Royal College of Physicians

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Implementing NICE public health guidance for the workplace:
a national organisational audit of NHS trusts in England
Round 2

Supported by:

NHS Employers

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Implementing NICE public health guidance for the workplace: a national organisational audit of NHS trusts in England Round 2

This report was produced on behalf of the Audit Development Group
by David Sloan, Sarah Jones, Hannah Evans, Leo Chant, Siân Williams and Penny Peel

With funding and support from:

NHS Employers

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ISBN 978–1–86016–525–2
eISBN 978–1–86016–526–9

Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE
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Registered Charity No 210508

Typeset by Cambrian Typesetters, Camberley, Surrey
Printed by The Lavenham Press Ltd, Suffolk

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Foreword

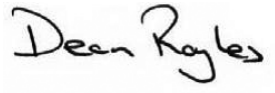
The health and wellbeing of the workforce in the NHS and across the health system is vitally important. The reports by Dame Carol Black and Steve Boorman have highlighted the way that improvements to staff health and wellbeing can not only reduce sickness absence rates but actually improve quality of care and patient outcomes.[1,2]

Following the Francis, Keogh and Berwick reports on the quality of NHS care, this audit is a timely reminder of what trusts can do to support the staff of the NHS while they strive to deliver high-quality patient care in challenging circumstances.[3–5]

This second round of audit of National Institute for Health and Care Excellence (NICE) public health workplace guidance shows how trusts are continuing to improve their implementation, though there is more work to do. It is heartening that 73% of trusts opted to participate and encouraging that the national benchmark has improved. However, as anticipated there continues to be wide variation in implementation, both between health promotion topics, and across trusts. There is potential to expand good practice through local partnerships across trusts, primary care and local authorities.

The audit has also captured the extent to which trusts take account of the diversity of their staff and whether they are addressing potential health inequalities in planning and delivering health promotion programmes. Here too there appears to be wide variation, especially in relation to staff who are not directly employed by the NHS.

Participating trusts can clearly see their progress against previous findings, which can help them to focus their efforts to improve. We would like to congratulate the Health and Work Development Unit, and participating NHS trusts, on their achievement. We commend this report to all those who have responsibility for improving both staff health and wellbeing, and the quality of patient care – from chairs and chief executives to frontline staff – as a useful resource to further raise standards.



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December 2013

Acknowledgements

The audit lead, members of the Audit Development Group (ADG) and staff of the HWDU at the RCP would like to thank all audit participants. We know that audit can be an onerous task. We hope that the act of participating, and the findings published here, support your work of improving staff health and wellbeing.

We are grateful to members of the ADG, HWDU Executive Group, NHS Employers and Public Health England who commented on the draft report and offered valuable advice throughout the project. Full ADG membership is listed in Appendix 2.

We thank the staff of the trusts that provided pilot data and very helpful feedback on the audit tools and help notes.

Funding

This project was funded and supported by NHS Employers with additional funding from Public Health England.

Executive summary

Background

This organisational audit, conducted by the Health and Work Development Unit (HWDU), is based on six pieces of guidance for the workplace published by the National Institute for Health and Care Excellence (NICE), and therefore represents evidence-based practice. We report here round two data collected in 2013 and compare results with round one (2010).[6–11]

There is good evidence that a healthy workforce contributes to better outcomes for organisations. The Black and Boorman reports have highlighted the need for a focus on staff health and wellbeing.[1,2] More recently the Francis review of events at Mid Staffordshire NHS Trust and the review by Keogh of hospitals at risk have underlined the importance of board leadership in defining and implementing priorities.[3,4] The Marmot review has shown that the workplace has an important role in both creating and addressing health inequalities.[12]

Results and key findings

There was a high participation rate: 73% of NHS trusts in England. A simple scoring system was used to measure the extent of the implementation of NICE guidance. Although many trusts perform well and have improved since the first round, the range of scores was wide, indicating that there remains room for improvement.

All trusts have a sickness absence policy and three-quarters have one for smoking cessation, but only 57% have one for mental wellbeing, 44% for physical activity and only 28% have an obesity plan. Where plans are in place, staff were usually involved in their production and the board in sign-off. In 2010 many trusts said they had plans in development; some trusts now have these in place but a significant number do not.

Data on inequalities, contract workers and outsourced services are illuminating. Generally trusts do take some account of diversity when producing plans but fewer measure uptake of health promotion programmes by inequality characteristics. Very few use such data to adjust programmes.

Some striking findings:

- 24% of trusts do not monitor the mental wellbeing of staff.
- Only 31% of trusts monitor long term sickness absence by age.
- Trusts had difficulty estimating their complement of contract or outsourced staff. The 178 participating trusts estimated that they had 35,918 outsourced staff.
- Outsourced staff have less access to trust health promoting initiatives than NHS employed colleagues.
- Staff working irregular or night shifts have poor healthy food choices.
- Fewer than half of trusts monitor uptake of programmes to encourage physical activity by any inequality characteristics (eg age, gender, ethnicity).
- 38% of trusts do not allow staff to attend smoking cessation services during working hours without loss of pay.

Many trusts gave us good examples of innovative practice, demonstrating that the NICE guidance can be successfully implemented. Trusts performing less well might learn from their peers by 'buddying-up' with neighbouring trusts, by coming to our free launch conference on 29 January 2014, and by following up the suggested checklists for action.

1 Background

The case for investing in health and wellbeing within the workplace was well made by Professor Dame Carol Black in her report W*orking for a healthier tomorrow* and by Dr Steve Boorman in his review of the health of NHS staff.[1,2] Boorman found important associations between better staff health and wellbeing and improved patient outcomes (including reduced MRSA rates, lower standardised mortality rates and increased patient satisfaction).

There is also clear evidence that the health of NHS staff influences organisational outcomes. Analysis of the NHS national staff survey data shows that the level of support from immediate line managers predicts staff sickness absence and patient mortality, and staff levels of work-related stress predict trusts' sickness absence levels.[13]

More recently, the Keogh review of 14 trusts with high levels of patient mortality found that these trusts had high rates of staff sickness absence, particularly among their doctors (12/14 trusts) and nurses (9/14 trusts).[4] These findings provide a compelling case for prioritising staff health, and this is reflected in two of the Keogh review 'ambitions' for all trusts:

> *All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.*
>
> *The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement.*[4]

Employee health is also an equity issue. The Marmot review recognised the importance of the workplace as a mediator of health and wellbeing and a place where inequalities in health, seen across society, are often visible.[12] A theme running through the Marmot review is that to reduce health inequalities it is necessary to give more help to those with the greater needs and fewer life chances but that this should be done across the spectrum of inequality, not just by targeting those in extreme need. This they call proportionate universalism.

The Marmot review's employment and work subgroup described how work can be either good or bad for health.[14] Their report includes proposals for health-promoting interventions in the workplace which have the potential, if applied appropriately, to contribute to reducing health inequalities. That means knowing who the most vulnerable staff are, and monitoring the uptake of programmes to see if they are accessing them. For that reason, in the second round of this audit we asked for much more detail about potential inequalities.

The Equality Act 2010 consolidated the list of protected characteristics against which it is illegal to discriminate, and mandated public organisations to promote equality and foster good relations.[15] We did not think that all of them were relevant to this audit and conversely there are other factors in relation to work, such as shift pattern and being employed by an outsourced service, which are very relevant. We have taken a pragmatic approach to the list of inequality characteristics we have used in this audit which we believe are those most relevant to its context. We have also added a section on contract workers and outsourced services.

NICE has published six pieces of evidence-based guidance which include recommendations for employers. These cover:

- the management of long-term sickness absence[6]
- promoting mental wellbeing[7]
- obesity[8]
- smoking cessation[9]
- promoting environments that encourage physical activity[10]
- physical activity in the workplace.[11]

In this document we refer to these sets of guidance as 'NICE workplace guidance'. Economic modelling shows that the recommendations are effective and cost-effective.

In addition to the areas covered by the NICE guidance, the audit addresses board level engagement. There is evidence that board engagement, or its absence, influences what an organisation sees as its priorities and what it does. The Francis Inquiry Report into the Mid Staffordshire NHS Foundation Trust clearly concluded that much of the blame for setting the culture of poorly maintained clinical standards rested with the trust board.[3] Board focus on staff health and wellbeing is likely to lend it greater priority.

Board involvement, and its importance, is a theme which runs through much of the work of NICE. For example, in producing guidance on the prevention of healthcare associated infections they found evidence that good board-level focus was associated with lower healthcare associated infection rates.[16] Similarly we believe that if boards focus on staff health and wellbeing it is likely to be prioritised and to improve.

In 2010 the HWDU conducted the first round of this national audit and measured how well trusts across England were progressing with implementing these six pieces of NICE workplace guidance.[17] Results indicated wide variation in activity across the participating NHS organisations.

Since the 2010 audit, the HWDU has held a conference and workshops free of charge for NHS organisations to support further implementation of the NICE workplace guidance. The HWDU also conducted the Staff Health Improvement Project in 2012 which involved documenting a wide range of cases studies from 22 organisations that had progressed well with implementing the NICE workplace guidance.[18] The findings were summarised in a report freely available on the RCP website. This project demonstrated the wide range of 'enablers' that organisations had identified to support their implementation. The learning from this project was shared directly with 40 NHS trusts in action-planning workshops. A separate analysis will be undertaken to attempt to measure to what extent these workshops supported implementation of the NICE workplace guidance.

2 Methods

2.1 Audit development group

The audit process, including design of the audit tool, was overseen by the HWDU and the ADG. The ADG includes experts in HR, public health and inequalities, NHS health and wellbeing, occupational health, medical statistics, and NHS employer and staff-side representation. Full group membership is listed in Appendix 2.

2.2 Tool design

Audit questions reflected the five NICE workplace guidance topic areas. The ADG considered a number of factors before including a recommendation 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.

The second round audit tool was kept as similar to the first round as possible so that direct comparisons could be made between the two rounds. The following changes were made:

- a new section to investigate access to services for outsourced staff
- additional questions to clarify how organisations are tackling potential health inequalities
- removal of a small number of questions which first round data showed were not useful.

Exploratory questions were also asked to put the recommendations into context and to review the quality of implementation, as well as the quantity. These are not drawn directly from the guidance but reflect best practice implementation of the recommendations in the guidance.

The audit tool and audit process were piloted in June 2013. The audit tool was revised in light of the data analysis and feedback from the pilot participants.

2.3 Recruitment

All NHS trusts in England were eligible to take part. The HWDU wrote directly to previous audit participants informing them that the second audit round would be taking place. Where a trust had not previously taken part, the HWDU wrote to the trust chief executive asking them to nominate their staff health and wellbeing lead, preferably at board level. The health and wellbeing leads were then contacted by email, letter and telephone, and invited to register their trust and to submit data. All the trusts that participated in round two are listed in Appendix 3.

2.4 Data collection and entry

All data for round two were submitted to the HWDU between 10 June 2013 and 2 August 2013. Extensions were provided to some trusts until the end of August 2013.

The HWDU uses a secure, web-based tool to collect trusts' data. 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 and the helpnotes can be accessed at www.rcplondon.ac.uk/staffhealth.

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

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

2.5 Data presentation and analysis

The national report shows the pooled, anonymised results from all participating trusts in round two, and comparison is made with the first round audit findings (excluding data submitted by primary care trusts (PCTs) since these were not in existence in the round two data collection period). Confidential trust-specific reports are provided to participants with trust level information presented alongside the national data. Where a trust has participated in both audit rounds a comparison is made between their responses.

Descriptive statistics are presented as n (%) in this report. When no denominator is given, the stated percentage is based on participants for that audit round. For any questions where the denominator does not reflect the total number of participants, the numerator and denominator are both given. Round one and round two question numbers are referenced within tables and diagrams, eg 1.1/1.2.

Some audit questions allowed for free text comments. Entered comments have been reviewed and the report highlights the common themes.

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 RCP using Stata version 12. Results were interpreted by the ADG and the project team.

2.6 Limitations of information

This audit uses self-reported data. The HWDU is reliant on trusts entering data that accurately reflect their policies and practices. For some questions on policy, an 'in development' response option was included to allow participating trusts to demonstrate that they were taking action.

3 Results

Notes on interpretation

Key findings from the audit data are presented in this chapter. They are organised to correspond to the seven parts of the audit tool, followed by the summary scores. In each part we present the most significant findings from the audit data and a commentary. This includes some interpretation of the audit data and comments made by trusts. We have also picked some illustrative examples of what appear to be interesting and innovative practice which trusts have told us about. Each section concludes with a checklist for action. Appendix 1 shows all audit results for round one and two.

In round two we wanted to know more about inequalities. It is well recognised that inequalities in health are influenced by social and environmental characteristics. These include working conditions and access to health promoting initiatives. In round one we had asked a single root question, eg: 'Does the (eg obesity) plan/policy address the needs of different staff groups?' with a yes/no answer. In round two we expanded this to ask specifically whether trusts took into account staff characteristics which might be associated with inequality or inequality of access to interventions in this context. We consulted widely on what to use, and agreed with the ADG those that seemed most relevant. We have used throughout:

- *age*
- *gender*
- *ethnicity*
- *staff grade*
- *occupational group*
- *shift pattern*
- *disability*
- *sexual orientation*
- *other.*

The round one data reported here do not correspond with the round one report. This is because PCTs were included in round one but no longer existed at the time of round two. In this document we have excluded their data from the round one figures so that comparisons are meaningful. For clarity, when comparing questions between the two rounds we have included the question numbers in tables and diagrams.

Overall performance is assessed using a summary score. This is derived from 37 standards in round two and 38 in round one, divided into six domains. Five domains match a guidance topic and the sixth is an overarching board engagement domain. It is important to be aware that some minor changes have been made between round one and round two. They are therefore not directly comparable but since they were only minor changes we believe that it is still useful to compare scores in round one and two. Full details of how each score is calculated and the difference between round one and round two can be found on the website (www.rcplondon.ac.uk/staffhealth).

3.1 Participation, organisation and board engagement

A theme that runs through much of the NICE guidance is that effective action on a public health topic generally requires a strategic approach, with commitment from the top of the organisation and engagement with key stakeholders, such as staff, to create an organisation-wide programme.

Audit data

Trust participation and demographics

The second round of the audit was conducted from June to August 2013. All NHS trusts in England were eligible to take part and at the time of recruitment 244 NHS trusts were identified. Of the 244 NHS trusts able to take part, 204 registered and 178 (73% of those invited) completed the audit. This compares with 72% in round one (172 of 239 invited, excluding PCTs). 221 trusts participated in either round one or two. 123 trusts took part in both rounds.

The categories of trusts participating, having excluded PCTs, were similar in round one and round two. The configuration of trusts has changed in that some now define themselves as community care trusts or a combination of mental health or acute with community care, and some have merged.

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

1.1/1.1 Please select the main type of care this trust provides:

	National Round one n	National Round two n
Acute	122	124
Ambulance	10	4
Mental health	39	23
Mental health and community	n/a	12
Acute and community	n/a	5
Community care	n/a	7
Other	1	3

Percentages are not included in this table as the dominator for some trust types is currently unknown due to the changing structure of trusts.

The total headcount of staff in all 178 trusts participating in round two was reported as 862,365. This represents 73% of all NHS staff in England.[19] Trusts estimated a total of 35,918 outsourced staff.

Trust board engagement

All but two trusts have a board member responsible for staff health and wellbeing. This is most commonly the HR or workforce director (78%) but nursing directors or non-executive directors are also cited by 5% of trusts.

Organisational arrangements

As well as asking whether trusts have an overarching strategy for staff health and wellbeing, we asked whether they have an organisation-wide plan or policy for each topic area. We also asked whether such plans had been signed off by the board and whether staff had been engaged in their planning and production.

There is a substantial increase in the number of trusts that have an overarching health and wellbeing strategy (from 41% in round one to 65% in round two). A further 29% of trusts report they have a plan in development.

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

Does the trust have an organisation-wide plan or policy on?

	National Round one n (%)	National Round two n (%)
Overall health and wellbeing	70 (41)	115 (65)
Obesity	23 (13)	50 (28)
Smoking	129 (75)	134 (75)
Physical activity	41 (24)	79 (44)
Long-term sickness absence	172 (100)	178 (100)
Mental wellbeing	83 (48)	101 (57)

Among those that said they had a plan, has the plan or policy been signed off by the board?

	National Round one n (%)	National Round two n (%)
Obesity	13/23 (57)	35/50 (70)
Smoking	115/129 (89)	117/134 (87)
Physical activity	28/41 (68)	50/79 (63)
Long-term sickness absence	Not asked	171/178 (96)
Mental wellbeing	69/83 (83)	88/101 (87)

Among those that said they had a plan, has the trust involved staff in planning and designing an organisational approach?

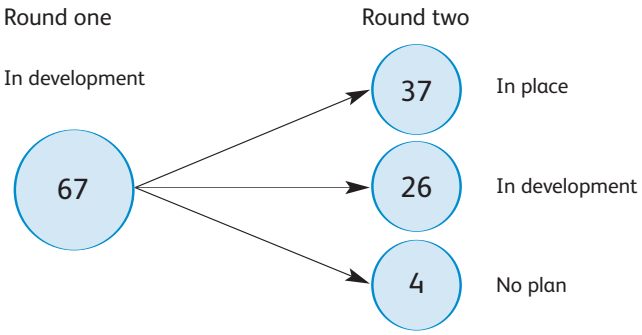
	National Round one n (%)[1]	National Round two n (%)
Obesity	17/23 (74)	41/50 (82)
Smoking	95/129 (74)	116/134 (87)
Physical activity	31/41 (76)	66/79 (84)
Long-term sickness absence	138/172 (80)	171/178 (96)
Mental wellbeing	67/83 (80)	88/101 (87)

[1] All trusts were asked this question in round one, whereas only trusts that had an organisation-wide policy/plan were asked in round two. In order to compare like with like the analysis for round one was restricted to those that had a policy/plan.

Long-term sickness absence is a regular board topic in all but one trust and in 95% of trusts this happens more frequently than every six months. Health and wellbeing also remains a regular board topic for 72% of trusts. We asked for the first time in round two whether long term sickness and staff health and wellbeing were discussed together by the board so that links could be made between the two. Just under half (48%) of trusts responded yes to this question.

In round one 90 trusts reported that they had on overarching health and wellbeing strategy in development; of these, 67 trusts took part in both rounds. The diagram shows how they have progressed.

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



About three quarters (76%) of trusts have a health and wellbeing group and of these 75% (102/136) are formally constituted within the trust governance structure. 93% (126/136) have staff-side representation.

Commentary

The high level of participation by trusts in a non-mandatory audit of this nature suggests that there is strong commitment to supporting staff health and wellbeing. The audit findings also indicate that there is good board engagement and staff involvement.

We asked trusts to tell us the approximate number of outsourced staff that they have. This generated many comments, with several respondents unable to access this information. This is a cause for concern, not least for health and safety reasons. Section 3.7 discusses contract workers and outsourced services in more detail.

> ***The wellbeing steering group have recently developed a wellbeing dashboard which links key organisational metrics including sickness absence to actions developed and delivered under the Trust's wellbeing strategy. The dashboard is currently under review by Senior Team and, once developed further and agreed, will be used to report back to the board on the impact of the wellbeing strategy/work on a six monthly basis.*** (East Cheshire NHS Trust)

When asked whether they have an overarching strategy for staff health and wellbeing 65% of trusts report that they have. Some comment that while they do not have an overarching strategy they do have plans for individual domains, such as obesity or mental health. And conversely some say that their plans for individual domains are contained in the overall strategy.

Several participants commented on the value of reviewing their NHS staff survey results and action planning as a route to promoting health and wellbeing. And there were several comments describing interesting initiatives suggesting strong commitment to staff health and wellbeing.

> ***We have developed a health and well-being programme called '5 ways to a healthier you' which has five themes. Within each we focus on public health priorities, organisational need ie reasons for sickness absence and referrals to occupational health. A three year plan was developed with board approval and is currently being evaluated and reviewed to determine the requirements for the next three years.*** (Guy's and St Thomas' NHS Foundation Trust)

Checklist for action

- Does the board appreciate the value of reviewing staff health and wellbeing alongside sickness absence data?
- Do you have a senior champion for staff health and wellbeing?
- Are staff sufficiently engaged in developing and planning health programmes?

3.2 Overweight and obesity

This should be read alongside section 3.3 Physical activity and building/site design.

NICE has produced three relevant sets of guidance with overlapping messages on: obesity; physical activity in the workplace; and environmental and building design to promote physical activity.[8,10,11] They recommend that as an employer the NHS should set an example in developing policies to prevent and manage obesity, including for its staff. We should be promoting healthy diets through healthy choices at all food outlets. We should create an environment to promote physical activity, such as travel policies which incentivise and enable walking and cycling. Where weight management programmes are offered they should meet best practice standards and address both eating and lifestyles.

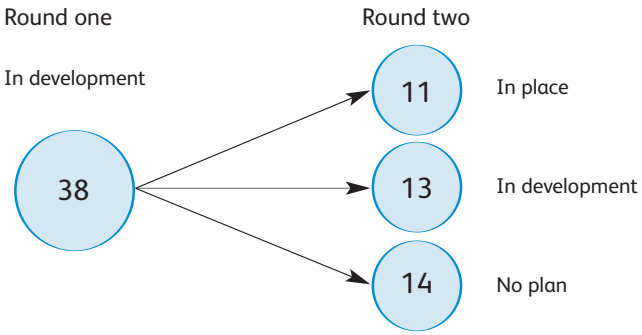
Audit data

Round one audit data in 2010 suggested that trusts had more difficulty in addressing obesity than any other topic, with only 13% (23/172) of trusts having an obesity plan or policy in place. It is therefore good to see that more than twice as many trusts now have a plan or policy in place. However, this still only represents 28% (50/178) of trusts.

In round two 70% (35/50) of the obesity plans have been signed off by the trust board and staff had been involved in design and production of 82% (41/50).

In round one 54 trusts reported that they had a plan or policy for overweight and obesity in-development; of these, 38 trusts took part in both rounds. The diagram shows how they have progressed.

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



In round one we asked whether trust obesity plans took account of the needs of different staff groups. 35% (8/23) of trusts with a plan reported that they did. In round two we asked for more detail. We listed eight commonly recognised inequality characteristics and asked whether they were taken into account when plans were produced and programmes monitored. We then asked whether programmes were adjusted in response to such monitoring. Round two data are presented in the table below.

Round two only	2.1.3 Does the obesity policy address the diverse needs of staff groups by taking account of:	2.1.4.1 Does the trust measure uptake of any programmes by different staff groups?
	National (n=50) n (%)	National (n=36) n (%)
Age	30 (60)	21 (58)
Gender	31 (62)	23 (64)
Ethnicity	30 (60)	16 (44)
Staff grade	28 (56)	18 (50)
Occupational group	29 (58)	20 (56)
Shift pattern	24 (48)	11 (31)
Disability	30 (60)	16 (44)
Sexual orientation	29 (58)	12 (33)

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

There is a small increase in the promotion of healthy food choices from vending machines, shops, hospitality and staff restaurants. Only 45% (74/166) of trusts say that they actively promote healthier foods in vending machines and 53% (76/143) from shops in round two.

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

	National Round one n (%)	National Round two n (%)
Vending machines	58/172(34)	74/166 (45)
Shops for staff and clients	59/172(34)	76/143 (53)
Hospitality	88/172(51)	98/150 (65)
Staff restaurant	133/172(77)	136/161 (84)

NB: the denominator varies because there was a N/A option to this question.

In response to a new question added in round two, 38% (52/136) of trusts say that they do not offer similar healthy food options in the evenings compared with the daytime, and 73% (99/136) say they do not offer such choices overnight.

The number of trusts offering their staff multicomponent interventions to tackle overweight and obesity has risen from 29% (50/172) in round one to 38% (67/178) in round two, but this leaves 62% (111/178) in round two that do not.

Commentary

The audit data for promoting weight loss show an improvement in attention to this significant public health problem but there is still a long way to go. More trusts now have an obesity plan and there are several examples of innovative practice to choose from.

As part of the Trust's '5 ways to a healthier you' programme under the 'Healthy Eating' section of the programme we have recruited a staff dietician to provide advice to staff. This includes roadshows with nutritional and weight loss advice, referrals from occupational health for staff who need to lose weight to improve a health condition, advising the catering and hospitality team on healthy options for staff and visitors and providing weight loss, diet and healthy eating advice and information on our intranet page. We have a dedicated page for healthy eating. We have piloted [commercial diet club] at work classes and are looking to increase the support available to staff next year. Current ideas include healthy eating on a budget advice, cooking skills workshops and our own internal weight loss class. (Guy's and St Thomas' NHS Foundation Trust)

It is worrying that many trusts do not appear to be offering much in the way of healthy food options. While three quarters of trusts promote healthy food options in their staff restaurants fewer than half do so in shops and vending machines. Participants' comments indicate that this area is particularly challenging where shops are contracted out and therefore out of the control of the trust. This is something trusts should consider when negotiating their PFI contracts, or letting contracts to shops providing services on their premises.

Food choices for night staff appear to be especially limited. Only 27% (37/136) of trusts responded that they offer night workers the same or similar healthy food options as day workers.

Only just over a third of trusts are offering their staff multicomponent interventions to help them lose weight. This is important as the evidence base for such interventions has been found by NICE to be both effective and cost effective.

The Trust has recently run a four week weight loss challenge. Teams of five staff entered and weight losses were entered by each of the teams on a weekly basis so that teams could see how they compared to other teams. 30 teams entered the challenge with 150 staff participating. The four weeks have just finished and we are awaiting entries for week four from 19 teams. Weight loss recorded to date totals 46 stone and 1lb. Some teams are carrying on the challenge themselves and we are looking to re-run the challenge in the New Year. (Bradford District Care Trust)

Regarding inequalities, it is of note that in round two more trusts report that their plan takes account of differing staff needs. However when asked whether they measure uptake of programmes by specific inequality characteristics the numbers drop, especially for ethnicity, shift pattern, disability and sexual orientation. Only 53% (19/36) of trusts with an obesity plan say that they make adjustments to their programmes on the basis of monitoring uptake. This represents 11% (19/178) of all participating trusts.

Checklist for action

- Are you offering healthy food options at all outlets and does your pricing and presentation promote healthy choices?
- Can you influence what contracted out services are offering?
- Do your evening and night staff get an equal offer of healthy options to day staff?
- Are you offering multicomponent interventions to tackle overweight?
- Does your obesity plan/policy address the diverse need of staff groups and are you monitoring uptake to further tailor your programmes?

3.3 Physical activity and building/site design

This should be read alongside section 3.2, Overweight and obesity.

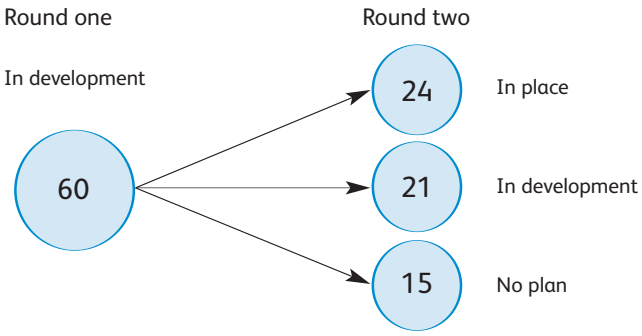
NICE has produced three relevant sets of guidance with overlapping messages on: obesity; physical activity in the workplace; and environmental and building design to promote physical activity.[8,10,11] They recommend that as an employer the NHS should set an example in developing policies to prevent and manage obesity, including for its staff. We should be promoting healthy diets through healthy choices at all food outlets. We should create an environment to promote physical activity, such as travel policies which incentivise and enable walking and cycling. And where weight management programmes are offered they should meet best practice standards and address both eating and lifestyles.

Audit data

Only 44% (79/178) of trusts have a physical activity plan although this has risen from 24% (41/172) in round one.

In round one 83 trusts reported that they had a physical activity plan or policy in development, of these, 60 trusts took part in both rounds. The diagram shows how they have progressed.

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



Of the 79 (44%) trusts with a physical activity plan, 63% (50/79) had been signed off by the board and 84% (66/79) had involved staff in its production.

In round one we asked whether trust physical activity plans took account of the needs of different staff groups. 59% (24/41) of trusts with a plan reported that they did. In round two we asked for more detail. We listed eight commonly recognised inequality characteristics and asked whether they were taken into account when plans were produced and programmes monitored. We then asked whether programmes were adjusted in response to such monitoring. Round two data are presented in the table below.

Round two only	3.1.3 Does the physical activity policy address the diverse needs of staff groups by taking account of:	3.1.4.1 Does the trust measure uptake of any programmes by different staff groups?
	National (n=79) n (%)	National (n=53) n (%)
Age	43 (54)	20 (38)
Gender	45 (57)	24 (45)
Ethnicity	36 (46)	18 (34)
Staff grade	37 (47)	20 (38)
Occupational group	39 (49)	19 (36)
Shift pattern	42 (53)	14 (26)
Disability	42 (53)	19 (36)
Sexual orientation	32 (41)	13 (25)

47% (25/53) of trusts who monitor programmes adjust them where there are clear differentials in uptake.

80% (143/178) of trusts have an active travel plan to encourage and enable staff to walk or cycle to work and between sites.

We asked a series of questions about facilities or information to encourage staff to be more physically active. The proportion of those saying yes to these questions has increased in every case since round one.

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

3.5/3.6 Does the trust help staff to be physically active during the working day by:

	National Round one n (%)	National Round two n (%)
Encouraging staff to walk or cycle to external meetings	79 (46)	95 (54)
Providing showers to encourage active travel	Not asked	139 (78)
Encouraging staff to use the stairs rather than lifts	65 (38)	87 (49)
Providing information about walking and cycling routes to and from work	81 (53)	102 (57)
Providing information about walking and cycling routes around the worksite	74 (43)	101 (57)
Encouraging staff to take short walks during work breaks	84 (49)	130 (73)
Encouraging staff to use local leisure facilities	137 (80)	154 (87)
Encouraging staff to set goals on how far they walk and cycle and monitor the distances they cover	52 (30)	81 (46)

A striking 87% (154/178) of trusts offer reduced membership to local leisure centres, 92% (164/178) a bike purchase scheme and 70% (125/178) on-site fitness classes.

Commentary

Judging by comments in this section there is a great deal of activity in trusts to encourage staff

The Trust has linked up with the City Council to provide cycle maps. (University Hospital of North Staffordshire NHS Trust)

to be physically active. Many run fitness classes and zumba appears to be particularly popular. There are accounts of trust football and cricket teams, netball, rounders, walking and pedometer challenges. Cycle schemes are also prevalent and there are several accounts of working with local authorities to develop joint schemes such as green travel plans.

The Trust is currently developing a Travel Plan and working with the City Council assisting in the development of an electronic travel plan survey. It is proposed to pilot the survey with one directorate before going trust wide. (Birmingham Children's Hospital NHS Foundation Trust)

It is, however, disappointing that few trusts are monitoring their physical activity programmes and especially that they are not monitoring them by inequality characteristics. Those that do have given us good examples of the benefits of doing so:

We have had to offer classes at different times for night workers, we have had a request for female only classes from some ethnic groups. (Derby Hospitals NHS Foundation Trust)

Provision of chair based exercises, walking groups and self-help options for those people who are unable to take part in mainstream activities. (Derbyshire Community Health Services NHS Trust)

Introduced more events to attract more men eg football tournament and cricket. (Gateshead Health NHS Foundation Trust)

The audit data demonstrate an increasing offer of opportunities to increase physical activity. However, we cannot know whether this simply represents good intention or whether it is converted into increased uptake.

Regarding inequalities, fewer than half of the 79 respondents with a physical activity plan say that it takes account of ethnicity (46%), staff grade (47%) and occupational group (49%). And only just over half consider shift pattern (53%) and disability (53%).

When it comes to measuring uptake of programmes there seems to be very little consideration of difference. Of the eight inequality characteristics uptake by gender is the most commonly monitored but only 45% do so. Measuring uptake by other characteristics is less frequent, for example only 35% monitor by disability, 26% by shift pattern, 34% by ethnicity and 25% by sexual orientation. And very few, only 25, trusts in total say that they make any adjustment to programmes having monitored them according to inequality characteristics.

While it is terrific to see so much activity we hope that all these initiatives are being evaluated to see if they are effective as well as popular. The NICE guidance is based on effective evidence but there are many gaps in that evidence. We encourage trust health and wellbeing leads to link up with their research departments to help add to the knowledge base.

Checklist for action

- Could you do more to help staff be more physically active?
- Are programmes offered in ways and at times which take account of the diverse needs of different staff groups?
- Do you know enough about what activities different staff groups would like?
- Are you evaluating the effectiveness of local initiatives?

3.4 Smoking cessation

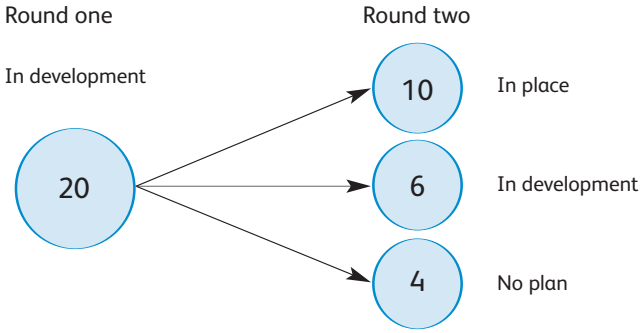
NICE recommendations on workplace interventions to promote smoking cessation say that there is very good evidence that stop smoking interventions work, and that the cost to the employer, through sickness absence and through presenteeism (someone present at work though unwell and therefore not productive) is considerable.[9] They therefore strongly recommend support by employers of their employees' efforts to quit, including allowing staff to attend stop smoking services during the working day without loss of pay.

Audit data

In round two, 75% (134/178) of trusts have an organisation-wide plan to encourage and support staff to quit smoking. Of these trusts, 87% (117/134) say that they have involved staff in its production and 87% (116/134) that the board has signed it off. These figures are unchanged since round one.

In round one, 27 trusts reported that they had a smoking plan or policy in development. Of these, 20 trusts took part in both rounds. The diagram shows how they have progressed.

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



In round one we asked whether trust smoking cessation plans took account of the needs of different staff groups. 50% (65/129) of trusts with a plan reported that they did. In round two we asked for more detail. We listed eight commonly recognised inequality characteristics and asked whether they were taken into account when plans were produced and programmes monitored. We then asked whether programmes were adjusted in response to such monitoring. Round two data are presented in the table below.

Round two only	4.1.3 Does the smoking cessation policy address the diverse needs of staff groups by taking account of:	4.1.4.1 Does the trust measure uptake of any programmes by different staff groups?
	National (n=134) n (%)	National (n=71) n (%)
Age	86 (64)	36 (51)
Gender	87 (65)	38 (54)
Ethnicity	83 (62)	28 (39)
Staff grade	78 (58)	26 (37)
Occupational group	80 (60)	30 (42)
Shift pattern	79 (59)	18 (25)
Disability	88 (66)	22 (31)
Sexual orientation	77 (57)	15 (21)

37% (26/71) of trusts who monitor programmes adjust them where there are clear differentials in uptake.

Trusts generally provide their staff with comprehensive information about available services, whether on site or not. However, in round two 14 (8%) trusts say they do not provide access to smoking cessation support (either on site or through arrangements with another local service).

In round two, 62% (111/178) of trusts say they allow staff to attend stop smoking services during working hours without loss of pay; 38% do not allow it.

Commentary

Access to stop smoking services is generally well established. However since the legislation banning smoking from the workplace there is a sense that some think that it is no longer a problem. This is not the case especially as continued smoking is increasingly associated with poverty and lower social class. In other words it is an inequality issue. It is therefore disappointing that the data on inequalities appear to show that little account is taken of inequalities when developing plans or monitoring programmes and that the data are not used to adjust stop smoking services.

There has been an improvement in monitoring uptake but still only 53% (71/134) of trusts with a smoking plan report that they measure uptake according to inequality characteristics. And even in those trusts who say they do so only 37% (26/71) of trusts monitor by staff grade, 42% (30/71) by occupational group and 25% (18/71) by shift pattern. Only 37% (26/71) of trusts say that they adjust the programme to reflect differentials in uptake of services.

It may be that since services are generally provided by non-trust staff more is happening than is reported but trusts should have a role in making sure that their lower paid staff and those working irregular shift patterns are able to access effective services. Examples of good practice were reported:

We have targeted certain staff groups such as porters with a dedicated smoking cessation service and consider other targeted approaches as identified through the health and well-being forum. (Guy's and St Thomas' NHS Foundation Trust)

Improved targeting of promotional materials, support sessions/appointments offered at convenient times for staff. (Worcestershire Acute Hospitals NHS Trust)

It is particularly disappointing that a third of trusts do not offer attendance at stop smoking services during the working day because it has been assessed by NICE as being cost effective and would thus be in trusts' financial interest to do so.

Checklist for action

- Are you allowing people to access stop smoking services during working hours?
- Are stop smoking services easily accessible, at convenient times and places, especially to lower paid and shift workers?
- Are you working with your local stop smoking provider to plan and monitor services for your staff?

3.5 Long-term sickness absence

NICE recommendations on long term sickness absence stress the importance of early identification and continuing close contact with employees who suffer recurrent short term or long term sickness absences.[6] They recommend systematic planning for return to work which takes account of individual need and circumstance. And they recommend use of a case-worker for complex cases, well coordinated care and where necessary referral for specialist help for physical or psychological advice.

Audit data

All trusts have a long-term sickness policy. Staff are engaged in their production and boards sign them off in 96% (171/178) of trusts. Long term sickness absence is reported to the board in 75% (131/178) of trusts.

We asked whether the trust long-term sickness policy required managers to contact the staff whose absence extended beyond a week or so. In round one 95% (163/178) said yes and in round two 94% (167/178) said yes.

We then asked whether the policy gave a trigger for when this should be done. 46% (75/163) of trusts reported that the trigger was two weeks or less in round one and in round two this had risen to 59% (98/167).

5.1.2.1/5.1.5.1 Does the policy give a trigger for when this should be done?

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

The proportion of trusts who use case managers for complex cases has risen from 64% (110/172) in round one to 76% (136/178) in round two.

The use of real time monitoring of sickness absence (eg through ESR) remains somewhat limited but some progress has been made. 42% (74/178) of trusts say that they do so completely in round two compared with 33% (57/172) in round one. But 28% (49/178) in round two do not do so at all.

In this section the questions about inequalities were structured slightly differently. In round one we did not ask whether a trust's sickness absence policy took into account the needs of different staff groups. However, in round two, we asked for the detail as described in the other topic areas, listing eight commonly recognised inequality characteristics. The round two data is presented in the table below. In round two, we also asked if the trust monitored trends in long-term sickness absence by the inequality characteristics. We did not ask if the policy was adjusted where there are clear differentials in uptake.

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

The extent to which OH providers collect and report on timing from start of absence to referral to OH appointment, and to issue of report have all increased. For example 77% (137/178) of OH providers now report on the interval between OH appointment to issue of report compared with 53% (91/178) in round one. Reporting is generally to HR departments rather than to trust boards.

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

	Round one	Round two
5.6.1/5/6/1 Time from start of absence to referral to OH	43 (25 %)	68 (38 %)
5.6.2/5.6.2 Time from receipt of OH referral to OH appointment	118 (69 %)	153 (86 %)
5.6.3/5.6.3 Time from OH appointment to issue of OH report	91 (53 %)	137 (77 %)
Trusts monitoring all three	34 (20 %)	65 (36 %)

There is a notable increase in trusts' provision of education and training events for staff, or programmes on mental coping strategies and resilience, from 69% (119/172) in round one to 83% (148/178) in round two. 97% (172/178) of trusts provide training for managers on how to manage long-term sickness absence.

Commentary

The elements of effective management of long term sickness are clearly set out in the NICE guidance and it appears that trusts are using the guidance extensively.

It is interesting to note that while the long term sickness policy takes account of inequality in most trusts across most characteristics, monitoring does not. Of particular concern; only 31% (55/178) of trusts say they monitor long term sickness absence by age. It is recognised that the likelihood of sickness increases with age and that the patterns of sickness absence are different as age increases.[20]

There are clearly pressures on trusts, especially where services for patients compete with those for staff. So while 89% (158/178) of trusts report that physiotherapy is available to staff several imply that access to the service is restricted. This is despite a range of national guidance recommending 'rapid access' physiotherapy services.[21] There will need to be clear, evidence-based criteria for referral to this limited resource.

> ***Current indications would seem to show that [referrals into patient physiotherapy services] are becoming less effective due to increasing patient pressures within the physiotherapy department. Business case has been prepared for direct access to physiotherapy through OH.*** (Dartford and Gravesham NHS Trust)

Almost all trusts provide training for their managers in dealing with long-term sickness (97% (172/178)). But this is seldom mandatory (19% (32/172)). This is not surprising given the long list of potential training requirements. We might usefully have asked about the uptake of training.

> ***We are doing a pilot for three months for physio for back injuries only from September–December 2013.*** (Epsom and St Helier University Hospitals NHS Trust)

> ***The training for managers on sickness absence management is not mandatory but take up is monitored and hot spots are targeted eg if there is a particular department with high levels of sickness and managers or team leaders have not attended training in sickness absence management they would be encouraged to do so.*** (Bradford District Care Trust)

Checklist for action

- Do your complex cases of long-term sickness have support from an appropriately trained case worker?
- Are you monitoring sickness absence in real time?
- Do you monitor by inequality characteristics?
- Is the coverage of training managers in managing long term sickness adequate?
- Do you have an effective mechanism for fast track physiotherapy referral?

3.6 Promoting mental wellbeing

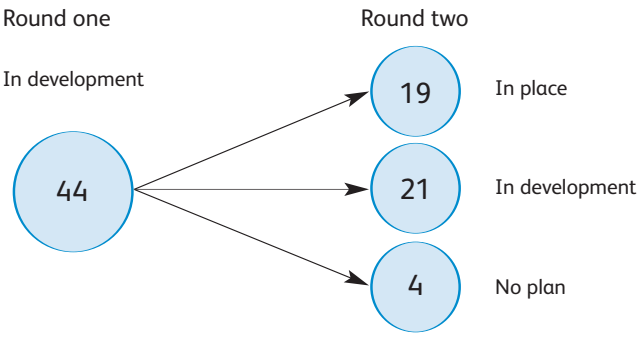
NICE recommendations on promoting mental wellbeing at work say that employers should adopt an organisation-wide approach to the promotion of mental wellbeing.[7] They focus on interventions to promote mental wellbeing through productive and healthy working conditions. They talk of creating a culture of participation, equality and fairness. They recommend putting in place mechanisms to monitor mental wellbeing of staff and the provision of training for managers.

Audit data

57% (101/178) of trusts have an organisation-wide mental wellbeing plan. This is a modest increase on the 48% (83/172) recorded in round one.

In round one 65 trusts reported that they had a plan or policy to promote staff mental wellbeing in development. Of these, 44 trusts took part in both audit rounds. The diagram shows how they have progressed.

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



Of those trusts with a plan, the majority, 87% (88/101) both involve staff in the production of the plan and have the plan signed off by the board.

In round one we asked whether trust mental wellbeing plans took account of the needs of different staff groups. 58% (48/83) of trusts with a plan reported that they did. In round two we asked for more detail. We listed eight commonly recognised inequality characteristics and asked whether they were taken into account when plans were produced and programmes monitored. We then asked whether programmes were adjusted in response to such monitoring. Round two data are presented in the table below.

Round two only	6.1.4 Does the mental wellbeing policy address the diverse needs of staff groups by taking account of:	6.1.5.1 Does the trust measure uptake of any programmes by different staff groups?
	National (n=101) n (%)	National (n= 66) n (%)
Age	71 (70)	30 (45)
Gender	71 (70)	34 (51)
Ethnicity	72 (71)	31 (47)
Staff grade	60 (59)	32 (48)
Occupational group	66 (65)	47 (71)
Shift pattern	63 (62)	19 (29)
Disability	77 (76)	29 (44)
Sexual orientation	64 (63)	24 (36)

50% (33/66) trusts who monitor programmes adjust them where there are clear differentials in uptake.

76% (136/178) of trusts report that they monitor the wellbeing of their staff, and there has been a striking increase in the percentage of trusts offering training for line managers on how to promote and protect employee mental wellbeing, from 60% (103/172) in round one to 75% (133/178) in round two.

	National Round one n (%)	National Round two n (%)
6.5/6.3 Does the trust provide training for line managers on how to promote and protect employee mental wellbeing?	103/172 (60)	133/178 (75)
6.5.1/6.3.1 If yes, is this training mandatory for all line managers?	16/103 (16)	13/133 (10)
6.6/6.4 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?	98/172 (57)	130/178 (73)
6.6.1/6.4.1 If yes, is this training mandatory for all line managers?	20/98 (20)	12/130 (9)
6.7/6.5 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?	155/172 (90)	163/178 (92)
6.7.1/6.5.1 If yes, is this training mandatory for all line managers?	46/155 (30)	26/163 (16)

Commentary

Trusts have made more comments and described more actions in the mental wellbeing domain than any other. This makes it all the more surprising that only 57% (101/178) trusts have a mental wellbeing plan. Many (84% (85/101)) have commented on the value of using the NHS staff survey as the starting point for planning and monitoring programmes to promote mental wellbeing.

> ***The (NHS) staff survey is used to identify those teams/departments where the levels of stress indicators are higher than other departments when compared to the rest of the Trust. Hotspot areas are then targeted in relation to providing training and support to managers and staff.*** (Bradford District Care Trust)

The Trust's NHS Staff Survey Action plan includes actions to improve the Trust's mental health and wellbeing scores for the 2013 survey. (University Hospital of North Staffordshire NHS Trust)

There are also other examples of monitoring staff mental health and wellbeing cited:

A wellbeing survey was conducted in February 2013 and an action plan developed for executive and board approval. Regular 'pulse surveys' to get a temperature check of how staff are feeling. Annual staff survey and action plan. Staff BME, LGBT and Disability networks and a strong staff side relationship all aid monitoring and feedback. (Kent Community Health NHS Trust)

There were many comments about training. Although few trusts say that training for line managers on how to promote and protect employee mental wellbeing is mandatory there are many examples of innovative and targeted training described.

We have an Employee Support officer whose role is to independently support staff and their managers who experience mental ill health. This role has received very good feedback from staff, managers, staff side and occupational health. (Tees, Esk and Wear Valleys NHS Foundation Trust)

There are also some good examples of the adjustment of programmes according to needs assessment or feedback.

We would look at issues where there is an over representation of stress from specific departments and produce local action plans. (Great Ormond Street Hospital for Children NHS Foundation Trust)

Regarding inequalities, in round one, 58% (48/83) say that their plan takes into account the differing needs of staff. In round two the figure is higher for all characteristics. However, far fewer measure uptake of programmes in the plan by these characteristics. For example 51% (34/66) monitor uptake by gender and only 29% (19/66) by shift pattern. Among trusts that say they measured uptake, only 50% (33/66) say that they adjust their plan or programmes in response to identified differentials in uptake.

It appears that of the trusts who have a plan to promote mental wellbeing, mental health and wellbeing is taken very seriously judging by the described initiatives to support staff. They provide good examples of ways in which mental wellbeing can be monitored and promoted and from which other trusts could learn.

Where certain occupational groups or wards/departments are identified with a high uptake they are offered group work and a departmental risk assessment is done by non-clinical risk manager. (Homerton University Hospital NHS Foundation Trust)

Where trends or hotspots are highlighted, the risk assessment is reviewed and where relevant measures are implemented to reduce the risk eg maternity. (Mid Cheshire Hospitals NHS Foundation Trust)

Checklist for action

- Do you have an organisation-wide plan for mental health?
- Does it take sufficient account of inequality characteristics?
- Do you use all available sources to monitor the mental health of staff?
- Is your training programme for managers adequate?

3.7 Contract workers and outsourced services

There is no NICE guidance associated with this domain. However the principle that all staff should be treated fairly is embedded in public policy. The NHS Constitution sets out the expectations which staff, whether working in the public, private or voluntary sector, should expect and specifically makes a pledge 'to provide support and opportunities for staff to maintain their health, wellbeing and safety'.[22] This applies to contract workers and outsourced staff as well as to staff employed by the NHS.

Audit data

This was a new section so there are no comparisons with round one.

We asked trusts to tell us the approximate number of outsourced staff that they have. This generated many comments, with several respondents unable to estimate their complement of outsourced staff. The total aggregate figure from all that were able to is 35,918. This compares with their 862,365 directly employed NHS staff.

The audit findings indicate that there is a sizeable section of the NHS workforce which is not directly employed since 65% (116/178) of trusts outsource some services. 94% (109/116) of these trusts say that outsourced staff work alongside NHS employees.

While 83% (96/116) of trusts report that fair terms and conditions are included in the procurement conditions, only 68% (79/116) say that they insist on a living wage. And 34% (39/116) of trusts report that outsourced staff do not have access to flexible working.

N/A/7.1.1 If yes (n=116), where services are outsourced, do your procurement arrangements with contractors include any requirements on the contractor to provide fair employment terms and conditions for their employees which address:

	National n (%)
Minimum wage	99 (85)
Living wage	79 (68)
Flexible working	77 (66)
Access to OH services (either their own or yours)	95 (82)
Fair terms and conditions	96 (83)

N/A/7.1.2.1 If yes (n=109), do these contract workers have equal access to your trust services for:

	National n (%)
Obesity	58 (53)
Smoking cessation	77 (71)
Physical activity	70 (64)
Mental wellbeing	57 (52)
Long-term sickness absence	40 (37)

Commentary

Trusts had some difficulty with this section. The information often did not appear to be easily available to those completing the audit. This may simply indicate that the information is difficult to find or it may be that it is incompletely known. This is disturbing, not least for health and safety reasons, but also because it demonstrates that there is a sizeable and worryingly invisible group of staff who, although not directly employed by the NHS are contributing to it.

It is clear that these outsourced staff do not have equal access to programmes or services aimed at promoting health and wellbeing. Outsourced staff tend to be lower paid and to work in manual jobs with arguably more health risks so this is an equity issue.

There appear to be many different arrangements in place. Outsourced staff sometimes have access to occupational health services either via a service level agreement or on an ad hoc basis. But they appear generally to have less access to health promoting interventions than employed staff.

Even if not employed by trusts there is a duty of care to people working on trust facilities, often alongside staff employed by the trust. Trusts are ultimately responsible through ensuring appropriate contracts with external providers and the monitoring of contract conditions.

Checklist for action

- Do you know who all your outsourced staff are?
- Do outsourced staff have access to health promoting services which are equivalent to employed staff?
- If not, can you influence the providers through the contracting process?

3.8 Summary scores

Summary scores were calculated for each domain in round one. In round two we decided not to include the new domain, *Part 7. Contract workers and outsourced services*, in the scoring system.

Round one (excluding PCTs):

Domain	National Median (IQR)
Board engagement	83.3 (66.7, 100.0)
Obesity	25.0 (12.5, 37.5)
Physical activity	37.5 (37.5, 50.0)
Smoking cessation	75.0 (62.5, 100.0)
Long-term sickness absence	78.6 (64.3, 85.7)
Promoting wellbeing	63.6 (31.8, 81.8)
Overall	59.2 (52.5, 68.9)

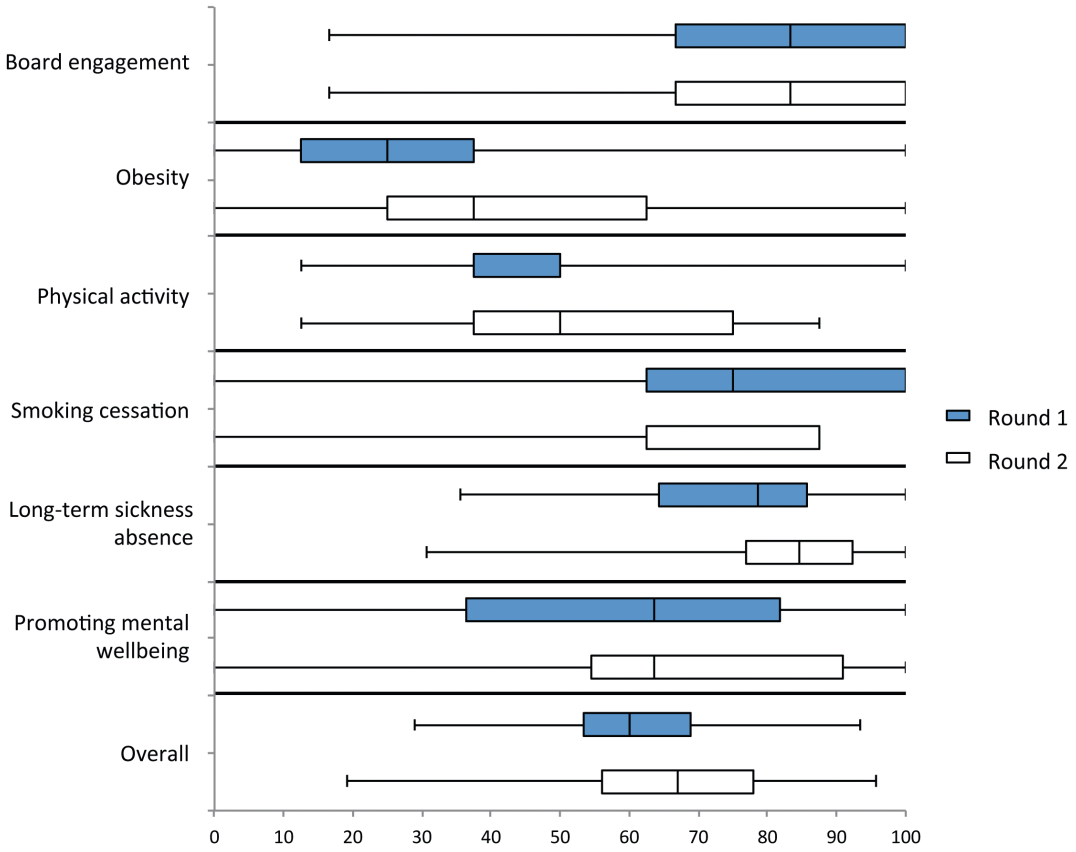
Round two:

Domain	National Median (IQR)
Board engagement	83.3 (66.7, 100.0)
Obesity	37.5 (25.0,62.5)
Physical activity	50.0 (37.5, 75.0)
Smoking cessation	68.8 (62.5, 87.5)
Long-term sickness absence	84.6 (76.9, 92.3)
Promoting wellbeing	63.6 (54.6, 90.9)
Overall	67.2 (56.8, 77.7)

Caution is needed in interpreting the scores. Some trusts participated in both rounds but some only participated in one round. In total there are 45 trusts that participated only in round one and 50 trusts that were only in round two. However we present here the data from all trusts. In addition the detail of how scores were derived was slightly different in rounds one and two.

We cannot therefore infer too much from an aggregate comparison between rounds one and two scores because the samples of trusts are not matched. However as a snapshot of two different times, it is of value. Those trusts that participated in both rounds will be able to compare their scores in rounds one and two.

Summary scores illustrated using a box and whisker plot



The box and whisker plots above show the distribution of data about the median (the middle ranked score). The horizontal line shows the range of scores achieved. The middle vertical line represents the median (ie the middle ranked score). The boxes contain the data in quartiles two and three.

The median is higher in the second round than the first overall and for obesity, physical activity and long term sickness. It remains unchanged for board engagement and mental wellbeing and is lower for smoking cessation. However the ranges remain wide, indicating that there continues to be room for improvement.

For the full details on the scores: www.rcplondon.ac.uk/staffhealth.

4 Discussion

The health and wellbeing of the NHS workforce is important. The title of the NHS business plan for 2013/14–2015/16, *Putting Patients First,* neatly describes the first priority of the NHS.[23] This priority is more likely to be achieved by a staff who value their own good health and wellbeing and whose employer supports them in achieving this.

The high participation rate in this audit represents a welcome commitment to staff health and wellbeing and insofar as it is possible to compare rounds one and two the overall performance appears to be improving. However the range of summary scores remains wide, suggesting that some trusts still have room for improvement. In round one many trusts reported that they had policies for the individual domains or overarching strategy in development. Some trusts have successfully completed them but it is disappointing to note that many have not. Furthermore, a few have moved from having a policy in development to now having no policy at all.

With regard to inequalities there is cause for concern. Most trusts take account of inequality characteristics when producing plans but fewer monitor by those characteristics and even fewer use that monitoring data to adapt programmes. It also appears that staff working for outsourced services make up a hidden population who have very poor access to health promoting activities. All contracts for outsourced services should take account of fair terms and conditions.

Some trusts have commented that they have no control over contracted out providers. For example shops on a hospital site can offer whatever food choices they like. It is important for both patients and staff that due consideration is given when letting such contracts to the food choices that will be offered.

We recognise that resources in trusts are tighter than ever before. That means that difficult choices have to be made. However, this audit is based on NICE guidance and all the recommendations included are shown to be effective and cost effective. So this is a good starting place and NICE has further workplace guidance in preparation.

With limited resources, it is worth considering a focus on organisational interventions that are likely to have the greatest influence on staff numbers affected and on outcomes. For example rolling programmes of training and support for all managers to help them understand and promote working conditions that support mental wellbeing may have greater influence than a poorly attended exercise class or pedometer challenge.

A launch conference will take place on 29 January 2014 where these results will be presented. The conference will be an opportunity to learn from your peers and there will be interactive sessions to facilitate this.

Next steps

To improve your trust's performance we suggest that you:

- consider the checklists for action below
- compare your results with the national picture and with round one
- consider how the success of your programmes and initiatives can be evaluated
- reserve your place at the launch conference
- consider 'buddying-up' with other local trusts for mutual support
- look out for new NICE guidance which is in production.

Checklists for action

3.1 Participation, organisation and board engagement

- Does the board appreciate the value of reviewing staff health and wellbeing alongside sickness absence data?
- Do you have a senior champion for staff health and wellbeing?
- Are staff sufficiently engaged in developing and planning health programmes?

3.2 Overweight and obesity

- Are you offering healthy food options at all outlets and, does your pricing and presentation promote healthy choices?
- Can you influence what contracted out services are offering?
- Do your evening and night staff get an equal offer of healthy options to day staff?
- Are you offering multicomponent interventions to tackle overweight?
- Does your obesity plan/policy address the diverse need of staff groups and are you monitoring uptake to further tailor your programmes?

3.3 Physical activity and building/site design

- Could you do more to help staff be more physically active?
- Are programmes offered in ways and at times which take account of the diverse needs of different staff groups?
- Do you know enough about what activities different staff groups would like?
- Are you evaluating the effectiveness of local initiatives?

3.4 Smoking cessation

- Are you allowing people to access stop smoking services during working hours?
- Are stop smoking services easily accessible, at convenient times and places, especially to lower paid and shift workers?
- Are you working with your local stop smoking provider to plan and monitor services for your staff?

3.5 Long term sickness absence

- Do your complex cases of long-term sickness have support from an appropriately trained case worker?
- Are you monitoring sickness absence in real time?
- Do you monitor by inequality characteristics?
- Is the coverage of training managers in managing long term sickness adequate?
- Do you have an effective mechanism for fast track physiotherapy referral?

3.6 Promoting wellbeing

- Do you have an organisation-wide plan for mental health?
- Does it take sufficient account of inequality characteristics?
- Do you use all available sources to monitor the mental health of staff?
- Is your training programme for managers adequate?

3.7 Contract workers and outsourced services

- Do you know who all your outsourced staff are?
- Do outsourced staff have access to health promoting services which are equivalent to employed staff?
- If not, can you influence the providers through the contracting process?

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Appendix 1 Complete results

The national results from round one and two are shown as number and percentage. Where a question was not asked in the first round, 'Not asked' is written in the relevant field. Unless otherwise indicated the denominator is 172 in round one and 178 in round two.

Audit question	Round one n=172* n (%)	Round two n=178† n (%)
Part 1: Organisational data		
1.1/1.1 Please select the main type of care this trust provides:		
Acute	122	124
Ambulance	10	4
Mental Health	39	23
Mental health and community care	Not asked	12
Acute and community care	Not asked	5
Community Care	Not asked	7
Other	1	3
1.2/1.2 What is the trust's total headcount?		
Total	735,073	862,365
Median (IQR)	3,660 (2,500–5,400)	4,343 (3,131–5,828)
N/A/1.3 What is the approximate total headcount of outsourced staff?		
Total	Not asked	35,918
Median (range)	Not asked	214 (2–3,305)‡
N/A/1.4 How many sites does your trust have?		
Total	Not asked	5,607
Median (range)	Not asked	4 (1–513)
1.3/1.5 Does the trust have a named board member with responsibility for staff health and wellbeing?		
Yes	168 (98)	176 (99)

[1] Unless otherwise indicated eg 2/168 where 168 is the denominator for the specific question.
[2] Unless otherwise indicated eg 2/168 where 168 is the denominator for the specific question.
[3] This is the median value for those trusts who employ outsourced staff and who were able to provide a headcount.

Audit question	Round one n=172* n (%)	Round two n=178† n (%)
1.3.1/1.5.1 If yes, is this board member:		
Executive: Medical director	2/168 (1)	3 (2)
Executive: Nursing director	14/168 (8)	9 (5)
Executive: HR/Workforce director	129/168 (77)	138 (78)
Executive: Finance director	1/168 (0.6)	0 (0)
Executive: Estates director	0/168 (0)	1 (1)
Executive: Operations director	6/168 (4)	3 (2)
Chief executive	3/168 (2)	2 (1)
Other executive board member	5/168 (3)	11 (6)
Non-executive board member	8/168 (5)	9 (5)
1.4/1.6 Is staff sickness absence reported regularly to the board?		
Yes	170 (99)	177 (99)
1.4.1/1.6.1 If yes, at what intervals?		
Annual	4/170 (2)	2/177 (1)
6 monthly	10/170 (6)	6/177 (3)
More frequently than 6 monthly	156/170 (92)	169/177 (95)
1.5/1.7 Is staff health and wellbeing a regular board agenda item?		
Yes	119 (69)	129 (72)
1.5.1/1.7.1 If yes, at what intervals?		
Annual	36/119 (30)	35/129 (27)
6 monthly	24/119 (20)	17/129 (13)
More frequently than 6 monthly	59/119 (50)	77/129 (60)
N/A/1.8 Does the board review staff sickness absence data and staff health and wellbeing data together so that links can be made between the two?		
Yes	Not asked	85 (48)
1.9/1.9 Does the trust have an umbrella/over-arching strategy or policy for staff health and wellbeing?		
Yes	70 (41)	115 (65)
No, strategy/policy in development but incomplete	90 (52)	52 (29)
No	12 (7)	11 (6)
N/A /1.10 Does the trust have a health and wellbeing group?		
Yes	Not asked	136 (76)

Audit question	Round one n=172* n (%)	Round two n=178† n (%)
N/A/1.10.1 If yes, is the group recognised within the formal governance structure of the organisation?		
Yes	Not asked	102/136 (75)
N/A/1.10.2 If yes, is there staff side or union representation on the group?		
Yes	Not asked	126/136 (93)

Audit question	Round one n (%)	Round two n (%)
Part 2: Obesity		
2.1/2.1 Does the trust have an organisation-wide plan or policy to help reduce overweight and obesity amongst its staff?		
Yes	23 (13)	50 (28)
No, plan/policy in development but incomplete	54 (31)	49 (28)
No	95 (55)	79 (44)
2.1.1/2.1.1 If yes, has the overweight and obesity plan/policy been signed off by the board?		
Yes	13/23 (57)	35/50 (70)
N/A/2.1.2 If yes, has the trust involved staff in planning and designing an organisational approach to overweight and obesity?		
Yes	Not asked	41/50 (82)
N/A/2.1.3 If yes, does the obesity plan/policy address the diverse needs of staff groups by taking account of:		
Age		
Yes	Not asked	30/50 (60)
Gender		
Yes	Not asked	31/50 (62)
Ethnicity		
Yes	Not asked	30/50 (60)
Staff Grade		
Yes	Not asked	28/50 (56)
Occupational group		
Yes	Not asked	29/50 (58)
Shift pattern		
Yes	Not asked	24/50 (48)
Disability		
Yes	Not asked	30/50 (60)
Sexual Orientation		
Yes	Not asked	29/50 (58)
Other (specify)		

Audit question	Round one n (%)	Round two n (%)
2.1.3/2.1.4 Does the trust measure uptake of any programmes in the plan/policy?		
Yes	8/23 (35)	36 (72)
N/A/2.1.4.1 If yes, is uptake measured by:		
Age		
Yes	Not asked	21/36 (58)
Gender		
Yes	Not asked	23/36 (64)
Ethnicity		
Yes	Not asked	16/36 (44)
Staff Grade		
Yes	Not asked	18/36 (50)
Occupational group		
Yes	Not asked	20/36 (56)
Shift pattern		
Yes	Not asked	11/36 (31)
Disability		
Yes	Not asked	16/36 (44)
Sexual Orientation		
Yes	Not asked	12/36 (33)
Other (specify)		
2.1.3.1/2.1.4.2 If yes, does the trust adjust the programme where there are clear differentials in uptake?		
Yes	7/8 (88)	19/36 (53)
N/A/2.1.4.2.1 If yes, how is the programme adjusted?	Not asked	Narrative response (not reported)
2.2/2.2 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	58 (34)	74 (42)
No	114 (66)	92 (52)
Not applicable	Not asked	12 (7)
Shops for staff and clients		
Yes	59 (34)	76 (43)
No	113 (66)	67 (38)
Not applicable	Not asked	35 (20)
Hospitality		
Yes	88 (49)	98 (55)
No	84 (51)	52 (29)
Not applicable	Not asked	28 (16)

Audit question	Round one n (%)	Round two n (%)
Staff restaurant		
Yes	133 (77)	136 (76)
No	39 (23)	25 (14)
Not applicable	Not asked	17 (10)
N/A/2.2.1 If yes for staff restaurant, does it provide and promote the same or similar healthy food choices:		
In the evening		
Yes	Not asked	84/136 (62)
Overnight		
Yes	Not asked	37/136 (27)
2.3/2.3 Does the trust offer overweight and obese staff multicomponent interventions that address components of activity, eating behaviour and weight reduction together?		
Yes	50 (29)	67 (38)

Audit question	Round one n (%)	Round two n (%)
3.1/3.1 Does the trust have an organisation-wide plan or policy to encourage and support employees to be more physically active?		
Yes	41 (24)	79 (44)
No, plan/policy in development but incomplete	83 (48)	51 (29)
No	48 (28)	48 (27)
3.1.1/3.1.1 If yes, has the physical activity plan/policy been signed off by the board?		
Yes	28/41 (68)	50/79 (63)
N/A/3.1.2 If yes, has the trust involved staff in planning and designing an organisational approach to physical activity?		
Yes	Not asked	66/79 (84)
N/A/3.1.3 If yes, does the physical activity plan/policy address the diverse needs of staff groups by taking account of the following?		
Age		
Yes	Not asked	43/79 (54)
Gender		
Yes	Not asked	45/79 (57)
Ethnicity		
Yes	Not asked	36/79 (46)

Audit question	Round one n (%)	Round two n (%)
Staff grade		
Yes	Not asked	37/79 (47)
Occupational group		
Yes	Not asked	39/79 (49)
Shift pattern		
Yes	Not asked	42/79 (53)
Disability		
Yes	Not asked	42/79 (53)
Sexual Orientation		
Yes	Not asked	32/79 (41)
Other (specify)		
3.1.3/3.1.4 Does the trust measure uptake of any programmes in the plan/policy?		
Yes	10 (24)	53/79 (67)
N/A/3.1.4.1 If yes, is uptake measured by:		
Age		
Yes	Not asked	20/53 (38)
Gender		
Yes	Not asked	24/53 (45)
Ethnicity		
Yes	Not asked	18/53 (34)
Staff grade		
Yes	Not asked	20/53 (38)
Occupational group		
Yes	Not asked	19/53 (36)
Shift pattern		
Yes	Not asked	14/53 (26)
Disability		
Yes	Not asked	19/53 (36)
Sexual Orientation		
Yes	Not asked	13/53 (25)
Other (specify)		
3.1.3.1/3.1.4.2 If yes, does the trust adjust the programme where there are clear differentials in uptake?		
Yes	8/10 (80)	25/53 (47)
N/A/3.1.4.2.1 If yes, how is the programme adjusted?	Not asked	Narrative response (not reported)
N/A/3.2 Does the trust have an active travel plan or strategy which encourages and enables staff to cycle or walk to work, and between sites?		
Yes	Not asked	143 (80)

Audit question	Round one n (%)	Round two n (%)
3.2/3.3 Does the trust provide safe and secure cycle parking for staff?		
Yes	161 (94)	167 (94)
3.3/3.4 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	93 (54)	93 (52)
No	27 (16)	20 (11)
Not applicable	52 (30)	65 (37)
3.4/3.5 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	81 (47)	73 (41)
No	21 (12)	24 (13)
Not applicable	70 (41)	81 (46)
3.5/3.6 Does the trust help staff to be physically active during the working day by:		
Encouraging staff to walk or cycle to external meetings		
Yes	79 (46)	95 (53)
Providing showers to encourage active travel		
Yes	Not asked	139 (78)
Encouraging staff to use the stairs rather than lifts		
Yes	65 (38)	87 (49)
Providing information about walking and cycling routes to and from work		
Yes	81 (53)	102 (57)
Providing information about walking and cycling routes around the worksite		
Yes	74 (43)	101 (57)
Encouraging staff to take short walks during work breaks		
Yes	84 (49)	130 (73)
Encouraging staff to use local leisure facilities		
Yes	137 (80)	154 (87)
Encouraging staff to set goals on how far they walk and cycle and monitor the distances they cover		
Yes	52 (30)	81 (46)
3.6/3.7 Does the trust provide:		
On-site gym for staff		
Yes	51 (30)	44 (25)
Staff access to patient physiotherapy gym		
Yes	Not asked	54 (30)
On-site swimming pool for staff		
Yes	16 (9)	16 (9)

Audit question	Round one n (%)	Round two n (%)
Staff access to patient hydrotherapy pool		
Yes	Not asked	13 (7)
On-site racket sports facilities		
Yes	26 (15)	24 (13)
Reduced membership fees for local leisure facilities		
Yes	140 (81)	155 (87)
Bike purchase scheme		
Yes	139 (81)	164 (92)
Free on-site bike repairs		
Yes	Not asked	42 (24)
On-site exercise classes for staff		
Yes	Not asked	125 (70)
Other on-site facilities or incentive schemes to encourage physical activity	Narrative response (not reported)	
N/A/3.8 Are these facilities open to all staff?		
Yes	Not asked	163 (92)
N/A/3.8.1 If no, please explain	Not asked	Narrative response (not reported)
3.8/3.9 Are staircases clearly signposted and attractive to use (eg well-lit and well-decorated)?		
All	44 (26)	62 (35)
Most	99 (58)	101 (57)
Approximately half	20 (12)	9 (5)
Few	9 (5)	3 (2)
None	0 (0)	3 (2)

Audit response	Round one n (%)	Round two n (%)
4.1/4.1 Does the trust have an organisation-wide plan or policy to encourage and support employees to stop smoking?		
Yes	129 (75)	134 (75)
No, plan/policy in development but incomplete	27 (16)	24 (13)
No	16 (9)	20 (11)
4.1.1/4.1.1 If yes, has this smoking cessation plan/policy been signed off by the board?		
Yes	115/129 (89)	117/134 (87)
N/A/4.1.2 If yes, has the trust involved staff in planning and designing an organisational approach to smoking cessation?		
Yes	Not asked	116/134 (87)

Audit response	Round one n (%)	Round two n (%)
N/A/4.1.3 If yes, does the plan/policy address the diverse needs of staff groups by taking account of the following?		
Age		
Yes	Not asked	86/134 (64)
Gender		
Yes	Not asked	87/134 (65)
Ethnicity		
Yes	Not asked	83/134 (62)
Staff grade		
Yes	Not asked	78/134 (58)
Occupational group		
Yes	Not asked	80/134 (60)
Shift pattern		
Yes	Not asked	79/134 (59)
Disability		
Yes	Not asked	88/134 (66)
Sexual Orientation		
Yes	Not asked	77/134 (57)
Other (specify)		
4.1.3/4.1.4 Does the trust measure uptake of any programmes in the plan/policy?		
Yes	30 (23)	71 (53)
N/A/4.1.4.1 If yes, is uptake measured by:		
Age		
Yes	Not asked	36/71 (51)
Gender		
Yes	Not asked	38/71 (54)
Ethnicity		
Yes	Not asked	28/71 (39)
Staff grade		
Yes	Not asked	26/71 (37)
Occupational group		
Yes	Not asked	30/71 (42)
Shift pattern		
Yes	Not asked	18/71 (25)
Disability		
Yes	Not asked	22/71 (31)
Sexual Orientation		
Yes	Not asked	15/71 (21)
Other (specify)		
4.1.3.1/4.1.4.2 Does the trust adjust the programme where there are clear differentials in uptake?		
Yes	18/30 (60)	26/71 (37)

Audit response	Round one n (%)	Round two n (%)
N/A/4.1.4.2.1 If yes, how is the programme adjusted?	Not asked	Narrative response (not reported)
4.2/4.2 Does the trust publicise smoking cessation services for staff?		
Yes	158 (92)	166 (93)
4.2.1/4.2.1 If yes, does this publicity include:		
Where services are available		
Yes	155/158 (98)	164/166 (99)
How to access these services		
Yes	156/158 (99)	166/166 (100)
The type of help available		
Yes	152/158 (96)	162/166 (98)
When services are available		
Yes	137/158 (87)	158/166 (95)
4.3/4.3 Does the trust provide access to smoking cessation support (either on site or through arrangements with another local service)?		
Yes	162 (94)	164 (92)
4.4/4.4 Does the trust policy allow staff to attend smoking cessation services during working hours without loss of pay?		
Yes	105 (61)	111 (62)

Audit question	Round one n (%)	Round two n (%)
5.1/5.1 Does the trust have an organisation-wide policy for the management of long-term sickness absence (either as a standalone policy or addressed explicitly within an absence policy)?		
Yes	172 (100)	178 (100)
No, plan/policy in development but incomplete	0 (0)	0 (0)
No	0 (0)	0 (0)
N/A/5.1.1 If yes, has this sickness absence plan/policy been signed off by the board?		
Yes	Not asked	171/178 (96)
N/A/5.1.2 If yes, has the trust involved staff in planning and designing an organisational approach to sickness absence?		
Yes	Not asked	171/178 (96)

Audit question	Round one n (%)	Round two n (%)
N/A/5.1.3 If yes, does the plan/policy address the diverse needs of staff groups by taking account of the following?		
Age		
Yes	Not asked	138/178 (78)
Gender		
Yes	Not asked	140/178 (79)
Ethnicity		
Yes	Not asked	137/178 (77)
Staff grade		
Yes	Not asked	126/178 (71)
Occupational group		
Yes	Not asked	129/178 (72)
Shift pattern		
Yes	Not asked	129/178 (72)
Disability		
Yes	Not asked	162/178 (91)
Sexual Orientation		
Yes	Not asked	126/178 (71)
Other (specify)		
5.1.1/5.1.4 If yes, does the policy require employees absent due to illness to inform their manager on the first day of absence?		
Yes	172/172 (100)	178/178 (100)
5.1.2/5.1.5 If yes, 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	163/172 (95)	167/178 (94)
5.1.2.1/5.1.5.1 If yes, does the policy give a trigger for when this should be done?		
Yes at 2 weeks (or less)	75/163 (46)	98/167 (59)
Yes by 3 weeks	9/163 (6)	2/167 (1)
Yes by 4 weeks	64/163 (39)	50/167 (30)
Yes by 5 weeks	0/163 (0)	0/167 (0)
Yes by 6 weeks	0/163 (0)	1/167 (0.6)
Yes, later than 6	1/163 (0.6)	0/167 (0)
No	14/163 (9)	16/167 (10)
5.1.2.2/5.1.5.2 If yes, does the policy (or accompanying guidance) ask managers to explore in this initial enquiry:		
The reasons for sickness absence		
Yes	160/163 (98)	166/167 (99)
Whether the staff member has received appropriate treatment		
Yes	137/163 (84)	157/167 (94)
When the staff member thinks that he/she will be back at work		
Yes	160/163 (98)	166/167 (99)

Audit question	Round one n (%)	Round two n (%)
Any perceived (or actual) barriers to returning to work (including the need for workplace adjustments)		
Yes	146/163 (90)	157/167 (94)
The potential need for a referral to OH		
Yes	157/163 (96)	164/167 (98)
The options for returning to work and what, if any, action is required to prepare for this		
Yes	152/163 (93)	162/167 (97)
5.1.3/5.1.6 If yes, does the policy require development of a return to work plan agreed between the manager and the employee?		
Yes	168/172 (98)	174/178 (98)
5.1.3.1/5.1.6.1 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	168/168 (100)	172/174 (99)
A return to some of the duties of the original job		
Yes	168/168 (100)	173/174 (99)
A move to another job within the organisation (on a temporary or permanent basis)		
Yes	167/168 (99)	173/174 (99)
5.2/5.2 Does the trust use case managers for the more complex cases of long-term sickness absence?		
Yes	110 (64)	136 (76)
5.2.1/5.2.1 If yes, what is the background of the case managers?		
Occupational Health		
Yes	48/110 (44)	72/136 (53)
Human Resources		
Yes	83/110 (75)	117/136 (86)
Line management		
Yes	75/110 (68)	96/136 (71)
Other (specify)	Narrative response (not reported)	
5.2.2/5.2.2 If yes, does the case manager:		
Monitor absence data in real time		
Yes	84/110 (76)	111/136 (82)
Coordinate any required assessments		
Yes	106/110 (96)	132/136 (97)
Timetable actions to eliminate delays between milestones		
Yes	100/110 (91)	127/136 (93)

Audit question	Round one n (%)	Round two n (%)
Initiate formal interventions		
Yes	107/110 (97)	132/136 (97)
Prompt and track actions		
Yes	105/110 (95)	131/136 (96)
Provide periodic reports to stakeholders		
Yes	100/110 (91)	121/136 (89)
5.3/5.3 Does the trust record absence data in real time (eg through Electronic Staff Record (ESR) self-service)?		
Yes fully	57 (33)	74 (42)
Yes partially	51 (30)	55 (31)
No	64 (37)	49 (28)
5.4/5.4 Does the trust routinely identify staff who are on long-term sick using a central system (eg by interrogating ESR and running reports at regular intervals)?		
Yes	168 (98)	175 (98)
5.5.1/5.4.1 If yes, who is long-term sickness absence information reported to:		
HR		
Yes	156/161 (97)	173/175 (99)
Line Manager		
Yes	146/161 (91)	170/175 (97)
Divisional/directorate manager		
Yes	156/161 (97)	162/175 (93)
Trust board		
Yes	128/161 (80)	131/175 (75)
Other (specify)	Narrative response (not reported)	
N/A/5.5 Does the trust monitor trust trends in long-term sickness absence by considering the following?		
Age		
Yes	Not asked	55 (31)
Gender		
Yes	Not asked	56 (31)
Ethnicity		
Yes	Not asked	50 (28)
Staff grade		
Yes	Not asked	81 (46)
Occupational group		
Yes	Not asked	105 (60)
Shift pattern		
Yes	Not asked	42 (24)
Disability		
Yes	Not asked	60 (34)

Audit question	Round one n (%)	Round two n (%)
Sexual Orientation		
Yes	Not asked	35 (20)
Other (specify)		
5.6/5.6 Does the trust's OH provider routinely collect and report on the following data?		
5.6.1/5.6.1 Time from start of absence to referral to OH		
Yes	43 (25)	68 (38)
5.6.1.1/5.6.1.1 If yes, who is this information reported to?		
HR		
Yes	35/43 (81)	63/68 (93)
Trust board		
Yes	6/43 (14)	19/68 (28)
Other (specify)	Narrative response (not reported)	
5.6.2/5.6.2 Time from receipt of OH referral to OH appointment		
Yes	118 (69)	153 (86)
5.6.2.1/5.6.2.1 If yes, who is this information reported to?		
HR		
Yes	96/118 (8)	134/153 (88)
Trust board		
Yes	22/118 (19)	42/153 (27)
Other (specify)	Narrative response (not reported)	
5.6.3/5.6.3 Time from OH appointment to issue of OH report		
Yes	91 (53)	137 (77)
5.6.3.1/5.6.3.1 If yes, who is this information reported to?		
HR		
Yes	68/91 (75)	119/137 (87)
Trust board		
Yes	15/91 (16)	37/137 (27)
Other (specify)	Narrative response (not reported)	
5.7/5.7 Does the trust provide:		
5.7.1/5.7.1 Education/ training events or programmes on physical and mental coping strategies/resilience for its staff		
Yes	119 (69)	148 (83)

Audit question	Round one n (%)	Round two n (%)
5.7.2/5.7.2 Physiotherapy for its staff		
Yes	141 (82)	158 (89)
5.7.3/5.7.3 Psychological therapies for its staff		
Yes	154 (90)	164 (92)
5.7.3.1/5.7.3.1 If yes, are these provided by:		
Qualified psychologists		
Yes	87/154 (56)	88/164 (54)
Counsellors trained in CBT approach		
Yes	134/154 (87)	150/164 (91)
OH staff trained in CBT approach		
Yes	47/154 (31)	56/164 (34)
Other staff trained in CBT approach		
Yes	29/154 (19)	32/164 (20)
Other (specify)	Narrative response (not reported)	
5.8/5.8 Does the trust provide training for managers on how to manage staff on long-term sick (either as stand alone training or part of broader sickness absence training)?		
Yes	167 (97)	172 (97)
5.8.1/5.8.1 If yes, is this training mandatory for all managers?		
Yes	52/167 (31)	32/172 (18)

Audit question	Round one n (%)	Round two n (%)
6.1/6.1 Does the trust have an organisation-wide plan/policy for promoting mental wellbeing amongst its staff?		
Yes	83 (48)	101 (56)
No, plan/policy in development but incomplete	65 (38)	40 (22)
No	24 (14)	37 (21)
6.1.1/6.1.1 If yes, has the plan/policy to promote mental wellbeing been signed off by the Board?		
Yes	69/83 (83)	88/101 (87)
N/A/6.1.2 If yes, were staff involved in the development of this plan/policy?		
Yes	Not asked	88/101 (87)
N/A/6.1.3 If yes, is it informed by a review of the NHS staff survey?		
Yes	Not asked	85/101 (84)

Audit question	Round one n (%)	Round two n (%)
N/A/6.1.4 If yes, does the plan/policy address the diverse needs of staff groups by taking account of the following?		
Age		
Yes	Not asked	71/101 (70)
Gender		
Yes	Not asked	71/101 (70)
Ethnicity		
Yes	Not asked	72/101 (71)
Staff grade		
Yes	Not asked	60/101 (59)
Occupational group		
Yes	Not asked	66/101 (65)
Shift pattern		
Yes	Not asked	63/101 (62)
Disability		
Yes	Not asked	77/101 (76)
Sexual Orientation		
Yes	Not asked	64/101 (63)
Other (specify)		
6.1.4/6.1.5 If yes, does the trust measure uptake of any programmes in the plan/policy?		
Yes	27/83 (67)	66/101 (65)
N/A/6.1.5.1 If yes, is uptake measured by:		
Age		
Yes	Not asked	30/66 (45)
Gender		
Yes	Not asked	34/66 (51)
Ethnicity		
Yes	Not asked	31/66 (47)
Staff grade		
Yes	Not asked	32/66 (48)
Occupational group		
Yes	Not asked	47/66 (71)
Shift pattern		
Yes	Not asked	19/66 (29)
Disability		
Yes	Not asked	29/66 (44)
Sexual Orientation		
Yes	Not asked	24/66 (36)
Other (specify)		
6.1.4.1/6.1.5.2 If yes, does the trust adjust the programme where there are clear differentials in uptake?		
Yes	20/27 (74)	33/66 (50)

Audit question	Round one n (%)	Round two n (%)
N/A/6.1.5.3 If yes, how is the programme adjusted?	Not asked	Narrative response (not reported)
6.2/6.2 Does the trust have systems for monitoring the mental wellbeing of employees?		
Yes	128 (74)	136 (76)
6.2.1/6.2.1 If yes, how do you monitor the mental wellbeing of staff?	Narrative response (not reported)	
6.4/6.1.3 If yes, is it informed by a review of the NHS staff survey?		
Yes	168/171 (98)	85/101 (84)
6.5/6.3 Does the trust provide training for line managers on how to promote and protect employee mental wellbeing?		
Yes	103 (60)	133 (75)
6.5.1/6.3.1 If yes, is this training mandatory for all line managers?		
Yes	16/103 (16)	13/133 (10)
6.6/6.4 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	98 (57)	130 (73)
6.6.1/6.4.1 If yes, is this training mandatory for all line managers?		
Yes	20/98 (20)	12/130 (9)
6.7/6.5 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	155 (90)	163 (92)
6.7.1/6.5.1 If yes, is this training mandatory for all line managers?		
Yes	46/155 (30)	26/163 (16)

Audit question	Round one n (%)	Round two n (%)
N/A/7.1 Does the trust outsource any services (eg catering, cleaning)?		
Yes	Not asked	116 (65)
N/A/7.1.1 If yes, where services are outsourced, do your procurement arrangements with contractors include any requirements on the contractor to provide fair employment terms and conditions for their employees which address:		
Minimum wage		
Yes	Not asked	99/116 (85)
Living wage		
Yes	Not asked	79/116 (68)
Flexible working		
Yes	Not asked	77/116 (66)
Access to occupational health services (either their own or yours)		
Yes	Not asked	95/116 (82)
Fair terms and conditions		
Yes	Not asked	96/116 (83)
Other (specify)	Not asked	Narrative response (not reported)
N/A/7.1.2 If yes, do any of the staff from outsourced services work alongside/on the same site as staff employed by your trust?		
Yes	Not asked	109/116 (94)
N/A/7.1.2.1 If yes, do these contract workers have equal access to your trust services for:		
Obesity		
Yes	Not asked	58/109 (53)
If no, please explain	Not asked	Narrative response (not reported)
Smoking cessation		
Yes	Not asked	77/109 (71)
If no, please explain	Not asked	Narrative response (not reported)
Physical activity		
Yes	Not asked	70/109 (64)
If no, please explain	Not asked	Narrative response (not reported)
Mental wellbeing		
Yes	Not asked	57/109 (52)
If no, please explain	Not asked	Narrative response (not reported)
Long-term sickness absence		
Yes	Not asked	40/109 (37)
If no, please explain	Not asked	Narrative response (not reported)

Appendix 2 Audit development group

David Sloan, project lead; HWDU, RCP; Chair of the ADG
Matilda Allen, researcher, UCL Institute of Health Equity
Robert Baughan, assistant national officer for health and safety, Unison
Karen Dawber, director of governance, workforce and nursing, Warrington and Halton Hospitals NHS Foundation Trust
Hannah Evans, statistician, RCP
Jennifer Gardner, programme lead for health and wellbeing, NHS Employers
Jane Huntley, associate director, Centre for Public Health, NICE
Sarah Jones, project manager, HWDU, RCP
Janice Lowndes, assistant director health improvement services; Salford City Council
Alex Nestor, deputy director of organisational development, University Hospitals Bristol NHS Foundation Trust
Tracy Selsby-Orlandi, head of occupational health, Derby Hospitals NHS Foundation Trust
Penny Peel, manager, HWDU, RCP
Kim Sunley, senior employment relations adviser, Royal College of Nursing
Jude Williams, independent consultant specialising in public health for health inequalities
Siân Williams, clinical director, HWDU, RCP

Additional thanks to Bobbie Jacobson, former director, London Health Observatory, for joining the first ADG meeting.

Appendix 3 List of participating trusts (round two)

(*NB Trusts that also participated in the pilot.)

2gether NHS Foundation Trust
5 Boroughs Partnership NHS Trust
Alder Hey Children's NHS Foundation Trust
Ashford and St Peter's Hospitals NHS Trust
Avon and Wiltshire Mental Health Partnership NHS Trust
Barking Havering and Redbridge University Hospitals NHS Trust
Barnet, Enfield and Haringey Mental Health NHS Trust
Barnsley Hospital NHS Foundation Trust
*Basildon and Thurrock University Hospitals NHS Foundation Trust
Berkshire Healthcare NHS Foundation Trust
Birmingham Children's Hospital NHS Foundation Trust
Black Country Partnership NHS Foundation Trust
Blackpool Teaching Hospitals NHS Foundation Trust
Bolton NHS Foundation Trust
Bradford District Care Trust
Bradford Teaching Hospitals NHS Foundation Trust
*Bridgewater Community Healthcare NHS Trust
Brighton and Sussex University Hospitals NHS Trust
Buckinghamshire Healthcare NHS Trust
Calderdale and Huddersfield NHS Foundation Trust
Calderstones Partnership NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
*Camden and Islington NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
City Hospitals Sunderland NHS Foundation Trust
*Colchester Hospital University NHS Foundation Trust
Cornwall Partnership NHS Trust
Countess of Chester Hospital NHS Foundation Trust
Croydon Health Services NHS Trust
Dartford and Gravesham NHS Trust
Derby Hospitals NHS Foundation Trust
Derbyshire Community Health Services
Derbyshire Health Care NHS Foundation Trust
Devon Partnership NHS Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
Dorset HealthCare NHS Foundation Trust
Dudley and Walsall Mental Health Partnership NHS Trust
Ealing Hospital NHS Trust
East and North Hertfordshire NHS Trust
*East Cheshire NHS Trust
*East Kent Hospitals University NHS Foundation Trust
*East Lancashire Hospitals NHS Trust
East London NHS Foundation Trust
East Sussex Healthcare 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
*Greater Manchester West Mental Health NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Heart of England NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust
Hinchingbrooke Health Care NHS Trust
Homerton University Hospital NHS Foundation Trust

Ipswich Hospital NHS Trust
Isle of Wight NHS Trust
Kent and Medway NHS and Social Care Partnership Trust
Kent Community Health NHS Trust
Kettering General Hospital NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
*Leeds and York Partnership NHS Foundation Trust
Leeds Community Healthcare NHS Trust
Lewisham Healthcare NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Liverpool Heart and Chest Hospital NHS Trust
Liverpool Women's NHS Foundation Trust
Luton and Dunstable University Hospital NHS Foundation Trust
Maidstone and Tunbridge Wells NHS Trust
Manchester Mental Health and Social Care Trust
Medway NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Mid Staffordshire NHS Foundation Trust
Milton Keynes Hospital NHS Foundation Trust
*Norfolk and Norwich University Hospitals NHS Foundation Trust
North Bristol NHS Trust
North Cumbria University Hospitals NHS Trust
North East Ambulance Service NHS Trust
North East London NHS Foundation Trust
North Essex Partnership NHS Foundation Trust
North Middlesex University Hospital NHS Trust
*North Tees and Hartlepool NHS Foundation Trust
North West Ambulance Service NHS Trust
Northampton General Hospital NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
*Nottingham University Hospitals NHS Trust
*Nottinghamshire Healthcare NHS Trust
Oxford Health NHS Foundation Trust
Oxford University Hospitals NHS Trust
Papworth Hospital NHS Foundation Trust
Pennine Care NHS Foundation Trust
*Peterborough and Stamford Hospitals NHS Foundation Trust
*Plymouth Hospitals NHS Trust
*Poole Hospital NHS Foundation Trust
Portsmouth Hospitals NHS Trust
Queen Victoria Hospital NHS Foundation Trust
Rotherham Doncaster and South Humber NHS Foundation Trust
Royal Berkshire NHS Foundation Trust
Royal Brompton and Harefield NHS Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon and Exeter NHS Foundation Trust
*Royal Free Hampstead NHS Trust
*Royal Liverpool and Broadgreen University Hospitals NHS Trust
Royal United Hospital Bath NHS Trust
Salford Royal NHS Foundation Trust
*Salisbury NHS Foundation Trust
*Sandwell and West Birmingham Hospitals NHS Trust
Sheffield Children's NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
Somerset Partnership NHS Foundation Trust
South Devon Healthcare NHS Foundation Trust
South Essex Partnership University NHS Foundation Trust
South London Healthcare NHS Trust
South Tees Hospitals NHS Foundation Trust
South Tyneside NHS Foundation Trust
South Warwickshire NHS Foundation Trust
South West London and St Georges Mental Health NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Southend University Hospital NHS Foundation Trust
Southport and Ormskirk Hospital NHS Trust
*St George's Healthcare NHS Trust
St Helens and Knowsley Teaching Hospitals NHS Trust
Staffordshire and Stoke on Trent Partnership NHS Trust
Stockport NHS Foundation Trust
*Surrey and Borders Partnership NHS Foundation Trust

*Sussex Community NHS Trust
Sussex Partnership NHS Foundation Trust
Taunton and Somerset NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
The Christie NHS Foundation Trust
The Clatterbridge Cancer Centre NHS Foundation Trust
*The Leeds Teaching Hospitals NHS Trust
The North West London Hospitals NHS Trust
The Queen Elizabeth Hospital King's Lynn NHS Trust
The Robert Jones/Agnes Hunt Orthopaedic Hospital NHS Trust
The Rotherham NHS Foundation Trust
*The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
The Royal Orthopaedic Hospital NHS Foundation Trust
The Royal Wolverhampton Hospitals NHS Trust
The Walton Centre NHS Foundation Trust
Torbay and South Devon Health and Care NHS Trust
*University College London Hospitals NHS Foundation Trust
University Hospital Birmingham NHS Foundation Trust
University Hospital of North Staffordshire NHS Trust
University Hospital of South Manchester NHS Foundation Trust
University Hospital Southampton NHS Trust
University Hospitals Bristol NHS Foundation Trust
University Hospitals Coventry and Warwickshire NHS Trust
University Hospitals of Morecambe Bay NHS Trust
*Walsall Healthcare NHS Trust
Warrington and 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 Foundation Trust
Western Sussex Hospitals NHS Foundation Trust
Weston Area Health NHS Trust
*Whittington Health
Wirral University Teaching Hospital NHS Foundation Trust
*Worcestershire Acute Hospitals NHS Trust
Worcestershire Health and Care NHS Trust
Wrightington, Wigan and Leigh NHS Foundation Trust
Wye Valley NHS Trust
Yeovil District Hospital NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

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