actions to eliminate delays between milestones • Provide periodic reports to stakeholders.	A case manager will: • Monitor absence data in real time • Co-ordinate any required assessments • Prompt and track actions • Timetable actions to eliminate delays between milestones • Initiate formal interventions • Provide periodic reports to stakeholders

continued

Part 5: Long-term sickness absence (NICE PH19) – *continued*			
Question number	**Question text**	**Extract from NICE guidance (full version)**	**Help notes**
5.2.1	If yes, what is the background of the case managers? • Occupational Health • Human Resources • Line management • Other (please specify)		
5.2.2	Does the case manager: • Monitor absence data in real time • Co-ordinate any required assessments • Timetable actions to eliminate delays between milestones • Initiate formal interventions • Prompt and track actions • Provide periodic reports to stakeholders		
5.3	Does the trust record absence data in real time (e.g. through ESR self-service)?		To answer yes to this question an individual's sickness absence must appear on a central database (usually ESR) during their absence, rather than being entered retrospectively (i.e. transferred at the end of month from paper records to a database).
5.4	Does the trust routinely identify staff who are on long-term sick using a central system (e.g. by interrogating ESR and running reports at regular intervals)?		
5.5	Does the trust monitor trust trends in long-term sickness absence?		This question refers to the trust as a whole, rather than the practices of individual departments.
5.5.1	If yes, who is long-term sickness absence information reported to? (tick all that apply): • HR • Line manager • Divisional/ directorate manager • Trust board • Other (please specify)		
5.6	Does the trust's OH provider collect and report on the following data?		This question is about monitoring possible delays in the process of long-tem sickness absence management. You may need to ask your OH department if they collect and report on this information.

continued

Part 5: Long-term sickness absence (NICE PH19) – *continued*

Question number	Question text	Extract from NICE guidance (full version)	Help notes
5.6.1	Time from start of absence to referral to OH		
5.6.1.1	If yes, who is this information reported to? • HR • Trust board • Other (please specify)		
5.6.2	Time from receipt of OH referral to OH appointment		
5.6.2.1	If yes, who is this information reported to? • HR • Trust board • Other (please specify)		
5.6.3	Time from OH appointment to issue of OH report		
5.6.3.1	If yes, who is this information reported to? • HR • Trust board • Other (please specify)		
5.7	Does the trust provide:		
5.7.1	Education/ training events or programmes for staff on physical and mental coping strategies/ resilience for its staff?	Consider helping people to develop problem solving and coping strategies using evidence-based psychological interventions.	There are many forms of training that address coping and resilience. Often these are provided by a learning and development service, or occupational health service.
5.7.2	Does the trust provide physiotherapy for its staff		
5.7.3	Does the trust provide psychological therapies for its staff 5.7.3.1 If yes, are these provided by: • Qualified psychologists • Counsellors trained in CBT approach • OH staff trained in CBT approach • Other staff trained in CBT approach • Other	Ensure psychological interventions and services are evidence based. Also ensure they are delivered by suitably trained and experienced practitioners. This may be health professionals (such as physicians, nurses or others specialising in occupational health, rehabilitation or ergonomics); social workers; clinical or occupational psychologists, specialist counsellors or therapists.	CBT is a specialised psychological ('talking') therapy. Some counsellors will use CBT but others do not. You may need to check with your provider of talking therapies and/or occupational health to identify if CBT is provided.

continued

Part 5: Long-term sickness absence (NICE PH19) – *continued*			
Question number	**Question text**	**Extract from NICE guidance (full version)**	**Help notes**
5.7.3.2	Does the trust verify the credentials of all practitioners providing psychological interventions for its staff (including outsourced provision)?		Where clinical services are provided by external agencies the credential of the practitioners should be checked (as they would for any other practitioner providing treatment for the Trust). For example, are all counsellors accredited by the BACP?
5.8	Does the trust provide training for managers on how to manage staff on long-term sick (either as stand alone training or part of a broader sickness absence training)?		
5.8.1	If yes, is this training mandatory for all managers?		

continued

Part 6: Promoting mental wellbeing (NICE PH22)

Question number	Question text	Extract from NICE guidance (full version)	Help notes
6.1	Does the trust have an organisation-wide plan/policy for promoting mental wellbeing amongst its staff?	Adopt an organisation-wide approach to promoting the mental wellbeing of all employees, working in partnership with them. This approach should integrate the promotion of mental wellbeing into all policies and practices concerned with managing people, including those related to employment rights and working conditions. Ensure that the approach takes account of the nature of the work, the workforce and the characteristics of the organisation.	The following definition of mental wellbeing is given in the NICE guidance: 'Mental wellbeing is a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.' (Foresight Mental Capital and Wellbeing Project (2008) Final project report. London: The Government Office for Science.) Mental wellbeing at work is determined by the interaction between the working environment, the nature of the work and the individual. A typical approach might be called a 'mental wellbeing' or 'stress' policy. Sometimes mental wellbeing will be included in a broader policy on staff health and wellbeing. To answer yes to this question the policy should consider positive actions to improve the mental wellbeing of all staff. You should only answer 'No, strategy/ policy in development but incomplete' if you are well under way in developing this policy. For example, meetings may have been held and a draft may be in circulation or under consultation.
6.1.1	If yes, has the plan/policy to promote mental wellbeing been signed off by the board?		To answer 'yes' the plan must have been signed off by the board.

continued

Part 6: Promoting mental wellbeing (NICE PH22) – *continued*			
Question number	**Question text**	**Extract from NICE guidance (full version)**	**Help notes**
6.1.2	Does this plan/policy integrate the promotion of mental wellbeing into all policies and practices concerned with managing people, including those related to employment rights and working conditions?	Adopt an organisation-wide approach to promoting the mental wellbeing of all employees, working in partnership with them. This approach should integrate the promotion of mental wellbeing into all policies and practices concerned with managing people, including those related to employment rights and working conditions.	
6.1.3	Does the plan/policy address the different needs of different staff groups, and include measures to maximise the opportunity for all employees to participate?		To answer 'yes', the plan/policy must be explicit in its approach to address the needs of different staff groups.
6.1.4	Does the trust measure uptake of any programmes in the plan/policy by different staff groups such as by grade, gender or ethnicity?		
6.1.4.1	If yes, does the trust adjust the programme where there are clear differentials in uptake?	Ensure that groups of employees who might be exposed to stress but might be less likely to be included in the various approaches for promoting mental wellbeing have the equity of opportunity to participate. These groups include part-time workers, shift workers and migrant workers.	
6.2	Does the trust have systems for monitoring the mental wellbeing of employees?	Ensuring systems are in place for assessing and monitoring the mental wellbeing of employees so that areas for improvement can be identified and risks caused by work and working conditions addressed. This could include using employee attitude surveys and information about absence rates, staff turnover and investment in training and development, and providing feedback and open communication.	To tick 'yes' to 'have systems for monitoring the mental wellbeing of employees' you must have systems such as employee attitude surveys, information about absent rates, information about staff turnover rates. Formal review means that the results are presented and considered by the trust board or a sub-committee of the board.
6.2.1	How do you monitor the mental wellbeing of staff?		

continued

Part 6: Promoting mental wellbeing (NICE PH22) – *continued*

Question number	Question text	Extract from NICE guidance (full version)	Help notes
6.3	Does the trust formally review the findings of the annual NHS staff survey?		
6.4	Does the trust develop an action plan based on the NHS staff survey findings?		
6.5	Does the trust provide training for line managers on how to promote and protect employee mental wellbeing?	Strengthen the role of line managers in promoting the mental wellbeing of employees through supportive leadership style and management practices. This will involve: • promoting a management style that encourages participation, delegation, constructive feedback, mentoring and coaching • ensuring that policies for the recruitment, selection, training and development of managers recognise and promote these skills • ensuring that managers are able to motivate employees and provide them with the training and support they need to develop their performance and job satisfaction	This should be a continual programme that meets the needs of new and existing managers. It may include: • promoting a management style that encourages participation, delegation, constructive feedback, mentoring and coaching • ensuring that managers are able to motivate employees and provide them with the training and support they need to develop their performance and job satisfaction

continued

Part 6: Promoting mental wellbeing (NICE PH22) – *continued*			
Question number	**Question text**	**Extract from NICE guidance (full version)**	**Help notes**
6.5.1	If yes, is this training mandatory for all line managers?	• increasing understanding of how management style and practices can help to promote the mental well-being of employees and keep their stress to a minimum • ensuring that managers are able to identify and respond with sensitivity to employees' emotional concerns, and symptoms of mental health problems • ensuring that managers understand when it is necessary to refer an employee to occupational health services or other sources of help and support • considering the competency framework developed by the Chartered Institute of Personnel and Development, the Health and Safety Executive and Investors in People as a tool for management development.	• increasing understanding of how management style and practices can help to promote the mental wellbeing of employees and keep their stress to a minimum.
6.6	Does the trust provide training to ensure line managers are able to identify and respond with sensitivity to employees' emotional concerns, and symptoms of mental health problems?		
6.6.1	If yes, is this training mandatory for all line managers?		
6.7	Does the trust provide training to ensure that line managers understand when it is necessary to refer an employee to occupational health services or other sources of help and support?		

Appendix 5 Summary score

Domain 1: Board engagement
Total for domain = 8

1.3 Does the trust have a named board member with responsibility for staff health and wellbeing?
Yes = 2 No = 0
Total available = 2

1.4 Is staff sickness absence reported regularly to the Board?
Yes = 2 No = 0
Total available = 2

1.5 Is staff health and wellbeing a regular Board agenda item?
Yes = 2 No = 0
Total available = 2

1.9 Does the trust have an umbrella/over-arching strategy or policy for staff health and wellbeing?
Yes = 2 No, strategy/policy in development but incomplete = 1 No = 0
Total available = 2

Domain 2: Obesity (NICE CG43)
Total for domain = 9

Policy:

2.1 Does the trust have an organisation-wide plan or policy to help reduce obesity amongst its staff?
Yes = 2 No, strategy/policy in development but incomplete = 1 No = 0
Total available = 2

2.1.1 Has the obesity plan/policy been signed off by the board?
Yes = 1 No = 0
Total available = 1

2.1.2 Does the obesity plan/policy address the different needs of different staff groups?
Yes = 1 No = 0
Total available = 1

Policy subtotal = 4

Activity:

2.2 Does the trust actively promote healthy food choices, for example using signs, pricing and positioning of products to encourage healthy choices in:

- Vending machines
- Shops for staff and clients
- Hospitality
- Staff restaurant

Yes = 1 No = 0
Total available = 4

continued

Domain 2: Obesity (NICE CG43) – *continued*
Total for domain = 9

2.3 To be effective interventions for obesity need to include the three components of activity, eating behaviour and weight reduction together. Does the trust offer overweight and obese staff multicomponent interventions that address all three?

Yes =1 No=0

Activity subtotal = 5

Domain 3: Physical activity (NICE PH13) and building/site design (NICE PH8)
Total for domain = 8

Policy:

3.1 Does the trust have an organisation-wide plan or policy to encourage and support employees to be more physically active?

Yes = 2 No, strategy/policy in development but incomplete = 1 No = 0

Total available = 2

If yes:

3.1.1 Has the physical activity plan/policy been signed off by the board?

Yes = 1 No = 0

Total available = 1

3.1.2 Does the physical activity plan/policy address the different needs of different staff groups?

Yes = 1 No = 0

Total available = 1

Policy subtotal = 4

Activity:

3.5 Does the trust help staff to be physically active during the working day by:

- Encouraging staff to walk or cycle to external meetings
- Encouraging staff to use the stairs rather than lifts e.g. by putting up signs at strategic points and distributing written information
- Providing information about walking and cycling routes to and from work
- Providing information about walking and cycling routes around the worksite
- Encouraging staff to take short walks during work breaks e.g. providing information about lunchtime walks
- Encouraging staff to use local leisure facilities
- Encouraging staff to set goals on how far they walk and cycle and monitor the distances they cover

No to all = 0

Yes to 1–4 responses = 1

Yes to 5–7 responses = 2

Total available = 2

3.8 Are staircases clearly signposted and attractive to use (e.g. well-lit and well-decorate

- All
- Most
- Approximately half
- Few
- None

Yes to all = 2

Yes to Most and approximately half =1

Yes to few or none = 0

Activity subtotal = 4

continued

Domain 4: Smoking cessation
Total for domain = 9

Policy:

4.1 Does the trust have an organisation-wide plan or policy to encourage and support employees to stop smoking?

Yes = 2 No, strategy/policy in development but incomplete = 1 No = 0

Total available = 2

If yes:

4.1.1 Has this smoking cessation plan/policy been signed off by the board?

Yes = 1 No = 0

Total available = 1

4.1.2 Does the plan/policy address the different needs of different staff groups?

Yes = 1 No = 0

Total available = 1

Policy subtotal = 4

Activity:

4.2 Does the trust publicise smoking cessation services for staff?

Yes = 1 No = 0

Total available = 1

4.2.1 If yes, does this publicity include:

- Where services are available
- How to access these services
- The type of help available
- When services are available

If none = 0

If yes to 1–2 options = 1

If yes to 3–4 options = 2

4.3 Does the trust provide access to stop smoking support (either on-site or through arrangements with another local service)?

Yes = 1 No = 0

Total available = 1

4.4 Does the trust policy allow staff to attend smoking cessation services during working hours without loss of pay?

Yes = 1 No = 0

Total available = 1

Activity subtotal = 5

continued

Domain 5: Long-term sickness absence
Total for domain = 12

Policy:

5.1 Does the trust have an organisation-wide policy for the management of long-term sickness absence (either as a stand alone policy or addressed explicitly within an absence policy)?

Yes = 2 No, strategy/policy in development but incomplete = 1 No = 0

Total available = 2

5.1.3 Does the policy require development of a return to work plan?

Yes = 1 No = 0

Policy subtotal = 3

Activity:

5.2 Does the trust use case managers for the more complex cases of long-term sickness absence?

Yes = 1 No = 0

Total available = 1

5.5 Does the trust monitor trust trends in long-term sickness absence?

Yes = 1 No = 0

Total available = 1

5.6 Does the trust's OH provider routinely collect and report on the following data?

5.6.1 Time from start of absence to referral to OH

Yes = 1 No = 0

Total available = 1

5.6.2 Time from receipt of OH referral to OH appointment

Yes = 1 No = 0

Total available = 1

5.6.3 Time from OH appointment to issue of OH report

Yes = 1 No = 0

Total available = 1

5.7 Does the trust provide:

5.7.1 Education/ training events or programmes on physical and mental coping strategies/resilience for its staff

Yes = 1 No = 0

Total available = 1

5.7.2 Physiotherapy for its staff

Yes = 1 No = 0

Total available = 1

5.7.3 Psychological therapies for its staff

Yes = 1 No = 0

Total available = 1

5.8 Does the trust provide training for managers on how to manage staff on long-term sick (either as stand alone training or part of a broader sickness absence training)?

Yes = 1 No = 0

Total available = 1

Activity subtotal = 9

continued

Domain 6: Promoting mental wellbeing
Total for domain = 8

Policy:

6.1 Does the trust have an organisation-wide plan/ policy for promoting mental wellbeing amongst its staff?

Yes = 2 No, strategy/policy in development but incomplete = 1 No = 0

Total available = 2

If yes:

6.1.1 Has the plan/policy to promote mental wellbeing been signed off by the board?

Yes = 1 No = 0

Total available = 1

6.1.2 Does this plan/policy integrate the promotion of mental wellbeing into all policies and practices concerned with managing people, including those related to employment rights and working conditions?

Yes = 1 No = 0

Total available = 1

6.1.3 Does the plan/policy address the different needs of different staff groups, and include measures to maximise the opportunity for all employees to participate?

Yes = 1 No = 0

Total available = 1

Policy subtotal = 5

Activity:

6.5 Does the trust provide training for line managers on how to promote and protect employee mental wellbeing?

Yes = 1 No = 0

Total available = 1

6.6 Does the trust provide training to ensure line managers are able to identify and respond with sensitivity to employees' emotional concerns, and symptoms of mental health problems?

Yes = 1 No = 0

Total available = 1

6.7 Does the trust provide training to ensure that line managers understand when it is necessary to refer an employee to occupational health services or other sources of help and support?

Yes = 1 No = 0

Total available = 1

Activity subtotal = 3

Appendix 6 Summary score by trust type

Domain 1: Board engagement	Median	IQR		N
Acute	83.3	66.7	100.0	122
Ambulance	91.7	50.0	100.0	10
Mental health	83.3	66.7	100.0	39
Primary care	83.3	50.0	100.0	108
Domain 2: Obesity	**Median**	**IQR**		**N**
Acute	25.0	12.5	37.5	122
Ambulance	18.8	12.5	25.0	10
Mental health	25.0	12.5	50.0	39
Primary care	25.0	12.5	37.5	108
Domain 3: Physical activity and building/site design	**Median**	**IQR**		**N**
Acute	37.5	37.5	50.0	122
Ambulance	43.8	37.5	50.0	10
Mental health	37.5	37.5	62.5	39
Primary care	50.0	37.5	75.0	108
Domain 4: Smoking cessation	**Median**	**IQR**		**N**
Acute	75.0	62.5	100.0	122
Ambulance	62.5	37.5	87.5	10
Mental health	75.0	50.0	100.0	39
Primary care	75.0	62.5	100.0	108
Domain 5: Long-term sickness absence	**Median**	**IQR**		**N**
Acute	71.4	64.3	85.7	122
Ambulance	78.6	78.6	92.9	10
Mental health	78.6	64.3	92.9	39
Primary care	71.4	64.3	85.7	108
Domain 6: Promoting mental wellbeing	**Median**	**IQR**		**N**
Acute	63.6	36.4	81.8	122
Ambulance	40.9	27.3	100.0	10
Mental health	54.5	27.3	63.6	39
Primary care	63.6	45.5	81.8	108
Overall score	**Median**	**IQR**		**N**
Acute	60.0	53.7	69.5	122
Ambulance	55.0	48.9	60.9	10
Mental health	58.9	46.9	68.4	39
Primary care	60.6	50.4	71.3	108

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