NHS Health & Well-being Improvement Framework

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Description	This document has been put together primarily for decision makers on Boards, to support them in establishing a culture that promotes staff health and well-being. It sets the framework for improvement work that is needed in many organisations and across the regions. It focuses, in particular, on improvement to occupational health services.
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For Recipient's Use	

NHS Health & Well-being Improvement Framework

2011/12

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Contents

Introduction

Why is it important to support staff health and well-being?

1. Delivery of NHS services involves one of the world's largest workforces and the health and well-being of this significant proportion of the UK working population is crucial to the delivery of continued improvement to patient care.

2. Organisations need to develop an approach to support the health and well-being of their staff that encompasses the full range of staff experiences. They need to support staff to assess and take responsibility for their own health as well as promoting healthy options and providing prevention, intervention and rehabilitation services where these are required. External scrutiny and monitoring will help to ensure that improvements are made. However, the real drive must come from within organisations, making a real commitment to improve in response to staff experiences. The NHS staff survey is a key source of staff experience information that will help to inform improvement.

3. The NHS Constitution includes a commitment to *"Provide support and opportunities for staff to maintain their health, well-being and safety"*. This commitment remains as strong now as it did when the NHS Constitution was launched in January 2010. Many organisations have taken this commitment on board in developing services. But in many organisations, staff still report poor experiences, suggesting that the pledge is not becoming a reality for all.

4. Strong evidence shows that NHS organisations that support the health and well-being of their staff achieve a range of positive outcomes. The level of health and well-being of the workforce is a key indicator of organisational performance and patient outcomes. The evidence makes it clear that cultures of engagement, mutuality, caring, compassion and respect for all - staff, patients and the public - provide the ideal environment within which to care for the health of the nation. When we care for staff, they can provide outstanding professional care for patients[1].

5. Dame Carol Black set out the national vision for a healthy workforce that would benefit the economy[2] and continues to drive improvement across the workforce. Following a commission from the Department of Health (DH), in 2009, Dr Steve Boorman conducted a review of NHS Staff Health and Well-being. In his report, Dr Boorman predicted that £555 million productivity improvements could be realised by reducing NHS staff sickness by a third[3].

6. The NHS has shown its commitment to reduce sickness absence to agreed levels by March 2013 through the Quality Innovation Productivity and Prevention (QIPP) programme. High levels of staff engagement, as reported through the NHS staff survey, also correlate with

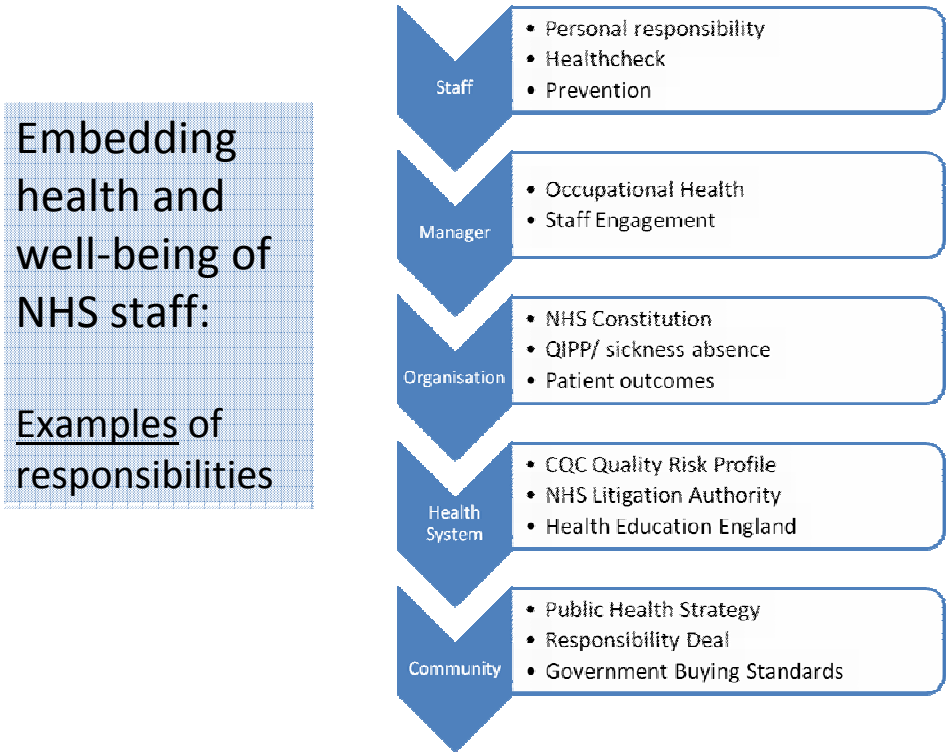
[1] Taken from draft research report by West, M.A and Dawson, J.D (2011) *NHS staff management and Health service quality* : publication forthcoming
[2] "Working for a healthier tomorrow" Dame Carol Black 2007
[3] Boorman, S, "NHS Health and Well-being: Final Report", Department of Health, November 2009

high performance as measured in the NHS Outcomes Framework. Focusing on health and well-being is an important way in which employers can raise levels of staff engagement, deliver QIPP ambitions and achieve better patient outcomes.

7. The Government is committed to establishing a culture that supports a healthy workforce[4]. The Government Strategy for Public Health[5] set out that employee health and well-being is vital to support staff quality of life and the performance of any organisation. The Public Health Responsibility Deal establishes a framework to improve the health and well-being of the population through their experience at work.

8. Our vision is for the full breadth of NHS staff health and well-being needs to be met as part of an organisation and system-wide approach to improving health in the workplace. Suppliers of occupational health services to healthcare staff will play a key part in the delivery of safe, effective and efficient patient care through promoting and protecting the health of staff. They will achieve this by working closely with HR departments and managers from across disciplines.

9. The diagram below illustrates key responsibilities in embedding improvements to the health and well-being of staff in the NHS.



[4] The Health White Paper "Equity and Excellence: Liberating the NHS", stated a clear commitment to improve staff health and well-being. This is repeated in the Public Health White Paper "Healthy Lives, Healthy People: Our Strategy for Public Health in England, December 2010". The Operating Framework for the NHS in England 2011/12 states that "The NHS remains committed to protecting and improving staff health and well-being and reducing unnecessary sickness absence".

[5] Healthy Lives, Healthy People: Our Strategy for Public Health in England

Purpose of this document

10. This document has been put together primarily for decision makers on Boards, to support them in establishing a culture that promotes staff health and well-being. It sets the framework for improvement work that is needed in many organisations and across the regions. Staff health and well-being needs to be championed at Board level but must be addressed at all levels to become embedded into practice.

    - Section 1 defines the scale of the challenge that is faced and the levels of service that regions have indicated they aspire to.

    - Sections 2 and 3 set out information on the service levels that are expected and the metrics available to monitor against these.

    - Section 4 signposts a wide range of materials that may be useful for HR Departments, Health and Well-being Leads and Occupational Health services. Managers across all specialities may find some of the materials helpful in supporting them in managing their staff and teams.

    - Section 5 signposts information that will be particularly helpful for those deciding what health and well-being services should be funded. It encourages the establishment of more formal processes to procure health and well-being services for staff.

Section 1. Ambitions for improvement

11. The NHS staff survey provides information about staff experiences of their health and well-being and the acute in-patient survey shows the value patients place on the quality and availability of staff. For example:

    - The 2010 acute in-patient survey showed that 10% of patients felt there were rarely or never enough nurses to care for them whilst in hospital and 3% did not have confidence and trust in the nurses treating them.

    - The 2010 NHS staff survey showed that 37% of staff reported that either their physical health or emotional well-being had some effect on keeping them from undertaking their daily activities.

12. Both staff and patients have indicated that there is room for improvement. The overarching ambition has to be to address these concerns. Evidence shows that organisations that focus on staff health and well-being will improve their business performance, staff health and patient outcomes. Aiming to achieve the levels of the best in relation to NHS staff survey results is a laudable ambition.

13. As a result of QIPP, the major focus for improving staff health and well-being has been in relation to reducing levels of sickness absence amongst NHS staff to achieve financial

savings. This sits alongside and will support the achievement of paybill and productivity plans. A monetary value is of course not the only indicator of change, but the focus brought by QIPP provides an important driver towards improvement.

14. Current levels of sickness absence among NHS staff mean that 10.3 million working days are lost in the NHS in England each year. The annual direct cost of absence is estimated to be £1.7 billion a year. Eighty percent of NHS staff report that they felt sickness absence had a damaging impact of the quality of patient care. The potential benefits to the NHS of a reduction of sickness absence by one third is equivalent to[6]:

    - a gain of 3.4 million working days per year
    - 14,900 extra whole time equivalents
    - direct cost savings of £555 million per annum
    - a reduction in indirect costs for temporary staff, currently £1.45 billion per annum
    - reduced staff turnover (recruitment costs for new members of staff estimated at £4500 per person)
    - reduced ill health retirement costs (currently estimated at £150 million per annum)

15. The 2011/12 NHS Operating Framework includes the reduction of sickness absence rates in the NHS as a key indicator against which SHAs will be held to account. SHAs agreed in October 2010 to reduce levels of sickness absence to 3% in the South (East of England, London, South East Coast, South Central and South West) and to 3.4% in the North (North East, North West, Yorkshire and Humber, East Midlands, West Midlands). These ambitions will continue as SHAs move to cluster arrangements.

Section 2. Service levels for improvement

16. The model of provision that organisations should aim to achieve is set out in "Healthy Staff, Better Care for Patients: Realignment of Occupational Health Services to the NHS in England" available on the DH Website. This document sets out key findings from a DH-led review. It provides a vision for the provision of health and well-being services to the NHS and recommendations for change. A copy of the recommendations is provided at Annex A.

[6] All reference in para 14 are taken from Boorman, S, 2009. The 2011 Audit Commission report "Management of Sickness Absence in the NHS" suggests more conservative estimates of potential savings.

17. "Healthy Staff, Better Care for Patients" establishes the expectation that organisations will ensure that six core services are available for staff in the NHS:

    - Prevention – of ill health caused or exacerbated by work.
    - Timely intervention – easy and early treatment for the main causes of sickness absence in the NHS.
    - Rehabilitation – to help staff stay at work or return to work after illness.
    - Health assessments for work – to help manage attendance, retirement and related matters.
    - Promotion of health and well-being – using work as a means to improve health and well-being and using the workplace to promote health.
    - Teaching and training – encouraging staff and managers to support staff health and well-being.

18. The Faculty of Occupational Medicine launched a new accreditation system for occupational health providers on 1 December 2010. NHS organisations should ensure the services they make available meet the NHS specific domain of this accreditation system (Annex B), which reflect the model outlined above. All NHS occupational health providers should be fully accredited, or ready for accreditation by 31 March 2012.

Section 3. Monitoring improvement

19. The NHS Commissioning Board will have a key interest in staff health and well-being in the future system. Alongside Clinical Commissioning Groups, the current Health and Social Care Bill proposes, subject to legislative scrutiny, that the NHS Commissioning Board will have a duty to promote and have regard to the NHS Constitution, of which a commitment to staff health and well-being is a part.

20. Other organisations could also have a role, to ensure that providers support the health and well-being of NHS staff, for example:

    - Local Authorities/ Health and Wellbeing Boards to act as a locus for workplace health.
    - Care Quality Commission to ensure providers meet essential quality and safety levels through their quality risk profile.
    - NHS Litigation Authority to take an organisations health and well-being record into account when assessing NHS organisations for risk management.
    - Healthwatch to highlight locations, where staff are not being properly supported, based on patient experiences and reporting.

- Health and Safety Authority to set and promote service levels for occupational health and safety.
- Local Education and Training Boards to ensure future delivery of supply for OH services through workforce planning and education commissioning.
- Health Education England to factor health and well-being into its Education Outcomes Framework, consider outcomes as part of its inspection regime and allocate Multi-Professional Education and Training funding accordingly.
- Continuous Quality Improvement Network (CQIN) to reward organisations that deliver high levels of health and well-being.
- The National Social Partnership Forum to help drive and promote local improvement.
- Staff and patients to report their experiences through annual surveys and through ongoing feedback mechanisms e.g. Local Healthwatch.

21. Organisations now, and in the future system, will draw on a range of metrics to monitor achievement of improvements and to hold providers to account. Information is available at three levels – local, regional and national.

22. At a local level, Boards of NHS organisations are accountable for the effective provision of services to meet the obligations in the NHS Constitution and to meet legal duties of care in relation to the health and safety of staff. Usually the HR Director, but sometimes the Medical Director or Director of Nursing, will take responsibility for championing this agenda, to ensure comprehensive health and well-being support is available. Improvement must be addressed at all levels though and it is the responsibility of all mangers and leaders. A joint approach between divisions and/or directorates may have most impact and effect. A wealth of data is available that could present a more holistic and accurate picture of progress. Key metrics are suggested at Annex C.

23. Organisational performance can be benchmarked using NHS staff survey results. Key factors to focus on are; whether staff feel satisfied with the quality of work and patient care they are able to deliver; having an appraisal in the last 12 months; suffering work-related stress; physical violence from staff, patients or members of the public in the last 12 months; having equality and diversity training in the last 12 months. Most importantly, trusts with engaged employees have much lower absenteeism. If staff survey engagement scores increase, absenteeism is much more likely to decrease.

24. At a regional level, SHAs monitor average sickness rates on a monthly basis so they can identify any trends in sickness absence. They can use this information to work with organisations to help identify the most appropriate support mechanisms to achieve improvements. This will continue as SHAs move to cluster arrangements.

25. At a national level, regional performance is compared against trajectories based on sickness absence figures. This data is submitted through the Centre for Workforce Intelligence and published on a quarterly basis by the Information Centre. Following each publication, the DH will assess progress of each region and discuss any areas of concern with the SHA.

26. In addition to quarterly sickness absence data, the NHS staff survey is published on an annual basis, to identify trends in staff experiences of health and well-being at work and presenteeism.

Section 4. Achieving improvement

27. Organisations that achieve improvements, by implementing the recommendations in "Healthy Staff, Better Care for Patients" and achieving Faculty of Occupational Medicine accreditation, will be well placed to:

- Deliver the duty to have regard to the NHS Constitution, including the health and well-being pledge to staff and legal duties in relation to staff health and safety.
- Provide improved and more consistent performance on staff health and well-being, which will support delivery of the NHS Outcomes Framework.
- Meet ambitions to reduce levels of sickness absence and contribute to QIPP savings.
- Be well positioned to meet CQC essential quality and safety levels and registration requirements.

28. The following information outlines the range of supporting materials that will help organisations to achieve the improvements and service levels required. Personalised and tailored support is available and there are coordinated initiatives that may provide the structure and direction that is helpful for some organisations.

Guidance

34. To support progress, organisations should consider adopting five high impact changes.

Five High Impact Changes for Health and Well-being

1. Ensure your health and well-being initiatives are backed with strong leadership and visible support at board level. Producing an annual report of the organisation's well-being will help to communicate commitment and progress
2. Develop and implement an evidence-based staff health and well-being improvement plan to meet your organisation's needs. This should be prepared and agreed in partnership between management, staff and unions and progress monitored regularly.
3. Build the capacity and capability of management at all levels to improve the health and well-being of their staff. This will include recognising and managing presenteeism, conducting return to work interviews and supporting staff with chronic conditions.
4. Engage staff at all levels with improving their own health through education, encouragement and support
5. Use an NHS occupational health service that offers a targeted, proactive and accredited support system for staff and organisations.

35. Two key web resources provide materials and guidelines to build on these five high impact changes. Firstly, the "Health and well-being toolkit" supports organisations to establish a baseline for the challenge they face. It includes a Board level business case presentation, a strategy template, a readiness assessment tool and a staff engagement questionnaire. Secondly, NHS Employers host the "NHS well-being portal". This brings together a comprehensive and continuously updated range of resources, including case studies of good practice.

36. Other national reviews and reports will provide a sense of the scale of the challenge and alternative perspectives on how to move forward. These include "Management of long-term sickness and incapacity for work" (NICE 2009) and "Management of Sickness Absence in the NHS" (Audit Commission 2011). The current DWP review of sickness absence will also provide insight into reform and rebalancing of incentives to support the management of sickness absence.

Initiatives

37. In the interests of saving Board time, the following paragraphs outline a number of initiatives that could be used by organisations to accelerate the pace at which they achieve improvements. By getting involved in these, organisations can share and compare progress with others and gain recognition for the commitment they are making to the health and well-being of their staff. This list is by no means exhaustive.

38. The NHS Sport and Physical Activity Challenge was launched by David Nicholson in July 2010. Staff who are more physically active are less likely to suffer mental and physical ailments. The London Olympics provide a real stimulus to many people to get active. The Sport and Physical Activity Challenge provides a mechanism through which NHS organisations can inspire their staff and show they value an active workforce.

39. The Public Health Responsibility Deal has been established by the Secretary of State for Health to tap into the potential for business and other organisations to improve public health and tackle health inequalities through their influence over food, alcohol, physical activity and health in the workplace. NHS organisations are well placed to become partners and join this broad partnership of public health, commercial and voluntary organisations. The Responsibility Deal's health at work and physical activity pledges aim to help employees and the wider public take positive steps to improve their health and well-being, these are well aligned with the ambitions set out in this framework. All NHS organisations are therefore strongly encouraged to sign up to the Responsibility Deal.

40. The Government buying standards for food were launched on 16 June 2011. NHS organisations were encouraged to use these through the Operating Framework for the NHS 2011-12. Developed by DEFRA and the DH, the standards support and encourage public bodies to provide a healthy balanced diet for public sector workers. They will also help to reduce the environmental impact of food and catering in the public sector.

41. David Macleod and Nita Clarke published “Engaging for Success: Enhancing Performance through Employee Engagement” in July 2009 and are now conducting a follow up to this review and report. This work illustrates the impact of engagement processes on competitiveness and performance. As the next stage of the work progresses, there will be opportunities for NHS organisations to demonstrate how they achieve an engaged workforce and the importance of valuing staff health and well-being in order to do so. A resource pack to support the achievement of high levels of staff engagement in the NHS was published in July 2011.

Practical support

42. A range of practical support can be accessed. NHS Employers provide on-line information and also run events and can tailor support for individual organisations. NHS Plus provide support to occupational health departments, have produced a range of helpful advice and tools and work closely with occupational health physicians across the country. The Health

and Work Development Unit (HWDU) at the Royal College of Physicians runs national audits of implementation of NICE public health guidance for the workplace. Trusts can use their individual results to monitor progress with implementing evidence-based guidance on sickness absence management and health promotion for staff. Trusts can also benchmark their progress against NHS trusts nationally. A range of commercial tools are available, as are free tools, which could help to deliver improvements. For example organisations could encourage their staff to use the NHS Choices Life Check.

Section 5. Procuring for improvement

43. Historically, most organisations have allocated a budget for occupational health services, which has rolled forward from one year to the next. There have been some mixed experiences of procurement of these services. The introduction of more formal processes to procure health and well-being services will unlock the potential to make significant improvements to the health and well-being of staff in the NHS.

44. Health and well-being services that meet the specialised needs of NHS staff will best arise from organisations coming together to form teams that procure services from multi-disciplinary providers offering a range of skills and expertise.

45. The key consideration in deciding on the health and well-being services that will be required is that this is not simply an issue linked to sickness absence or attendance. The aim of the NHS should be to ensure staff are healthy in work and that work helps maintain and improve the health of staff for the benefit of the patients they treat and the organisation employing them. To achieve this, those that decide which services will be funded should concentrate on understanding and addressing the root causes of poor health and well-being rather than just treating the issues arising. Further information will be made available by NHS Employers.

Conclusion and next steps

46. NHS organisations have been set a big challenge, by Dame Carol Black, Dr Steve Boorman and the Government, to improve the health and well-being of their staff. Experts have reviewed the evidence and suggested the improvements that are needed in order to meet this challenge. A wide range of tools and support are available that will guide organisations towards realising change. The framework is now set. The challenge lies with each part of the system to mobilise improvement.

47. The revised timings for transition mean SHAs will continue to oversee performance until the regional ambitions for reduction in sickness absence are due to be achieved in March 2013. They will drive improvement over the next 2 years. During 2011-12 SHA clusters will lead work with pilot sites, to model the way that local health economies can support the health and well-being of their staff.

48. As parts of the new system become established, they will help ensure accountability for staff health and well-being and drive improvement.

49. As NHS organisations consider service changes they must give consideration to the potential impact any changes may have on individuals, to the pressure and apprehension that many staff will feel and the impact this can have on their health. The approach set out through this Improvement Framework is more important now than ever before, to ensure that the future healthcare system is one built on an engaged, healthy and productive workforce.

Annex A

"Healthy Staff, Better Care for Patients" recommendations

Minimum service level agreements for occupational health services

1. It is essential that occupational health services for healthcare staff meet a minimum specification based on the six core services of prevention, timely intervention, rehabilitation, health assessments for work, promotion of health and well-being and teaching and training.

2. All occupational health services must work towards the Faculty of Occupational Medicine accreditation, including a series of quality service levels specific to the NHS. They should achieve this, or be ready to do so, by March 2012.

3. Clear contracts are necessary setting out the services required, the quality and delivery levels expected, together with the cost.

4. NHS organisations should develop the organisational model for their occupational health services that suits the needs of their locality and meets the challenges that geography imposes on accessibility. However, any model adopted should adhere to a set of principles that outline the characteristics of the service:

    - Strong and demonstrable focus on a high quality, clinically-led and evidence-based service.
    - An equitable and accessible service.
    - Impartial, approachable and receptive to both clients and employer.
    - Contribute to improved organisational productivity.
    - Work in partnership with all healthcare services and within the community.
    - Underpinned by innovation.
    - Offer diversity and depth of specialisation and training opportunities.

5. The preferred model needs to ensure that existing staff resources are deployed efficiently using the skills of the whole team more effectively.

6. Consideration should be given to piloting the appointment of occupational health professionals to a number of local public health teams where they could take lead responsibility for advising on occupational health matters.

7. Trainee doctors, in key specialties, should have the opportunity of a clinical attachment to an occupational health department as part of their training. A complimentary arrangement for occupational health trainees would also be helpful.

8. Occupational health services need to have the resource to train both doctors and nurses to specialist level. Effective commissioning of occupational health professionals must be planned carefully.

9. The academic base for occupational health services should be strengthened.

10. The NHS should act on the outcome of the 2003 Public Accounts Committee's recommendation to fast track healthcare staff.

Occupational health data collection and information sharing

11. The collection of information and review of data should be used to:

    - Assess and monitor the health and well-being of the trust workforce.
    - Monitor the activities of the occupational health service.
    - Monitor the quality of the occupational health care.

12. Trusts should receive regular reporting on the work of occupational health services. Key performance Indicators should be reported at a senior level with Trust Boards having the opportunity on a periodic basis to discuss high level data.

Engagement of and with occupational health services.

13. Occupational health services need to take a more proactive leadership role and engage with managers and staff representatives to align their services to the delivery of high quality patient care, HR strategies and NHS Constitution pledges.

14. Training and tailored toolkits should be made available, to all levels of staff, to help provide effective engagement skills.

15. All occupational health services should develop an annual business plan articulating the range of services required and how they will be promoted and marketed.

Annex B

NHS specific occupational health accreditation

NHS Occupational Health Accreditation

The Faculty of Occupational Medicine launched the new accreditation system for Occupational Health providers on 1 December 2010 (www.seqohs.org.uk) Providers of occupational health services to NHS organisations are also required to meet some NHS specific accreditation, detailed below, in addition to SEQOHS service levels.

NHS Service Levels (also referred to as Domain G)

Reference	Minimum Requirements	Prescriptive Evidence
G1 CORE SERVICES		
G1.1	An OHS must be able to deliver each of the six NHS core services to NHS customers	Service Legal Agreement, contract or other document describes an agreement setting out arrangements for each of the six NHS core services, or documentation to demonstrate that the OHS offered such services and that the commissioner declined that service. The six core services are: Prevention – the prevention of ill health caused or exacerbated by work. Timely intervention – easy and early treatment of the main causes of sickness absence in the NHS. Rehabilitation – processes to help staff stay at work or return to work after illness. Health assessments for work – supporting organisations manage attendance, retirement and related matters. Promotion of health and well-being – using work as a means of improving health and wellbeing and using the workplace to promote health. Teaching and training – promoting the health and wellbeing approach amongst staff and managers.
G1.2	An OHS must review services with the NHS customer at least six monthly	Notes of review meeting with the NHS customer dated within the last six months, and documented amendments to the schedule of services applicable.

G2 BUSINESS SERVICE LEVELS		
G2.1	An OHS must cost out services using a costing model that is reviewed or updated annually	A current costing model/tool that covers the main areas of pay and non-pay expenditure. It should include an allowance for 'non-revenue-generating time' e.g. annual leave, other absences, training and development, etc. It should allow for supporting professional activity. It must incorporate an allowance % for Trust overheads. An OHS not providing external services must be able to demonstrate that it has costed out its own internal service provision to its host Trust.
G2.2	An OHS must have a current business plan	The business plan does not need to follow a set format. It may consist of a statement of the key planned work activities and areas for improvement or service development. The plan must be for a minimum of 12 months and up to 5 years. There needs to be evidence that the plan is being reviewed and updated annually.
G3 DELIVERY SERVICE LEVELS		
G3.1	An OHS must offer dates for an appointment within the timescales stipulated within the Service Level Agreement or contract.	Record of an audit within the last 12 months showing that the mean waiting time for access to a service are within the criteria set out in the SLA or contract.
G3.2	An OHS must send reports within the timescales stipulated within the Service Level Agreement or contract.	Record of an audit within the previous 12 months showing the mean time for dispatch of reports are within the criteria set out in the SLA or contract.
G4 CLINICAL SERVICE LEVELS		
G4.1	An OHS must perform systematic audits of clinical care.	Records of two local clinical audits every year and participation in any national NHS OH clinical audits.

Annex C

Key metrics for local monitoring

Table 1 Metrics to monitor staff health and well-being

Metric	Source	Notes	Monitoring period/interval
Sickness absence percent	ESR	% of FTEs lost, overall and by medical cause (may also be broken down by staff category)	Month, year
Incidence of long-term (> 4 weeks) sickness absence[a]	ESR	Number and as % of staff employed, overall and by medical cause (may also be broken down by staff category)	Quarter, year
Prevalence of frequent sickness absence (> 3 spells per year)[a]	ESR	Number and as % of staff employed, overall and by staff category	Year
Prevalence of zero sickness absence[a]	ESR	Number and as % of staff employed, overall and by staff category	Year
Incidence of ill-health retirement	Trust finance department and the NHS Pensions Agency	Number and per 1000 staff employed	Year, annual 5-year moving average
Staff turnover	ESR	Numbers of joiners and leavers expressed as counts and as % of average number of employees during measurement period	Year
Self-rated health	NHS Staff Survey	Frequency distribution – numbers and % of responders	Annual
Disability from poor mental	NHS Staff	Frequency	Annual

health	Survey	distribution – numbers and % of responders	
Perceived managerial interest in personal health and well-being	NHS Staff Survey	Frequency distribution – numbers and % of responders	Annual
Adequacy of adjustments at work for long-standing illness/disability	NHS Staff Survey	Frequency distribution – numbers and % of responders	Annual
Job satisfaction[b]	NHS Staff Survey	Frequency distribution – numbers and % of responders	Annual
Enjoyment of work[b]	NHS Staff Survey	Frequency distribution – numbers and % of responders	Annual
Violence at work[b]	NHS Staff Survey	Frequency distribution – numbers and % of responders	Annual
Harassment at work[b]	NHS Staff Survey	Frequency distribution – numbers and % of responders	Annual

[a]Would be facilitated by development of new reports from NHS Information Centre
[b]Requires derivation and reporting of new summary measures from NHS Staff Survey

Table 2 Metrics to monitor activities of occupational health service

Metric	Source	Monitoring period/interval
Numbers of referrals from managers	OH records	Month, year
Numbers of self-referrals	OH records	Month, year
Numbers of telephone enquiries handled	OH records	Month, year
Numbers of email enquiries handled	OH records	Month, year
Numbers of sharps injuries managed	OH records	Month, year
Numbers of vaccinations given	OH records	Month, year
Numbers of workplace visits	OH records	Month, year
Numbers of training courses/lectures delivered	OH records	Month, year
Numbers of health surveillance assessments made	OH records	Month, year

Table 3 Metrics to monitor quality of occupational health care

Metric	Source	Notes	Monitoring period/interval
Time from management referral to first appointment	OH records	Frequency distribution	Quarter, year
Time from first appointment following management referral to delivery of a report to the manager	OH records	Frequency distribution	Quarter, year
Completeness of referral for longer term sickness absence[a]	OH records and ESR	Number of patients seen by OH service after > 4 weeks absence as % of all employees with > 4 weeks absence beginning in same period	Quarter, year
Return to work following longer term absence[b]	ESR	Number and % of employees with sickness absence spells lasting > 4 weeks who remain off work at 12 weeks	Quarter, year
Completeness of hepatitis B immunisation	OH records	Number and % of sharps injuries managed in which injured member of staff was fully immunised against hepatitis B	Quarter, year
Prevalence of return-to-work planning[a]	OH records	Number and % of patients who when first seen after an absence of four weeks or longer have a documented return-to-work plan	Quarter, year
Prevalence of referral of musculoskeletal disorders for treatment[a]	OH records	Number and % of patients seen after an absence	Quarter, year

		of > 4 weeks because of a musculoskeletal disorder, who are under care of or have been referred to a treatment service by 6 weeks from the start of their absence	
Prevalence of employees on half or no pay because of prolonged sickness absence	ESR	Numbers and as a % of all employees (separately for half and no pay)	Quarterly, annually
Prevalence of dissatisfied OH patients	OH patient satisfaction surveys	Number and % dissatisfied with summary of main reasons for dissatisfaction	Quarterly, annually
Prevalence of dissatisfied managers	OH manager satisfaction surveys	Number and % dissatisfied with summary of main reasons for dissatisfaction	Annually or less
Incidence of patient complaints	OH records	Number with breakdown by nature of complaint	Year
NHS Litigation Authority level	Trust management records		Annually