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Improving Mental Wellbeing in Mental Health Trusts

Mental Health Needs Assessment Findings

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Authors:

Dr. Margaret Coffey, University of Salford
Professor Lindsey Dugdill, University of Salford
Libby Sedgley, Health Education – North West

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Background

The NHS is required to make savings of up to £20 billion by 2015. In 2009, Dr Steve Boorman highlighted concerns about health and well being of staff, and identified 'improving the mental health and wellbeing of NHS staff' as one of the 5 key priorities for the NHS in order to meet their goal of delivering high quality care for all. His review highlights that the NHS loses over 10 million working days each year due to sickness absence, of which just over 25% is due to stress, depression and anxiety. Musculoskeletal disorders, stress and acute medical conditions, including mental ill-health are the primary causes of long-term sickness absence (NICE, 2009).

NHS Mental Health Trusts across the North of England consistently reported lower attendance rates than Acute and former Primary Care Trusts. Discussions with trusts across the North of England indicated that there were growing concerns over the levels of stress, anxiety and depression causing absence and the impact on the overall sickness absence figures.

Aims/Objectives of the research:

The aim of the project was to improve the mental wellbeing of NHS staff employed in five mental health Foundation Trusts in the North of England, through implementation of primary and secondary level interventions, identified through the development and delivery of a mental wellbeing needs assessment.

<u>Key Objectives were to:</u>

- Design, with five Mental Health Foundation Trusts a mental wellbeing needs assessment process and guidance
- Design a systematic process for determining the necessary intervention(s) to meet the identified need(s), from those available with an evidence base of effectiveness
- Pilot and qualitatively evaluate the process/toolkit
- Support commissioning, by the trusts, of the identified interventions
- Qualitatively evaluate the impact and effectiveness of the interventions at an individual and organisation level

Methods

A health needs assessment (HNA) was carried out in each of the five trusts and trusts were provided with a detailed report on the findings. Clarke et al. (2009) describe HNA as "an essential part of planning for health care and public health" (p.1549). Data for the health needs comprised:

- ESR data using absence codes for stress, anxiety and depression by band, location/business unit/directorate, inpatient and outpatient services
- Data across three years of mental health targeted services from OH and Counselling services
- Data identifying violent incidents to staff
- Trust narrative on organization changes over the timeframe
- Policies relevant to mental wellbeing as determined by the trust
- The training environment aimed at improving mental wellbeing within the trusts.
- NSS data on the six key predictors of absenteeism:
    - Staff satisfaction with the quality of work and patient care they can deliver
    - Having had an appraisal
    - Suffering from work-related stress
    - Physical violence from staff, patients, members of the public
    - Equality and Diversity Training
    - Engagement Score

Findings

Objective 1: Using **ESR data**, the HNA indicated that there has been a year-on-year increase in the numbers of days lost due to mental ill health and on the rate of mental ill-health episodes per person. The national average for days lost for an episode of stress is 27 days, however the findings indicated that over a three year period two of the five trusts are consistently above this average, one of the trusts equates to this average, and two of the trusts are below this average

Trusts were provided with individual data for each business unit, which highlighted that the trends for some business units were showing a decreasing level of FTE days lost in respect of mental ill-health, whilst others were reporting increasing rates of FTE days lost. In addition, trusts were provided with a breakdown of FTE days lost by Band. This level of detail allowed the trusts to calculate the cost of absence due to mental ill health more accurately, and drill down to where the impact of mental ill health was primarily located (i.e. 'hotspots'). This was useful as it identified priority locations (e.g. directorates, staff bands) within the Trust, needing intervention.

Trusts were asked to consider/explore further, in a participatory way with managers and staff:

- Factors that may be accounting for the variations, both positive and negative, by bands, locations and business units.
- To identify areas that were showing improvements in FTE days lost, i.e. areas of good practice that could be shared with the rest of the Trust.

As part of the HNA Trusts were also ask to provide **Occupational Health** (OH) reports, including the number of referrals to Cognitive Behavioural Therapy (CBT) and Counselling. Across the trusts the quality of these reports varied, which is unsurprising, given the number of different providers of services, which were mainly external, and in some cases had changed over the three year period.

The findings in respect of the OH data were that stress was the main reason for OH referral and that CBT was used considerably less than counselling services. Key difficulties identified with the data were that: OH reports do not match the ESR reporting periods; data did not relate to the business units or banding; there was a lack of detail in respect of outcome data; trusts lacked 'feed-back' loops to help them to identify problematic areas early; and the people who attended OH Services were reported as numbers of people, which (given the lack of detail about that person in terms of banding/business etc.,) could not be translated into useful information.

RIDDOR data was also requested as part of the HNA, and similar issues were identified as with the counselling data above, namely; the data could not be incorporated into existing ESR data; there was a lack of clarify as to whether the assessment of severity of the violent incident was based on the mental or physical effects of violence, or indeed both; the data could not be linked to the counselling data; data was not broken down by business unit or band; and the people who reported violent incidences were reported as numbers of people, which (given the lack of detail about that person in terms of banding/business etc.,) this could not be translated into useful information.

The trust profiles highlighted the changing nature of Mental Health Trusts over a short three-year period. This changing picture was due to restructuring, merging of services, and changes to service providers during a period of economic recession.

Policy information was gather in respect of the key policies that were actively being used to support good mental health in the workforce and identify whether they are used 'proactively' (i.e. in a preventative/supportive way, e.g. activities that occur before someone becomes ill), or 'reactively' (after an event, e.g. when there has been a violent incident). There was a lack of agreement between the trusts as to which policies had direct and indirect impact on mental wellbeing and the only policy to feature more than once in 'direct impact' policies was 'prevention and management of violence'. In respect of 'indirect policies', the pattern was similar with 'managing attendance/sickness absence' policy being the only indirect policy to be identified by two of the five trusts.

Overall there was a wide breath of policy across the trusts identified as having a direct impact on mental wellbeing with a similar picture for indirect impact. These choices reflect, to a degree, findings from The European Network for Workplace Health Promotion (ENWHP) which considers that promoting health in the workplace requires focus on areas of policy, human resources (HR) and work organisation, social responsibility, the planning and implementation of WHP and its evaluation (ENWHP, 2011). It is interesting to note that no policies regarding improving lifestyles were chosen whilst we know that the evidence indicates that physical activity has both protective and rehabilitative impacts on individuals with common mental health illnesses, and is very cost effective.

Trusts were also asked to identify what **training** was available that related to the policies above. Again, the range of training that the Trusts reported being either directly or indirectly related to mental wellbeing were very diverse. The only training that was identified by more than one trust as relating to wellbeing included Managing Attendance, and Leadership training

Staff survey data were used to identify the five key indicators that have been shown to be predictors of absenteeism. The findings indicated that in respect of 'staff being satisfied with the quality of work' all four trusts for which we had data were close to the national average. In respect of 'having an appraisal in the last 12 months' three of the trusts were below the average, with one trust being above the average; for 'staff suffering from work related stress' all of the trusts were slightly below the average; for 'physical violence from staff, patients, or members of the public' one trust was above the average, with the other three close to, or below the national average; and in respect of having 'equality and diversity training' two of the trusts were above the average, with two of the trusts significantly below the average.

Findings in respect of 'Engagement' indicated that the average score over the 3 years that were reported are equal or higher to the national average for staff engagement. Whilst it has been reported that more engaged employees have lower absenteeism levels, of note is the fact that across the five trusts there did not appear to be any relation between the NSS predictors of absenteeism, or engagement scores, and the ESR statistics on mental wellbeing.

Objective 2: A new 'dashboard' (eWIN Staff Health Indicator) was developed as part of this project to include both ESR data and data collected through the NHS staff survey. It is anticipated that this dashboard will enable organisations to: identify potential areas of concern; demonstrate good practice reporting methods; and provide accurate and transparent calculations. The anticipated benefits of this dashboard are: links to Health and Well-Being Community homepage and resources to link data to action plans; ESR data from the data warehouse; timely workforce analysis on a rolling basis, providing trend and current position; it

will streamline organisation-level reporting to enable organisations to focus on absence types and patterns; there is potential for benchmarking and comparison promoting good practice and cross-organisation engagement; and also a benefit of showcasing different analysis of ESR data that can be replicated at business unit level within the Trusts..

Objective 3: Evaluating the process of the intervention identified that whilst staff were enthusiastic about the HNA, there was concerns about the amount of work and length of time involved. In this respect, the process was generally more arduous and time-consuming than trusts initially thought. Notwithstanding this, the process was considered useful in helping trusts to use the information they already collected in a different way, to identify areas of good and poor practice, and to commission services differently, especially OH services, in order to be able to collate all of the data meaningfully. The process was also considered useful, particularly in respect of its participatory nature in informing potential interventions to address some of the issues raised.

Objective 4: A range of interventions were put in place following the HNA including; new pathways for staff with mental health issues; a 1st day absence reporting system; a six-month trial with EAP to provide fast track counselling; a 'manager advice line'; a series of 2 days events to include self care, and consultation on interventions to set future directions for the health and wellbeing strategy; an audit to inform a more strategic approach to managing mental ill-health; and workshops supporting personal change.

Objective 5: Due to the timescales being extended, it was not possible to evaluate the interventions at the individual and organisation levels, as these were either awaiting implementation, or had very recently been implemented. Notwithstanding this, the trusts are in a good position to evaluate these interventions themselves, against the baseline identified in the HNA carried out as part of this study, together with further exploration that was carried out by the individual trusts.

Recommendations

1. To continue to use the ESR system in a systematic way – reporting mental ill health absences per capita rates (as opposed to numbers) and by band, business unit/quarter and look at changes in trends in order to understand where improvements are being made or 'hotspots' are occurring in the organisation. Ideally this data set should be linked (whilst confidentiality is maintained) to other key indicators of health and wellbeing in the organisation, such as OH data, RIDDOR reporting, Staff Survey Data etc.,

to generate the most meaningful and useful information on different sectors of the workforce.

2. To discuss this data/information at senior level (Chief Executive/Board) meetings across the organisation so that management of health of the workforce becomes a high-level business priority for the organisation.
3. To ensure the workplace acts as an exemplar for health and wellbeing, particularly in respect of healthy lifestyle choices, such as good nutrition, physical activity provision etc.
4. To continue to engage a multi-disciplinary team across the organisation (HR, H&S, Trade Unions, OH etc) who can ensure a joined up health and wellbeing agenda (including ongoing, participatory HNA) for the workforce can be taken forwards.
5. To improve engagement of staff in health and wellbeing planning.
6. To encourage the ongoing development of the policy environment in order to proactively support the health of the workforce, particularly looking at the types of policies which encourage: a positive psychosocial environment, where autonomy and flexibility are encouraged; and a 'healthy' corporate culture including staff leadership, staff development, worklife balance, and health promoting lifestyles.
7. To continue to encourage the involvement of middle managers in the active use of the data/information in order to proactively manage the health of their staff and ensure early intervention is achieved and facilitate rapid return to work when a member of staff is off sick.
8. To ensure that training provision for managers and staff is fit for purpose in terms of the management of mental health and sickness absence.
9. To provide managers with a forum for capturing and exchanging good practice with respect of managing health at work issue, in particular mental well being.
10. To ensure that OH provision is required to provide detailed evidence of effectiveness including (this should be included in the contracting requirements)
    a. data on throughput of staff through the service: by band, grade, location per capita/quarter
    b. data on completion and/or adherence of OH programme: by band, grade, location per capita/quarter
    c. data on effectiveness of OH programme: by band, grade, location per capita/quarter
11. To improve the reporting requirements of RIDDOR data, as above, namely, by band, business unit/quarter within the organisation in order that rates, rather than numbers can be generated, which are more useful to develop a risk assessment process that can ensure that psychological impact is assessed in terms of harm alongside physical impact.

It should also be noted that psychological impact may not be immediate and may need reassessment if the harm presents after a period of time.

12. To map future mental health and wellbeing interventions against the specific needs of the organisations using data as identified above and an ongoing process of needs assessment
13. To evaluate these interventions in terms of
    a. throughput of staff through the interventions: by band, grade, location per capita/quarter
    b. data on completion of/adherence/compliance with interventions: by band, grade, location per capita/quarter
    c. data on effectiveness of interventions: by band, grade, location per capita/quarter

1.0 Aims/Objectives of the research

The aim of the project was to improve the mental wellbeing of NHS staff employed in five Mental Health Foundation Trusts in the North of England, through implementation of primary and secondary level interventions, identified through the development and delivery of a mental wellbeing needs assessment.

Key Objectives were to:

- Design, with five Mental Health Foundation Trusts a mental wellbeing needs assessment process and guidance
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In order to achieve these objectives a project board was established which consisted of project leads of five 'pathfinder' Mental Health Foundation Trusts in the North of England (known as Trust 1, Trust 2, Trust 3, Trust 4, and Trust 5); academics from Salford University and Health and Wellbeing Leads from the region. The Board's role was: to provide regional implementation of the NHS North of England's Pathfinder aimed at 'Improving Mental Wellbeing in Mental Health Trusts; to oversee the progress of the mental health needs process within the participating trusts; to meet on a monthly basis; and to make recommendations on the roll out of successful processes and interventions.

1.1 Policy context and current evidence base for the research

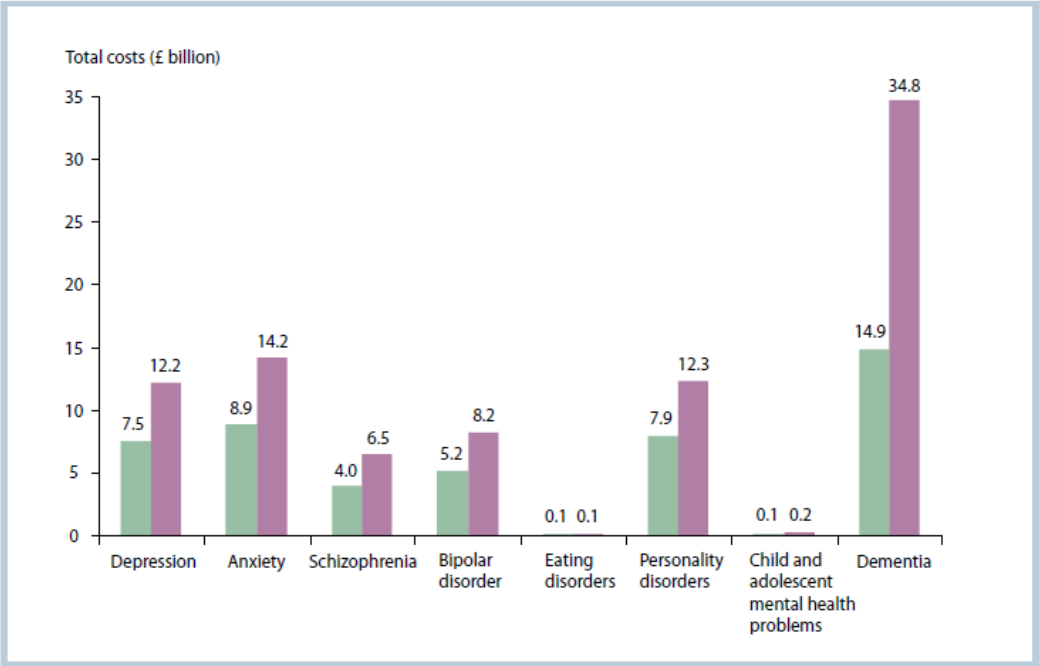
The Organisation for Economic Co-operation and Development (OECD) has very recently published a report 'Sick on the Job' (December, 2011a), which highlights the enormous costs of mental ill-health for individuals, employers and society at large. They report that between 30% and 50% of all new disability benefit claims are for mental ill-health, and among young adults that proportion goes up to over 70%. The report highlights *"there is only little awareness about the connection between mental health and work, and the drivers behind the labour market outcomes and the level of inactivity of people with mental ill-health. Understanding these drivers is critical for the development of more effective policies"*.

Within the NHS it is recognised that one of the drivers of mental health morbidity is physical violence (Kessler et al., 1995, cited in Shephard & Bisson, 2012). In the healthcare setting there is a high level of non-reporting of aggression and violence, as this can be considered 'part of the job'. However, notwithstanding this, in healthcare, the HSE received 1414 major and over-3-day injury reports as a result of physical assaults in 2009/10 (HSE, 2013). This physical violence against NHS employees was estimated to have cost the NHS £60.5 million during 2007/08.

The NHS is required to make savings of up to £20 billion by 2015. In 2009, Dr Steve Boorman highlighted concerns about health and well being of staff, and identified 'improving the mental health and wellbeing of NHS staff' as one of the 5 key priorities for the NHS in order to meet their goal of delivering high quality care for all. His review highlights that the NHS loses over 10 million working days each year due to sickness absence, of which just over 25% is due to stress, depression and anxiety. Following on from this the Audit Commission (2011) reported, as part of its series looking at improving value for money in the NHS, the direct costs of sickness absence were £1,300 million to NHS Trusts and Foundation Trusts, and £330 million to PCTs. In respect of long term conditions, it is notable that 'musculoskeletal disorders, stress and acute medical conditions, including mental ill-health are the primary causes of long-term sickness absence' (NICE, 2009).

In 2010, The Department of Health commissioned a report, to explore whether the *'prevention of mental health needs and the promotion of mental wellbeing might represent a good use of available resources'* (2011b, pg.1). The rationale behind the report was the predicted substantial increase in the impact of mental health problems on the economy if the current employment patterns and treatment and support arrangements remain unchanged (see below).

Figure 1: Current and projected future costs by mental health disorder, England 2007, 2026

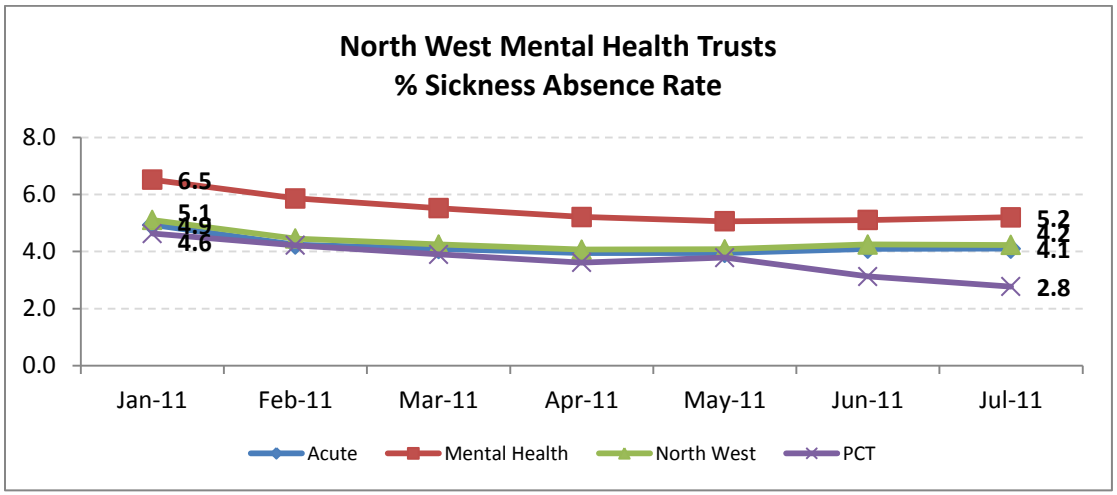


Source: McCrone, Dhanasiri, Patel, Knapp, Lawton-Smith. *Paying The Price*. London: King's Fund, 2008.

Figure 1 shows the costs of mental health problems for England, in 2007, and what the expected costs will be in 2026 if current treatment and support arrangements remain unchanged. *"The projections clearly show a substantial increase in the impact of mental health problems on the economy under current treatment and care arrangements"* (p. 1). Looking at depression and anxiety (commonly found in the workplace) the figures are predicted to rise from £16.4 billion to £26.5 billion during the period in question, which are clearly undesirable, and potentially unaffordable, given the current economic climate.

1.1.1 Mental Health Foundation Trusts in the North West of England

NHS Mental Health Trusts across the North of England consistently reported lower attendance rates than Acute and former Primary Care Trusts. The NW data below illustrates consistently higher trends in sickness absence in Mental Health Trusts compared to Acute Trusts, PCTs, and the NHS North West sickness absence average.



Source: Electronic Staff Record Data Warehouse (2011)

Discussions with trusts across the North of England indicated that there were growing concerns over the levels of stress, anxiety and depression causing absence and the impact on the overall sickness absence figures. Musculoskeletal disorders, stress and acute medical conditions, including mental ill-health are the primary causes of long-term sickness absence (NICE, 2009).

2.0 Health needs assessment

The process of HNA is not new but has developed both theoretically and practically over time. HNAs have been used previously to inform health at work development activities in the NHS (Dugdill, 1996) for instance during the "Health at Work in the NHS" project of the 1990s. The philosophy behind most organisational models of HNA is that of developing a participatory

process involving all segments of the workforce and during which managers and employees come together to identify priorities in terms of health needs. This should not only help to develop a cohesive "health action planning process" (Dugdill, 1996, p3) but enable joint decision-making around the best interventions to put in place and what areas of the workforce might need to be targeted. If this process can become embedded in workforce planning the result is a more structured and proactive planning approach to health intervention which should be more effective and cost-effective, and pick up issues at a stage where early intervention can be implemented, and sickness absence minimised.

Also there is clear evidence that involving stakeholders in the planning for, and choice of health intervention, is more likely to result in their uptake and subsequent adherence of employees to those interventions thus influencing the effectiveness of the intervention outcomes (NICE, 2006). Participatory action research can overcome some of the manager-led models of workplace health promotion which tend to decide on the key questions to be addressed in the workplace without firstly checking this out with the workforce (Dugdill and Springett, 2001, p 292). Manager-led models can reinforce the status quo and individualise problems around health at work rather than strive for innovation (such as changing the organisation) in order to improve health and wellbeing of the workforce.

Clarke et al. (2009) describe HNA as *"an essential part of planning for health care and public health"* (p1549). It is the precursor to the provision of services or interventions for a population and takes issues such as effectiveness, affordability, efficiency, equity and access into account. The National Institute for Health and Clinical Excellence (NICE) stated that a HNA is *"a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities"* (2005, p 3).

The crucial aspect of this type of approach is to understand what 'need' really means within the context of study and aspects such as professionally-defined needs, and publically defined 'wants' (demand). Of crucial importance when trying to address the issue of appropriate

intervention is understanding who, within a population, really requires an intervention and then ensuring the intervention reaches that group – rather than attendance from the 'worried well' – as inappropriate utilisation of health interventions may just serve to widen the gap in health inequalities within a population.

A HNA is highly reliant on data to inform the process and also the ability (robustness, quality and completeness) of the data to differentiate the severity of a condition (level of need) (for further discussion see Clarke et al., 2009). A key limitation to date of HNA models is that they are often based on a deficit-based model of health (defining illness, e.g. sickness absence) rather than an asset-based model of health aspiration i.e. wellbeing. It is imperative that aspects of organisational wellbeing such as team cohesion and support, and good work design are considered in this work (Knight and McNaught, 2011).

NICE (Cavangh et al., 2005) consider the integral benefits of taking part in a needs assessment are to:

- Strengthen stakeholder involvement in decision-making
- Improve team and partnership working
- Develop professional skills and experience (e.g. in terms of data analysis)
- Improve communication with other agencies
- Improve use of resources

With respect to this project the participatory action research approach was utilised in order to support the development of knowledge and skills, across each of the organisations taking part– such as better understanding of health and wellbeing at work; integrating different types of workplace data sets which could contribute to understanding health and wellbeing at work; developing a process for deciding on joint priorities across the organisation; deciding what interventions to invest in and putting a framework in place to evaluate these interventions.

Cavanagh and Chadwick (2005) considered two key criteria to be important in selecting priorities for action:

- Impact – size and severity of the health problem
- Changeability – extent to which the problem can be addressed within the current context

2.1 Stages involved in HNA (Cavanagh et al., 2005)

NICE (Cavangh et al., 2005) developed a model of the HNA process which was divided into 5 key stages as set out below and which will largely be followed in this project (these stages are also reflected in a further discussion of HNA by McIntyre et al., 2009).

2.1.1 Stage 1 – Getting Started

In this stage the following steps take place:

- Setting aims and objectives for the HNA process and ensuring the relevant policy directives and organisational priorities that relate to the population/organisations involved have been considered.
- Defining the population groups and sub-groups involved and potentially impacted by the interventions.
- Ensuring the right 'mix' of stakeholders are involved (i.e. those with knowledge and expertise about the issues under consideration and who will be responsible for managing the resource allocation process.
- Allocation of resources to conduct the HNA.
- Development of a risk management strategy for managing the HNA process.

2.1.2 Stage 2 – Identifying Health Priorities

In this stage the following steps take place:

- Profiling the relevant population including describing who they are, why they are located, any important aspects regarding any groups (e.g. hard-to-reach), perceived needs.
- Identifying relevant data (this could be individual or organisational).
- Understanding perceived needs across the population by using pre-existing data or collecting new data directly from the population.
- Agreeing priorities for action.

2.1.3 Stage 3 – Assessing Health Priorities for Action

In this stage the following steps take place:

- Choosing health conditions and determinant factors with the most significant size and severity impact.
- Determining effective and acceptable interventions. This process will involve looking at the evidence base of what is known to work against what is pragmatic to implement (e.g. affordable) and acceptable to the target population.

2.1.4 Stage 4 – Planning for Change

In this stage the following steps take place:

- Clarifying the aims of the intervention.
- Action planning/delivery of the intervention.
- Monitoring and evaluation strategy.
- Risk management.

2.1.5 Stage 5 – Moving on/Review

In this stage the following steps take place:

- Learning from the HNA process.
- Measuring impact.
- Choosing the next priority.

3.0 Literature Review

3.1 Key Features/Models and Approaches to Healthy Work

Models of workplace health broadly focus on the two areas: OH and safety and; workplace health promotion. This can be seen in the range of guidance/models for health workplaces, see for example:

The Faculty of Public Health and the Faculty of OH Medicine guidance on 'Creating a Healthy Workplace' (2006), which focuses on:

- Creating a safe and healthy workplace
- Recruitment retention and rehabilitation
- Mental wellbeing and minimizing stress
- Minimising and treating musculoskeletal disorders
- Minimising Tobacco smoke through smoking cessation
- Reducing Alcohol and other substance abuse
- Encouraging physical activity
- Encouraging healthy eating

Similarly, the European Network for Workplace Health Promotion (ENWHP) *"supports corporate health management which combines behaviour prevention, i.e. individual measures, with technical/organisational changes (circumstantial prevention)"* (ENWHP, 2012).

Workplace Health Promotion is defined as "*the combined efforts of employers, employees and society to improve the health and wellbeing of people at work"* which involves (Adapted from ENWHP, 2005):

- Having an organisational commitment to improving the health of the workforce

- Providing employees with appropriate information and establishing comprehensive communication strategies
- Involving employees in decision making processes
- Developing a working culture that is based on partnership
- Organising work tasks and processes so that they contribute to, rather than damage, health
- Implementing policies and practices which enhance employee health by making the healthy choices the easy choices
- Recognising that organisations have an impact on people and that the workplace is not always conducive to their health and wellbeing

In respect of involving employees in decision making processes, Robertson & Cooper (2010) highlight that *'One of the biggest pitfalls for well-being initiatives is 'consultation without action' – every year staff in organisations show a lot of goodwill when they complete all manner of surveys and they are entitled to expect of see a clear plan of action when the results are in'* (pg. 333). Similarly, research (see for example, Marmot, 2010; Cherti & Platt, 2010; NICE, 2009b; HSE, 2002) together with practical experience indicates that interventions that are designed with the involvement of staff, i.e. using a participatory approach, are the most likely to be effective in the long-term. This could be in the form of 'problem solving committees' or 'health circles' (Aust & Ducki, 2004, cited in Marmot 2010).

Promoting health in the workplace requires focus on the areas of corporate policy, human resources (HR) and work organisation, social responsibility, the planning and implementation of WHP and its evaluation (ENWHP, 2011). This concurs with the Centers for Disease Control and Prevention Workplace Health Model, which advises a stepped approach, which identifies 4 key steps in working towards a healthy workplace:

1. Assessment (at individual, organizational and community level)
2. Planning/workplace governance (leadership support, management, workplace health improvement plan, dedicated resources, communications and informatics)

3. Implementation (programs, policies, health benefits, environmental)
4. Evaluation (worker productivity, healthcare costs, improved health outcomes, organizational change 'culture of health')

Considering the issue of 'evaluation' Cherti & Platt (2010) stress that *"constant evaluation is vital to making sure that any initiative is working…it is important to allocate sufficient resources to evaluation and not view it as a tick-box exercise*" (pg. 25). Similarly, NICE (2009b) assert that to help improve the evidence base in this area better evaluation processes are needed.

Areas of activity for WHP should include, lifestyles, ageing, corporate culture including staff leadership, staff development, work-life balance, stress and mental health, wellness, nutrition and health and corporate social responsibility (ENWHP, 2011).

Organisational facilitators for a healthy workplace, include organisations with the ability to:

1. Measure and monitor their absence levels and can highlight both trends over time and 'hotspots' across the organisation.

2. Calculate and track the costs of sickness absence, especially if they can quantify the indirect costs (i.e. by going beyond salary costs alone).

3. Have clear and simple attendance management policies and procedures, especially if they emphasise the role of employees and their line managers.

4. Have access to responsive Occupational Health services which can help to intervene early in complex cases of long-term absence and which can facilitate early return to work.

5. Adopt simple but targeted workplace health promotion practices to improve employee awareness of health and lifestyle issues (e.g. diet, exercise, smoking) through education, information and involvement (Pilgrim, 2008).

6. Recognise through action that sickness absence is lower among highly motivated, engaged and well-managed employees, who are working in good quality jobs with high levels of control and discretion (Coats and Max, 2005). (Bevan, 2010, p.13)

In respect of 'measuring and monitoring' absence levels, including trends over time, the DWP/ACAS recognise the importance of collecting and monitoring sickness absence data in order to identify any patterns in absence, recurring problems with specific workers and designing and implementing strategies that are tailored to encourage good attendance at work (DWP/ACAS 2010a). Zwetsloot et al., (2010) assert that *"for evaluation and monitoring purposes it is important to have longitudinal data, involving a representative group of employees from relevant parts of an organisation"* (pg. 152). However, findings from their research highlighted that while organisations gathered data that was potentially useful, these data were only available and useable in a fragmented manner. *As a result, the business impact of health interventions was neither properly evaluated nor consistently managed"* (Zwetsloot et al., 2010, pg. 143). Similarly, NICE (2009b) found that routine data collection was not *"standardised, recorded and made accessible for research...there is no standardised database which links across government department"* (pg. 86). Moreover, an important variable, namely occupational or employment status, is often not recorded (NICE, 2009b), which makes it difficult to assess whether interventions are equally effective across different groups. The NHS (2011) have recently asserted that NHS organisations should develop and implement an *evidence-based* staff health and wellbeing improvement plan. Undoubtedly this evidence-based plan would need to draw on high quality data, as detailed above.

3.2 Wellbeing in the Workplace

There is growing interest in 'wellbeing', in recognition of the impact of poor psychological well-being on the economy. Robertson & Cooper (2010) draw our attention to the number of UK government sponsored working groups and reports which have focused on health, work and wellbeing, including the Foresight report on Mental Capital and Well-being; and Dame Carol Black's (2008) report. Within the context of the NHS the emphasis on employee wellbeing has

recently been reinforced by the Boorman Review (2009). Boorman (2009) highlighted concerns about health and well being of staff, and identified 'improving the mental health and wellbeing of NHS staff' as one of the 5 key priorities for the NHS in order to meet their goal of delivering high quality care for all.

Robertson & Cooper (2010) argue that employee engagement, i.e. where discretionary effort is willingly released and employees are prepared to go the 'extra mile' for their organisation', can only be achieved when employee wellbeing, particularly psychological well-being, is positive (see also CIPD, 2007). In this respect, findings from their research indicate that engagement is strongly linked to both productivity and psychological wellbeing (Roberton & Cooper, 2010). As a result, Robertson & Cooper (2008, cited in Tinline & Crowe 2010) have developed a measure of psychological employee engagement and wellbeing, which incorporates *'the enablers and blockers of wellbeing and engagement, plus health outcomes and related factors like motivation and self-reported productivity levels"* (pg. 20).

Personal well-being in the workplace exists with a social context, rather than existing on its own (CIPD, 2007). The definition of workplace wellbeing that the CIPD put forward (2007) is *"creating an environment to promote a state of contentment which allows an employee to flourish and achieve their full potential for the benefit of themselves and their organisation* (pg. 4). In this respect, research indicates (see for example the Work Foundation's Report by Bevan (2010) '*The Business Case for Employees Health and Wellbeing* http://www.investorsinpeople.co.uk/documents/research/the%20business%20case%20for%20employee%20health%20and%20wellbeing%20feb%202010.pdf) that there are benefits to organisations, both in operational and financial terms, of having a healthy workplace.

3.3 Current evidence of effectiveness of mental health and wellbeing interventions

Waddell & Burton's (2006) review of the evidence indicates that the beneficial effects of work on wellbeing outweigh any adverse effects of work on mental health, particularly given the likely adverse effects of long-term sickness absence of unemployment. However,

> *"For those employees susceptible to depression and anxiety because of financial, material or other health problems (e.g. chronic conditions) a psychologically unhealthy workplace can be a dangerous place"* (Bevan, 2010, pg. 21).

There is a vast body of literature on health promotion interventions in the workplace aimed at improving mental health. In addition, there have been a number of systematic reviews of the literature on the effectiveness of interventions to promote mental health and prevent mental illness. However, whilst there is evidence that with the appropriate support, those with long-term mental health problems can return to work (Leff & Warner, 2006 cited in Marmot, 2010) it is important to recognise that the evidence base is hampered by data shortages. For example in 2009(b) the review by NICE, which focused on the management of long-term sickness absence and incapacity for work, found that "*relatively little evidence was identified on the effectiveness and cost effectiveness of interventions (such as those focusing on stress and mental illness or psychological interventions for specific population groups). Either they had not been evaluated or the evaluations were not publicly available"* (pg. 17). In addition NICE (2009b) reported that there was limited evidence in respect of: interventions that helped people with mental health problems to return to work after sickness absence; the effectiveness of biopsychological interventions; the specific components/processes that make interventions effective; and barriers to successful interventions. The Royal College of Psychiatrists (2008) point out that the majority of evidence comes from large, often multi-national corporations, much of it is from outside the UK, and there is very little evidence relating to small and medium sized organisations. However, the absence of evidence should not be taken as an indication that such interventions should be stopped (if they help to improve work-related or treatment

outcomes). It is against this backdrop, that the range of potentially effectively interventions are discussed.

A systematic review of the job-stress evaluation literature from 1990- to 2005 (Lamontagne et al., 2007) highlighted that a growing proportion of job stress interventions are both organisationally and individually focused (termed 'high-rated approaches'). It must be noted that the results from recent systematic reviews, the findings of which were synthesised for the Marmot Review (2010), have shown that the majority of interventions have addressed behavioural changes, particularly stress management programmes, while fewer have tested the effects of changes to the work environment (Marmot 2010). Baxter et al., (2008) state that "*the emphasis on individual interventions...tends to imply a responsibility on individual employees, rather than on a change within the workplace"* (pg. 9). As a result, there is a lack of evidence of the effectiveness of: organisation-wide interventions that aim to improve mental wellbeing; cost effectiveness of organisation-wide approaches; and of the factors that help or hinder the development of these initiatives (NICE, 2009a). Conversely, there is stronger evidence for individual interventions (NWPHO, 2010, Lamontagne et al., 2007, British Occupational Health Research Foundation (BOHRF), 2005).

3.4 Organisational and Individual Level Interventions combined

Emerging evidence is suggesting that interventions that combine changes to the work-environment, whilst at the same time providing employees with mechanisms for coping with adverse work, are stronger and more sustainable than their separate effects (Biron et al., 2009, cited in Marmot, 2010; Lamontagne et al., 2007; NWPHO, 2010, BOHRF, 2005, Jordan et al., 2003, cited in Burton, 2010). For example, combining healthy lifestyle interventions with changes to the work environment has been found to increase the probability of employees adopting health promoting behaviours in a number of studies (Marmot, 2010).

3.5 Organisational Level Interventions

Organisationally-only focused systems approach interventions have been found to have favourable impacts at both individual and organisational levels (Lamontagne et al., 2007). For example Marine et al., (2006, cited in Hassan et al., 2009, and Caulfield et al., cited in Burton, 2010) found some evidence to suggest that certain types of organisational-level interventions which include changes in the work environment or communication can have a positive effect on stress levels, with positive effects lasting on average from six months to two years. Similarly changing shift-patterns has been found to positively impact on police officers (Graveling et al., 2008).

However, a systematic review of workplace interventions that promote mental wellbeing in the workplace was carried out by Graveling et al. (2008). Their findings showed that participatory approaches had been adopted (in all but one intervention) to improve wellbeing in the workplace and that 5 of the 11 studies had indicated that these participatory interventions had had a positive effect. However, the quality of the interventions was queried, and the overall conclusion of the review was that *"there is currently insufficient evidence of quality to judge the effectiveness of the use of organisational participatory interventions in the workplace to improve mental wellbeing and further research is required"* (Graveling et al., 2008, pg. ii).

3.6 Job Control/job demands/job design and social support

Findings from the Marmot Review (2010) indicated that increasing an individual's job control and degree of autonomy at work showed consistently positive effects on mental health and where data was available, on sickness absence. There was less evidence for the positive effects as a result of reducing job demands or improving social support (Egan et al., 2007, cited in Marmot, 2010).

Increasing task variety was found to produce very modest, if any, improvements in health (Bambra et al., 2007, cited in Marmot, 2010). Health promoting psychosocial work environments have been shown to improve return to work in people with mental health conditions, indicating that preventative and rehabilitative efforts need to be improved (Black, 2008).

3.7 Stress Prevention/Management

Organisational sources of stress have been found to include:

Work context	***Work content***
Management style	Work demand and level of control
Organisational justice	Effort and reward
Workplace support	Role
Participation	Working schedule
Communication	Sense of fulfilment
	Job stability

Source: NICE (2009a)

This list of sources of stress are often reduced to six key areas of work design, that if not properly managed are associated with stress, namely; demands; control; support; relationships; role; and change (see HSE stress management standards).

"Lack of control and lack of reward at work are critical determinants of a variety of stress-related disorders and more prevalent among lower occupational status groups" (Marmot, 2010, pg. 115). Unsurprisingly therefore, reward-enhancing measures, based on organisational and personal development, including leadership have been found to significantly reduce work-related burnout and psychobiological stress reactions (Marmot, 2010). Organisational justice, which encompasses issues relating to equity and fairness, is also an important component, and the experience of unfairness can increase risks to mental health and stress (NICE, 2009a).

A Cochrane Review (Marine et al., 2006, cited in Burton, 2010) concluded that interventions to prevent occupational stress in healthcare workers, can be effective in reducing burnout and stress, when compared to no intervention. In addition NICE (2009a) found that there was reasonable evidence that training, which is multi-faceted, and covers coping and stress reduction, and stress awareness, can be effective. Similarly Seymour & Grove (2005, cited in NWPHO, 2010) and the BOHRF (2005) assert that among employees who have not yet developed a mental health condition, a range of stress management interventions can be effective in improving health and work outcomes.

> *"The interventions utilized combinations of stress management techniques i.e. problem-solving, brief individual counselling, social support skills enhancement and improved communications, relaxation, training and educational interventions on the nature of stress and possible coping strategies. Programmes that provided personal support and offered individual skills training were more effective in reducing depression levels and sickness absence. Interventions that utilised multimodal approaches, i.e. combined physiological, education and individual skills training demonstrated the most long-lasting effect for those elements that provided interpersonal skills and stress management training". (BOHRF, 2005, pg 23-25)*

Lamontagne et al., (2007) found that individual level job stress interventions (termed 'low-rated approaches') favourably affected individual level outcomes, *but tend not to have favourable impacts at the organizational level"* (pg.268). Psychosocial intervention courses were also found by Graveling et al (2008) to have a positive impact on burnout in the short term, although the longer term impact is not known. However, Graveling et al's. review (2008) asserted that it was difficult to evaluate the evidence in respect of stress management interventions, as most of the programmes reported in the literature were multi-factorial and the individual aspects of them had not been separately examined.

3.8 The role of employers/managers in promoting mental health at work

Evidence suggests that *"the involvement of employers (in terms of, for example proactively managing sickness absence or temporarily adapting work) is crucial in achieving retention in, or*

return to, work among workers with common health conditions" (NWPHO, 2010, pg. 20). In this respect, recently NHS Employers, (2011) asserted that health and wellbeing initiatives should be backed with strong leadership and visible support at board level, whilst at the same time NHS organisations should build the capacity and capability of management at all levels to improve the health and wellbeing of their staff. This will include recognising and managing presenteeism, conducting return to work interviews and supporting staff with chronic conditions. More recently The European Union Programme for Employment and Social Solidarity (EUPESS, 2012) highlighted three roles that employers should adopt in managing mental health in the workplace, these include: leadership; communication; and engagement. Looking at these turn:

- *Leadership on promoting good mental health, reducing stigma and raising awareness of mental health in the workplace;*
- *Communication with staff about policies and procedures: with staff on a health-related absence from work; and with occupational health, GPs, trade unions and the individual in supporting someone back to work; and*
- *Engagement in making changes at work that can support an individual to remain in employment or return to work quicker* (EUPESS, 2012, pg. 2)

Increasing the awareness of mental wellbeing and reducing stigma and discrimination has also been recommended by NICE (2009b) as part of a strategic and co-ordinated approach to promoting employee wellbeing. In addition, the NICE (2009a) guidance recommends strengthening the role of line managers in promoting the mental wellbeing of employees through supportive leadership style and management practices which will include;

- Promoting a management style that encourages participation, delegation, constructive feedback, mentoring and coaching
- Increasing the understanding of the how management style and practices can help to promote the mental wellbeing of employees and keep their stress to a minimum

- Consider the competency framework developed by the Chartered Institute of Personnel and Development, the Health and Safety Executive and Investors in People as a tool for management development

Graveling et al's (2008) systematic review found, from high quality RCTs that *"neither web-based training nor the more traditional lecture based training (3 hours in total) for supervisors has been found to improve mental wellbeing in subordinate workers"* (pg. iii). It was suggested that further research in this area is needed. However, a recent evaluation of a NHS Yorkshire & Humber training package to provide line managers with the skills to deal with mental health in the workplace (Challis & Wilkinson, 2011) found that *"people had a better understanding of mental health at work after the training, and were able to intervene earlier through better recognition of the early signs and symptoms of mental health conditions. It also showed that people's awareness of best practice in supporting people with mental health conditions had improved and that they were more confident in their ability to support people with a mental health condition at work..."* (pg. 36).

3.9 Early diagnosis and treatment

Early intervention is especially important, because the longer someone is off work, the greater the barriers are to returning (NWPHO, 2010). Black (2008) highlighted that most of the evidence in respect of 'early intervention' has focused on back pain, and that similar evidence is needed in respect of mental ill-health. Layard et al, 2006, cited in Black 2008) point out that *"with a natural recovery rate of only 20% for depression and 5% for anxiety disorders, the majority of people need support to achieve recovery from common mental health problems and to help keep them in work"* (pg. 76). However, previous studies have shown that early diagnosis and treatment at work can be effective in tackling depression and reducing productivity losses (Michie & Williams, 2003.

There is some evidence that interventions that are targeted, for example among workers with common mental health conditions are more effective than generic interventions (Seymour & Grove, 2005, cited in NWPHO, 2010). Moreover the findings from BOHRF (2005) indicate that for those found to be at risk, individual, rather than organization-wide approaches, were the most effective. In this respect, workplace screening and early intervention for depression has been shown to generate financial returns which are almost five times the annual costs of the programme from increased productivity (The Foresight Report, 2008, McDaid et al., 2011).

3.10 The role of Counselling and Cognitive Behavioural Therapy (CBT)

There appears to be consensus that CBT is effective in reducing the risk of depression in the workplace (Van der Klink et al., 2003, cited in Department of Health, 2010 no health without public health), and is the most effective approach for people already experiencing common mental health problems at work (BOHRF, 2005), and in high control jobs. Similarly, Seymour & Grove (2005, cited in NWPHO, 2010) found that *"CBT is most effective for workers with common mental health conditions who have high levels of job control and when provided in short courses (of up to eight weeks) after two weeks sickness absence"* (pg 20). BOHRF (2005) assert that the effectiveness of CBT appears to be the same whether delivered via a computer programme, or delivered face-to-face. In this respect, a study undertaken in the NHS indicated that a computerised CBT programme (run over eight weeks) showed positive effects on mental wellbeing in the short term (NICE, 2009a, Graveling et al., 2008). In addition CBT has been found to be effective for women with musculoskeletal pain (NICE, 2009a).

A study using 'workplace-based enhanced depression care' which comprises a screening questionnaire, followed by a care management package for those found to be at risk of developing or suffering from depression and/or anxiety orders, found that CBT over 12 weeks was effective in reducing productivity losses and tackling depression (Knapp et al., 2011). It was estimated that the cost of the workplace-based enhanced depression care package was £30.90 (per person – and covers the cost of facilitating the completion of the screening questionnaire,

follow-up assessment to confirm depression, and care management costs (at 2009 prices); however, the intervention *"appears cost-saving, despite the cost of screening all employees. Benefits are gained through both a reduction in the level of absenteeism and improved levels of workplace productivity in presentation"* (Knapp et al., 2011 pgs 20-21). Similarly Hill et al., (2007, cited in Hassan et al., 2009) found that absenteeism, as well as psychological health, were improved by CBT (see also Bamberg & Bush, 1996 cited in ibid).

NICE (2009a) reported that in a UK randomised control trial, therapy and counselling delivered over three half days in work time had a positive impact on mental wellbeing in the short term. Danna & Griffin (1999) assert that home/work interface difficulties may be alleviated by counselling services and/or the introduction of flexible working arrangement and family friendly policies. However, a systematic review by McLeod (2001, cited in Royal College of Psychiatrists, 2008), reportingcounselling to be effective in alleviating stress, depression and anxiety and in reducing sickness absence by 25-50%, has been challenged. *"Its critics contend that most of the studies reviewed have major methodological limitations and that the only true randomised controlled trial showed no benefit of counselling (Henderson et al., 2003). There is at best an absence of evidence that workplace counselling improves occupational outcomes"* (Royal College of Psychiatrists, 2008, pg. 31).

3.11 Personalised case management support

Following Dame Carol Black's (2008) review, a Fit for Work service was proposed, to offer support for people, particularly in small and medium-sized enterprises, who were in the early stages of sickness absence. Interestingly, the most commonly reported health conditions were mental health conditions, although clients often had more than one condition (Hillage et al., 2012). There were 11 UK pilots of Fit for Work, and clients were assigned to a case manager, who conducted *"a wide-ranging biopsychosocial assessments of the client's health and non-health-related conditions and circumstances"* (Hillage et al., 2012, pg. 4). This was generally conducted via telephone assessment; although the findings were that face-to face assessment

was more effective. Early results from the Fit for Work pilots indicated that *"62% of the clients who were supported by the pilots in the first year had been discharged by the end of March, 2011...74% of absentees who joined the pilots in the first year and who were discharged before the end of March 2011 were back at work by the time they left...and qualitative evidence from the clients interviewed in the panel indicates that the service provided significant support to return to work, without which the return would not have happened"* (pg. 6).

3.12 The availability of health and fitness facilities

"From the 1970s onwards there has been a surge of papers consistently demonstrating a positive relationship between physical activity and mental health" (see for example Crone et al., 2009, pg. 205). Looking at the workplace, studies have indicated that employees who use corporate health and fitness facilities *"report better psychological mood states and physical well-being than employees who did not use the facility, and also have fewer days absent from work and report more satisfaction with their jobs"* (Daley & Parfitt, 1996, cited in Danna & Griffen, 1999, pg. 378). The findings of the Fit Business initiative (Cherti & Platt, 2010) indicated that employees should be involved in health initiatives, which help employees to feel engaged in the process. Graveling et al's systematic review (2008) found that aerobic exercise had a positive impact on anxiety and stress, using questionnaire based measured. However, there is insufficient research available to support the use of relaxation or massage therapy for improving mental wellbeing (Graveling et al., 2008), whilst further research is needed in respect of the effectives of meditation on mental wellbeing (see Dugdill et al., (2008) – NICE Guidelines for Promotion of Physical Activity in the Workplace).

3.13 Key findings from the literature

Key findings from the literature concluded that:

- The available evidence on interventions to promote mental health and prevent mental illness is hampered by data shortages, particularly in relation to cost effectiveness.
- There is more evidence of interventions that focus on 'behavioural changes', rather than organisational interventions
- Emerging evidence suggests that interventions which combine changes to the work environment, whilst at the same time providing employees with mechanisms for coping with adverse are stronger and more sustainable than their separate effects.
- While participatory interventions have been shown to have a positive effect, there is insufficient evidence in respect of participatory interventions to improve mental wellbeing and further research is needed.
- Increasing job control and autonomy has been shown to have positive effects on mental health, and where data is available, on sickness absence.
- Return to work, in people with mental health conditions, has been shown to improve in health promoting psychosocial work environments.
- Organisational sources of stress, if not properly managed, include; demands; control; support; relationships; role; and change.
- The involvement of employers/managers in promoting mental health at work has been found to be crucial to retention and return to work for those with common health conditions.
- Leadership, communication and engagement have been found to be key areas that employers should focus on in managing mental health in the workplace
- Further research is needed to understand the role of training/training packages for managers to improve mental wellbeing. Currently the evidence is equivocal.
- Early diagnosis of those at risk, together with early treatment has been found to be cost effective.
- CBT (delivered face-to-face or by computer programme) has been found to be the most effective approach for people already experiencing common mental health problems at work.

- There is an absence of evidence that workplace counselling improves occupational outcomes.
- Early indications are that ‘personalised case management support’ may be effective in reducing sickness absence.
- Physical activity and health and fitness activities have been shown to have a positive impact on anxiety and stress.

4.0 RESULTS

Looking at the key objectives of the project in turn:

4.1 Objective 1 – design, with five Mental Health Foundation Trusts a mental wellbeing needs assessment process and guidance:

In this section, the findings from the 'needs assessment' process will be considered, under the following key stages:

Stage 1: To determine key areas where levels of sickness absence due to mental ill health are relatively high (from ESR data).

Stage 2: Determine the take up of in-house services aimed at staff suffering from mental ill health and the pattern of their take up by staff that have mental ill health (derived from OH and Counselling data).

Stage 3: Determine the impact on mental health sickness absence from violent incidences whilst at work from patients, (from RIDDOR data).

Stage 4: Determine the organisational changes and influence that may have had an impact on mental wellbeing, (informed by a trust narrative written by project leads).

Stage 5: Determine level of policy information available to staff and managers, (derived from reactive and proactive policies influencing mental well-being as determined by the trust).

Stage 6: Determine level of training aimed at improving mental wellbeing within the trust, (derived from lists of mandatory and non-mandatory training at each trust).

Stage 7: Determine the self-reported mental wellbeing of staff, (taken from five key staff survey measures).

Stage 1- ESR Data

Five Mental Health Trusts supplied absence data per quarter, for 09/10, 10/11 and 11/12 all categories, and mental ill health absence, which was a summation of stress, anxiety and depression absence codes. We also requested data split by directorate, location, in-patient, community setting, and Band. To ensure rates could be calculated we requested FTE (full time equivalent – i.e. a FTE of 1.0 means that the person is equivalent to a full-time worker) and headcount for each category.

The initial data enquiry established full time equivalent mean days lost per location and business unit.

Table 1 – Mental Ill-health FTE days lost (averaged per year)

Average MWB FTE days per business unit per year					
Year	**TRUST 1 6 b.u.'s**	**TRUST 2 14 b.u.'s**	**TRUST 3 7 b.u.'s**	**TRUST 4 6 b.u.'s**	**TRUST 5 12 b.u.'s**
2009-2010	766.16	139.06	538.79	581.70	608.72
2010-2011	1038.98	190.53	573.02	632.32	837.38
2011-2012	1224.51	333.55	544.49	703.49	1039.61

Table 1 indicates that in all five trust there has been a year-on-year increase in the numbers of days lost due to mental ill health, which has been having a significant impact on the overall absence rates of the trusts involved.

Table 1 provides an overview of the averages across the trusts, however, trusts were provided with individual data for each business unit, which highlighted that the trends for some business units were showing a decreasing level of FTE days lost in respect of mental ill-health, whilst others were reporting increasing rates of FTE days lost. In addition, trusts were provided with a breakdown of FTE days lost by Band. This level of detail allowed the trusts to calculate the cost of absence due to mental ill health more accurately, and drill down to where the impact of

mental ill health was primarily located (i.e. 'hotspots'). This was useful as it identified priority locations (e.g. directorates, staff bands) within the Trust, needing intervention.

The overall findings showed the impact of days lost for mental ill health has altered between grades over time.

Trusts were asked to consider/explore further, in a participatory way with managers and staff:

- Factors that may be accounting for the variations, both positive and negative, by bands, locations and business units.
- To identify areas that were showing improvements in FTE days lost, and identify areas of good practice that could be shared with the rest of the Trust.

In Table 2 below we have converted the days lost into a per capita rate of FTE days lost to common mental ill health absence (averaged per year) by business unit.

Table 2 –Per Capita Rate of FTE days lost to common mental ill health (averaged per year) by business unit

Per Capita Rate of FTE days lost to common mental ill health (averaged per year) by business unit					
Year	**TRUST 1 6 b.u.'s**	**TRUST 2 14 b.u.'s**	**TRUST 3 7 b.u.'s**	**TRUST 4 6 b.u.'s**	**TRUST 5 12 b.u.'s**
2009-2010	1.1461	.5753	.9661	1.5278	1.8484
2010-2011	1.5678	.6281	1.0308	1.4967	1.8684
2011-2012	1.5383	.8907	1.0315	1.7452	2.4412

Table 2 highlights that in line with Table 1 (above) the per capita rate of absence was increasing in each of the five trusts over the three year time period, except for Trust 1, which plateaued in 2011/12. This information was broken down for each trust by Band, business unit, and location, and when this was done, the patterns were less consistent, enabling trusts to identify areas where trends were improving or worsening. This information could be used to enable

them to interrogate these patterns further with staff and managers in order to identify areas for intervention.

Tables 3 & 4 report the rates according to the average number of mental ill-health episodes per year, and the average length of mental ill-health absence per year. Over the three-year period, whilst the rate of mental ill-health episodes per person generally showed a year-on-year increase, the average length of absence for mental ill-health reduced in two out of the five trusts.

Table 3 – Per capita rate – Mental ill-health episodes per person (averaged per year) by business unit

Per capita rate – Mental ill-health episodes per person (averaged per year) by business unit					
Year	**TRUST 1 6 b.u.'s**	**TRUST 2 14 b.u.'s**	**TRUST 3 7 b.u.'s**	**TRUST 4 6 b.u's**	**TRUST 5 12 b.u.'s**
2009-2010	.03919	.02018	.03431	.04242	.05316
2010-2011	.04459	.02676	.03688	.04545	.05215
2011-2012	.04370	.03901	.03789	.05243	.06460

Table 4 – Average length of Mental ill-health absence (averaged per year) per Mental ill-health Episode by business unit

Average length of Mental ill-health absence per Mental ill-health Episode (averaged per year) by business unit					
Year	**TRUST 1 6 b.u.'s**	**Trust 2 14 b.u.'s**	**TRUST 3 7 b.u.'s**	**TRUST 4 6 b.u's**	**Trust 5 12 b.u.'s**
2009-2010	29.34	29.95	22.50	34.97	27.36
2010-2011	34.82	23.53	23.35	33.86	28.98
2011-2012	35.12	22.34	23.53	32.13	27.44

Of note in Table 4 is the mean length of each episode of absence for each mental ill health episode. The national average for days lost for an episode of stress is 27 days and we can see that the two of the five trusts are consistently over this average, one of the trusts equates to this average, and two of the trusts are below this average (Stress and Psychological Disorders

HSE 2011, http://www.hse.gov.uk/statistics/causdis/stress/stress.pdf). Whilst this must be noted in the context that the average number of days lost for common mental illness nationally is higher than any other single cause including musculoskeletal disorders, it does show that there is variation between the trusts, which needs to be investigated further with staff and managers.

The trusts had a further breakdown of the above absenteeism metrics by band, business unit and location. This information was provided to enable further exploration into areas of good and potentially weak practice with respect to absenteeism, the factors causing absenteeism, or its management. This data set gives Trusts the baseline against which they can target and measure the effectiveness of interventions to reduce absenteeism.

Trusts were asked to consider, in a participatory way with staff and managers:

- The average length of absence for common mental ill-health reasons
- The current pathways for common mental illness with service providers
- Identify where they may be 'blockages' to return to work which could be improved
- Identify areas of good practice, which could be shared in the trust

The ESR data was also interrogated to identify if there were any differences in absence related to whether the post is In-patient of based in the community, however no clear trends/patterns emerged from this data that needed further investigation**.**

Stage 2- OH and Counselling data

Trusts were ask to provide OH reports, including the number of referrals to CBT and Counselling. Across the trusts the quality of these reports varied, which is unsurprising, given the number of different providers of services, which were mainly external, and in some cases had changed over the three year period.

The key difficulties identified were:

- OH reports do not match the ESR reporting periods
- Data not relating to the business units
- Lack of banding data
- Lack of detail in respect of outcome data
- Lack of 'feed-back' loop to the trusts to identify problematic areas early
- The people who attended OH Services were reported as numbers of people, which (given the lack of detail about that person in terms of banding/business etc.,) could not be translated into useful information, i.e. rates of attendance

The findings indicated that CBT was used considerably less than counselling services, and that stress was the main reason for OH referral.

Stage 3- RIDDOR data

Violent incidents are defined as 'an act of non-consensual physical violence done to a person at work', and were (up until April 2012) reportable if as a result the individual is incapacitated for three or more days, i.e. absent from work.

RIDDOR data was requested from all trusts, however, the data provided highlighted that there was no common format to internal recording of these issues, for example how 'severity' was determined/reported.

In addition, similar issues (identified with the counselling data) were highlighted such as:

- The data could not be incorporated into existing ESR data
- A lack of clarity as to whether the assessment of severity was based on the mental or physical effects of violence, or indeed both
- Data could not be linked to sickness absence or counselling data

- Data was not broken down by business unit
- Lack of banding data
- The people who reported violent incidences were reported as numbers of people, which (given the lack of detail about that person in terms of banding/business etc.,) this could not be translated into useful information, i.e. rates of violent incidences.

Whilst we are aware from the Boorman Review that violence does have a significant effect on absence we cannot judge the picture in the trusts, due to the lack of detailed and useful information about violent incidents.

Stage 4: **trust narrative**

The trust profiles highlighted the changing nature of Mental Health Trusts over a short three-year period. This changing picture was due to restructuring, merging of services, and changes to service providers during a period of economic recession.

Stage 5: **Policies**

We requested that each trust pick the key policies that were being used actively to support good mental health in the workforce and identify whether they are used 'proactively' (i.e. in a preventative/supportive way, e.g. activities that occur before someone becomes ill), or 'reactively' (after an event, e.g. when there has been a violent incident), using the following template:

Table 5 - Self assessed impacts of policies and procedures on mental wellbeing

Direct Impact (Examples)	Indirect impact (examples)
Prevention and Management of Violence	Sickness Absence Policy
Health at work policy	Substance Misuse Policy

The lack of agreement between the trusts as to which policies had direct and indirect impact on mental wellbeing is of note. The only policy to feature more than once in 'direct impact' policies was 'prevention and management of violence'. In respect of 'indirect policies', the pattern was similar with 'managing attendance/sickness absence' policy being the only indirect policy to be identified by two of the five trusts.

Whilst there was little agreement between the Trusts, overall they included a wide breath of policy as having a direct impact on mental wellbeing with a similar picture for indirect impact. This most likely reflects the make-up of the group that determined the categories, with individuals working to a particular set of policies championing their importance within this arena. These choices reflect, to a degree, findings from ENWHP (2011) which consider that promoting health in the workplace requires the focus on areas of policy, human resources (HR) and work organisation, social responsibility, the planning and implementation of WHP and its evaluation.

It is interesting to note that no policies regarding improving lifestyles were chosen, whilst we know that the evidence indicates (Daley & Parfitt, 1996, cited in Danna & Griffen, 1999; Graveling et al., 2008; WHO, 2008, & Matson-Koffman et al., 2005 cited in Burton, 2010) physical activity has both protective and rehabilitative impacts on individuals with common mental health illnesses, and is very cost effective.

We would like to encourage the trusts to consider further whether the policy environment supports research from Marmot (Status Syndrome 2004) with employees reporting worse health when:

- Their employment is unsecure
- Their work is monotonous
- They have little control
- They feel exploited

- There is an absence of social support networks and 'voice institutions' such as Trade Unions
- There is an absence of procedural justice, they are not confident of being treated fairly

In The Marmot Review of 2010 (Fair Society: Healthy Lives) the report describes how work can prevent ill health through developing what is called 'good work'. Good work is characterised by the following:

- A living wage
- Having control over work
- In-work development
- Flexibility
- Protection from adverse working conditions
- Ill health prevention and stress management strategies
- Support for the sick and disabled that facilitates a return to work

Trusts were asked to consider, in a participatory way with staff and managers:

- Whether the policy environment of the trust supported the development of 'good jobs'
- Whether the current policies were proactive to prevent, where possible, the onset of problems
- Whether the current policies sufficiently negated the work-based causes of poor mental health

To improve psychosocial health, policies for which evidence of effectiveness exists (see above) include those that focus at both organizational and individual levels (particularly, multidisciplinary approaches), for example:

- Interventions that combine changes to the work environment, whilst at the same time providing employees with mechanisms (including psychosocial training) for coping with adverse events – an example of these would be work/life balance policies which provide flexible working opportunities, plus the opportunity for policies, i.e. 'stuck not sick' policies that can be used in emergencies
- Improved leadership and communication
- Policies relating to lifestyle, particularly those i.e. focusing on physical activity, diet, smoking and alcohol use – e.g. healthy eating policies, facilities to enable employees to shower at work etc.
- Job redesign (including for example: increasing job control and autonomy, changing shift designs)
- Involving employers/managers in promoting mental health at work
- Early diagnosis and treatment, particularly CBT for those who are experiencing mental health problems at work

Stage 6: -Training

Following on from the policies we asked trusts to identify what training was available that related to the policies identified above.

Table 6 - Self assessed impact of available training on mental wellbeing

Training – Direct Impact	Training – Indirect Impact
Managing Attendance Training	Conflict resolution
Leadership and Management Development Pathway	Effective People Management
Health & Safety Training	

Again, the range of training that the Trusts reported being either directly or indirectly related to mental wellbeing were very diverse. The only training that was identified by more than one trust as relating to wellbeing included Managing Attendance, and Leadership training.

The NICE Guidelines on 'Promoting mental wellbeing through productive and healthy working conditions: guidance for employers' advocates the strengthening of the role of line managers in promoting the mental wellbeing of employees through supportive leadership style and management practices through:

- Promoting a management style that encourages participation, delegation, constructive feedback, mentoring and coaching
- Ensuring that policies for the recruitment, selection, training and development of managers recognise and promote these skills
- Ensuring that managers are able to motivate employees and provide them with the training and support they need to develop their performance and job satisfaction
- Increasing understanding of how management style and practices can help to promote the mental wellbeing of employees and keep their stress to a minimum
- Ensuring that managers are able to identify and respond with sensitivity to employees' emotional concerns, and symptoms of mental health problems
- Ensuring that managers understand when it is necessary to refer an employee to OH services or other sources of help and support
- Considering the competency framework developed by the Chartered Institute of Personnel and Development, the Health and Safety Executive and Investors in People as a tool for management development

Trusts were asked, in a participatory way with staff and managers:

- To review the current suite of training against the NICE guidelines
- To identify and fill any gaps between the NICE Guidelines and their own policy environment
- Consider how future training will be targeted in light of the data analysis

Stage 7: **Staff Survey data**

The staff survey results for 5 key indicators, identified in the NHS Health and Well-being Framework as 'key factors to focus on', have been mapped over three years, although the violence indicators questions have been subject to some change. These 5 key indicators have been found to be predictors of absenteeism, with more engaged employees having much lower absenteeism levels (West, Dawson, Admasachew & Topakas, 2011). Table 7b (below) also shows the Overall Staff Engagement Score, abstracted from the NSS, and averaged over 3 years.

Table 7a – Staff Survey Results

Key Indicators of absenteeism		Average over 3 years (where data available)					
		National 2012 Average	TRUST 1	TRUST 2	TRUST 3	TRUST 4	TRUST 5
Staff satisfied with the quality of work	**KF1 (No Change)**	76%	78%	-	76%	76%	74%
Having an Appraisal in the last 12 months	**KF12 > KF13 (No Change)**	84%	79%	-	73%	81%	87%
Suffering from work related stress	**KF18 > KF19 (No Change)**	35%	30%	-	30%	33%	29%
Physical violence from staff, patients, members of the public	KF23 > KF24 Change in the wording and format of the questions used to calculate the Key Finding	15%	19%	-	13%	15%	11%
E+D training in the last 12 months	**KF36 > KF38 (No Change)**	62%	64%	-	48%	40%	66%

Table 7a indicates that for KF1 all four trusts for which we had data were close to the national average. In respect of KF12/13 three of the trusts were below the average, with one trust being above the average; for KF18/19 all of the trusts were slightly below the average; for KF23/24 one trust was above the average, with the other three close to, or below the national average; in respect of KF35/KF38 two of the trusts were above the average, with two of the trusts significantly below the average.

Table 7b – Overall Engagement Score

Average over 3 years (where data available)					
	TRUST 1	**TRUST 2**	**TRUST 3**	**TRUST 4**	**TRUST 5**
Overall Staff Engagement Score	3.71	3.64	3.68	3.64	3.66

The Overall Engagement Score is made up of the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (KF22); their willingness to recommend the trust as a place to work or receive treatment (KF22); and the extent to which they feel motivated and engaged with their work (KF25) For mental health and disability trusts the UK national average Engagement Scores for 2009, 2010, and 2011 were 3.63, 3.64, and 3.61 respectively. We can see from Table 7b that the average score over the 3 years that were reported are equal or higher to these averages.

Across the five trusts there did not appear to be any relation between these indicators and the ESR statistics on mental wellbeing. For example Trust 1 and Trust 5 had the highest per capita rates of FTE days lost to common mental ill health per business unit per year – however, this does not seem to relate to staff satisfaction (above); the number of people reporting suffering from work-related stress or the other staff wellbeing indicators.

4.2 Objective 2 – Design a systematic process for determining the necessary intervention(s) to meet the identified need(s), from those available with an evidence base

An outcome of the project was the proposal to develop a new 'dashboard' (eWIN Staff Health Indicator), which would include both ESR data and data collected through the NHS survey. It is anticipated that this dashboard will enable organisations to:

- Identify potential areas of concern
- Demonstrate good practice reporting methods
- Provide accurate and transparent calculations

The anticipated benefits of this dashboard are:

- Links to Health and Well-Being Community homepage and resources to link data to action plans
- ESR data from the data warehouse
- Timely workforce analysis on a year basis, providing trend and current position
- Give a template of calculations to promote a streamlined organisation-level reporting to enable identification of absence types and patterns
- Potential for benchmarking and comparison promoting good practice and cross-organisation engagement
- The benefit of showcasing different analysis of ESR data that can be replicated at business unit level within the trusts

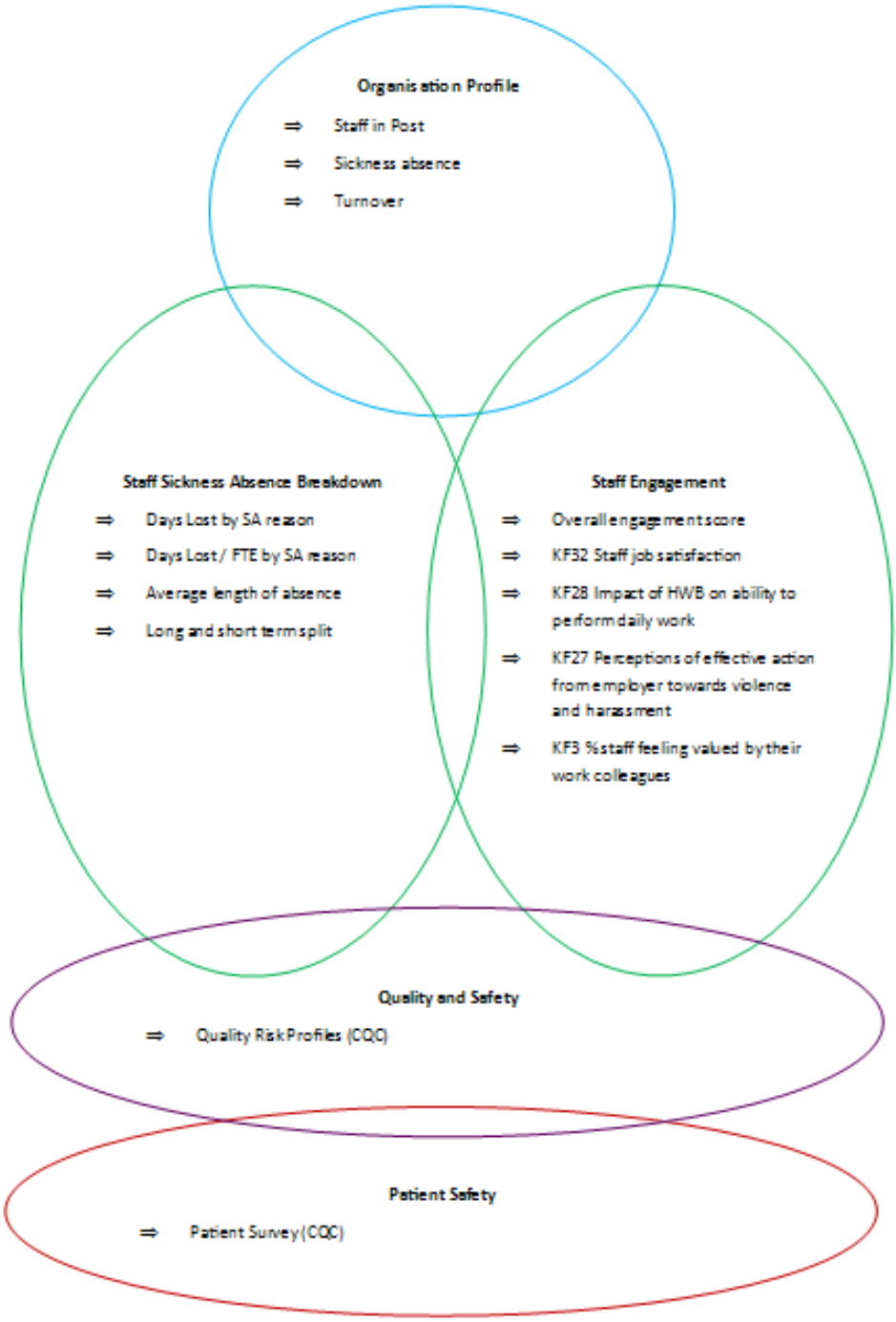
Reports

Analysis Theme	Metric	Measure	Calculations	Inclusions/Exclusions	Time Frame	Frequency	Source
Organisation Profile	Staff in Post	FTE	= sum organistion FTE	**Inclusions:** Permanent, Fixed Term, Temporary, Hosted staff against employing authority **Exclusions:** Bank, Agency, Locum, GP and Practice, Honorary Staff, Hospice assignments	Rolling three year	Monthly update	ESR Data Warehouse
	Sickness Absence	Sickness absence rate Can be drilled down by Staff Group and Afc Band	= (FTE Days lost / FTE Days available) * 100	**Inclusions:** Permanent, Fixed Term, Temporary, Hosted staff against employing authority **Exclusions:** Bank, Agency, Locum, GP and Practice, Honorary Staff, Hospice assignments	Rolling three year	Monthly update	ESR Data Warehouse
	Turnover	Annualised turnover	= sum 12 month ((total leavers/(month SIP + next month SIP)/2)*100))	**Inclusions:** Permanent, Fixed Term, Temporary, Hosted staff against employing authority **Exclusions:** Bank, Agency, Locum, GP and Practice, Honorary Staff, Hospice assignments	Rolling three year	Monthly update	ERS Data Warehouse
Staff Sickness Absence Profile	Days Lost by Sickness Absence Reason	FTE or calendar days	= sum days lost by sickness absence reason	**Inclusions:** Permanent, Fixed Term, Temporary, Hosted staff against employing authority **Exclusions:** Bank, Agency, Locum, GP and Practice, Honorary Staff, Hospice assignments	Rolling annual or Rolling quarter	Monthly Update	ESR Data Warehouse

	Days Lost per FTE by sickness absence reason	FTE or calendar days	= sum days lost by sickness absence reason / sum FTE	**Inclusions:** Permanent, Fixed Term, Temporary, Hosted staff against employing authority **Exclusions:** Bank, Agency, Locum, GP and Practice, Honorary Staff, Hospice assignments	Rolling annual or Rolling quarter	Monthly Update	ESR Data Warehouse
	Average length of employee absence	FTE or calendar days	= sum days lost by sickness absence reason / sum employees by sickness absence reason	**Inclusions:** Permanent, Fixed Term, Temporary, Hosted staff against employing authority **Exclusions:** Bank, Agency, Locum, GP and Practice, Honorary Staff, Hospice assignments	Rolling annual or Rolling quarter	Monthly Update	ESR Data Warehouse
	Long and short term split	FTE or calendar days Long-term = equal to or greater than 28 days lost Short-term = less than 28 days lost	Long term = count of summation of days lost equal to or greater than 28 by sickness absence reason Short term = count of summation of days lost less than 28 by sickness absence reason	**Inclusions:** Permanent, Fixed Term, Temporary, Hosted staff against employing authority **Exclusions:** Bank, Agency, Locum, GP and Practice, Honorary Staff, Hospice assignments	Rolling annual or Rolling quarter	Monthly Update	ESR Data Warehouse
Staff Engagement	Overall Engagement Score	Score	Calculated by NHS Staff Survey	Survey completed from portion of organisation's staff	Annual	Annual	NHS Staff Survey
	KF32 Staff job satisfaction	Score	Calculated by NHS Staff Survey	Survey completed from portion of organisation's staff	Annual	Annual	NHS Staff Survey
	KF28	Score	Calculated by	Survey completed from	Annual	Annual	NHS Staff Survey

	Impact of HWB on ability to perform daily work		NHS Staff Survey	portion of organisation's staff			
	KF3 % staff feeling valued by their work colleagues	%	Calculated by NHS Staff Survey	Survey completed from portion of organisation's staff	Annual	Annual	NHS Staff Survey
	KF27 Perceptions of effective action from employer towards violence and harassment	Score	Calculated by NHS Staff Survey	Survey completed from portion of organisation's staff	Annual	Annual	NHS Staff Survey
Quality and Safety	Quality Risk Profiles	N/A	N/A	N/A	N/A	N/A	Link to: http://www.cqc.org.uk/organisations-we-regulate/registered-services/quality-and-risk-profiles-qrps
Patient Survey	Patient Survey	N/A	N/A	N/A	N/A	N/A	Link to: http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

Dashboard Map



4.3 Objective 3 – Pilot and qualitatively evaluate the process/toolkit

Evaluation Questions:

What were your initial feelings about the process of going through an assessment of mental health needs in your trust (both positive and negative)?

The Trust were really enthusiastic about being selected for this process and thought that we would be able to gather further data to enhance our own sickness recording figures. The Trust were also really positive and looking forward to the recommendations and outcomes of the data.

Positive feelings to a) see if what we currently do is worth doing, b) learn more about a mental health needs assessment process on a large scale, c) To learn something that we can put into practice if we are not already doing it, d) continue to drive forward wellbeing momentum within the trust.

Negative feelings were a) how long will this take, b) data collection and analyzing can take time, c) Will we gain anything from this process?

How did you find the process of data-collection (both positive and negative)?

From the first initial meetings the Trust thought that the data collection would be fairly straight forward as our Workforce Department already collect most of the information required using ESR.

However, by the end of the process we were very disheartened. The process turned out to be a huge task for our Workforce Analyst as after two attempts at submitting data we were eventually sent a template with the specific data requirements.

It would have been useful if every Trust had been given the same template to complete at the start of the data collection and not at the end of the process.

Honest answer is very time consuming due to the fact that we had to go back and re-do all of our data reports. I think for the future it would be good to establish the data set criteria first.

It was however good to look at all the data together rather than in silos. This gave us a much bigger picture and colleague can see how lots of things impact on wellbeing.

What was the learning involved when you received your report (both positive and negative)?

The report did not provide the Trust with any additional information that was any different to what we already collect and submit on a monthly basis.

I'm not sure that the report gave us any new information. But what it has taught us is the process and to look at everything all together. The main thing that I took away was about how we commission future services for our staff and how we ask them to report to including rates!

Do you think the data told you much about the mental health needs of the workforce?

Again it told us what we already know that there are certain Bands within the Trust that have higher sickness levels than others. It did however, highlight higher sickness levels in different Boroughs and the Trust can identify issues at the times of higher sickness levels.

Yes I think it did and it also highlighted areas that we should perhaps seek further support for, or engage with to make improvements but also areas that appear to be managing absence well to see how they are doing it. It did also further support the need to reduce the number of days absent people are due to mental ill health and support our pilot of a mental health pathway.

How did you use the data to determine the types of interventions needed?

We identified the need to support employees by providing early intervention for mental ill health. We want to reduce the length of absence moving forward.

Did you collect any additional data to help you with the above task?

No

No, but we are collecting data from our pathway pilot to help determine if it is effective.

Has the process impact on the ways you are currently now (e.g. how you collect/use data, performance management etc)

No I think we already collect sufficient sickness figures and can manipulate them in different formats.

It will help us when we look at our support services such as OH and Staff Counselling to identify pathways and the timeliness of the support that they provide. We will also be looking to revise the way that we ask these services to report in the future and how we can link to ESR data.

What interventions have you (or are you going to) put in place as a result of this process?

Not yet, we have a meeting on the 1 October to decide which interventions we are going to use and areas to target.

The Trust already have a robust Physical Health and Well Being Programme in place.

Promoting Healthy Minds at Work – Mental health pathway. We are also looking at offering CBT for all staff.

If you have put intervention in place – how do you think they are going?

Too early to say

Anything you would like to say about the process?

The project timescales have been pushed out significantly, which we presume to be due to the submission of data from all Trust's. It would have been better to have already have the interventions in place and up and running for a while prior to the Showcase Event taking place to be able to demonstrate any outcome and impact of the project.

It has been a good learning experience and I am sure some of the pilot group members will remain in touch to support each other. It has been beneficial and valuable to work with Salford University to debate and discuss issues.

4.4 Objective 4 – Support Commissioning, by the trusts, of the identified interventions

Following the needs assessment process, the five trusts put a range of interventions in place, see Table 8 below:

Table 8 - The identified interventions in each Trust

Trust	Intervention	Rationale for intervention
TRUST 3	Implementing a new OH pathway for staff with mental health issues with earlier intervention following triage and onward referral to therapy, counselling, psychiatry or back to OH nurse or GP. 1st day absence reporting system funding now being sort internally	Levels of mental ill health related absence in the trust. Pilot sites were targeted at the areas with the highest MH absence The average length of absence for mental ill health causes indicated a need to intervene more quickly Can link to ESR giving live data and look to reducing repetitive absences
TRUST 4	Six month trial with EAP provided to offer fast track counselling and face to face counselling (difference from original supplier) Noted provider was happy to deliver data that would match to ESR. Self referral service with triage and link to OH provider Also now offering, again through the EAP provider, a 'manager advice line' to assist managers to broach the subject of mental ill health with staff.	Reports broken down to directorate level and areas of concern reviewed at a 'local' level. Further data gathered directly from individuals who had had a MH related absence more than 6 months ago
TRUST 1	Series of 2 day events targeting Adult Impatient and Forensics (though the latter may be delayed as not the 'right' time given organisational change) Pathfinder monies are funding the courses. 2 day agenda previously sent, includes some self care alongside further consultation on interventions to set future directions of the HWB strategy	Discussion at HWB Group, data confirmed hotspots they were also identifying. Now targeting 2 of the hotspots and want to measure the impact.
TRUST 2	Not known	Further focus groups were being undertaken and a report was due to go to the board with priorities.
TRUST 5	Utilising the services of an Occupational Psychologist to undertake a wider audit using NICE guidelines and inform a 'more strategic approach'. (Pathfinder monies are funding this) Instigated workshops on supporting personal change that includes a session on MWB and change.	Secondment of project lead (Vanessa) has "given the trusts an opportunity for a pause". Current work chosen does not appear to have been driven by pathfinder work or have a MH priority.

4.5 Objective 5 – Qualitatively evaluate the interventions at the individual and organisational level

Due to the timescales being extended, at the time of writing it was not possible to evaluate the interventions at the individual and organisation levels, as these were either awaiting implementation, or had very recently been implemented. Notwithstanding this, the trusts are in a good position to evaluate these interventions themselves, against the baseline identified in the HNA carried out as part of this study, together with further exploration that was carried out by the individual trusts.

5.0 Conclusion

We would like to thank the trusts for their time and considerable effort in providing us with the wide variety of data that has been requested during this phase of the pathfinder. The information has varied in quality and quantity and confirmed the findings of others in that whilst much useful data is gathered, the data is generally only available in and useable in a fragmented manner. Zwetloot et al. (2010) found that '*as a result, the business impact of health interventions was neither properly evaluated not consistently managed*'. The Boorman Review has asserted that all NHS Trusts have an evidence based health and wellbeing improvement plan. For this to occur the plan and actions need to be drawn from high quality data, that allows success to be measured.

The current data picture does not allow for success to be shown from either internally or externally provided interventions, and therefore precludes any ability to place a value against current and future work. We recognize the importance of the Quality, Improvement, Productivity and Prevention (QIPP) agenda in ensuring finances are targeted in the most critical areas. In order for this to truly apply to health and wellbeing a needs assessment approach, of which this report forms a part, is required to be able to see where the targets lie and provide a baseline of data to monitor the impact of future work aimed at those targets.

6.0 Recommendations

1. To continue to use the ESR system in a systematic way – reporting mental ill health absences per capita rates (as opposed to numbers) and by band, business unit/quarter and look at changes in trends in order to understand where improvements are being made or 'hotspots' are occurring in the organisation. Ideally this data set should be linked (whilst confidentiality is maintained) to other key indicators of health and wellbeing in the organisation, such as OH data, RIDDOR reporting, Staff Survey Data etc., to generate the most meaningful and useful information on different sectors of the workforce.
2. To discuss this data/information at senior level (Chief Executive/Board) meetings across the organisation so that management of health of the workforce becomes a high-level business priority for the organisation.
3. To ensure the workplace acts as an exemplar for health and wellbeing, particularly in respect of healthy lifestyle choices, such as good nutrition, physical activity provision etc.
4. To continue to engage a multi-disciplinary team across the organisation (HR, H&S, Trade Unions, OH etc) who can ensure a joined up health and wellbeing agenda (including ongoing, participatory HNA) for the workforce can be taken forwards.
5. To improve engagement of staff in health and wellbeing planning.
6. To encourage the ongoing development of the policy environment in order to proactively support the health of the workforce, particularly looking at the types of policies which encourage: a positive psychosocial environment, where autonomy and flexibility are encouraged; and a 'healthy' corporate culture including staff leadership, staff development, worklife balance, and health promoting lifestyles.
7. To continue to encourage the involvement of middle managers in the active use of the data/information in order to proactively manage the health of their staff and ensure early intervention is achieved and facilitate rapid return to work when a member of staff is off sick.
8. To ensure that training provision for managers and staff is fit for purpose in terms of the management of mental health and sickness absence.
9. To provide managers with a forum for capturing and exchanging good practice with respect of managing health at work issue, in particular mental well being.
10. To ensure that OH provision is required to provide detailed evidence of effectiveness including (this should be included in the contracting requirements)
    a. data on throughput of staff through the service: by band, grade, location per capita/quarter

b. data on completion and/or adherence of OH programme: by band, grade, location per capita/quarter
c. data on effectiveness of OH programme: by band, grade, location per capita/quarter

11. To improve the reporting requirements of RIDDOR data, as above, namely, by band, business unit/quarter within the organisation in order that rates, rather than numbers can be generated, which are more useful to develop a risk assessment process that can ensure that psychological impact is assessed in terms of harm alongside physical impact. It should also be noted that psychological impact may not be immediate and may need reassessment if the harm presents after a period of time.
12. To map future mental health and wellbeing interventions against the specific needs of the organisations using data as identified above and an ongoing process of needs assessment
13. To evaluate these interventions in terms of
    a. throughput of staff through the interventions: by band, grade, location per capita/quarter
    b. data on completion of/adherence/compliance with interventions: by band, grade, location per capita/quarter
    c. data on effectiveness of interventions: by band, grade, location per capita/quarter

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