NHS England

NHS staff health & wellbeing: CQUIN Supplementary guidance

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Contact Details for further information	e.cquin@nhs.net contracting and incentives Quarry House Leeds LS2 7UE

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1 What is the purpose of this guidance?

This document outlines the need for the NHS to improve its offer as an employer to look after the health and wellbeing of its staff. In doing so we will highlight the reasons for taking action, drawing on the emerging evidence within the NHS Healthy Workforce Programme, whilst also providing specific clarification and support to help introduce the measures in the Health & Wellbeing CQUIN.

In addition to this guidance NHS England, alongside NHS Employers and Public Health England, will also provide further support during the year by holding workshops and webinars, producing case studies and providing more hands on support. Further details of this support are outlined on page 9.

1.1 Why is it being issued?

- This guide has four main aims. They are:
    - To provide more context about the need for focussing on health and wellbeing;
    - To provide more information about the content of the schemes, drawing on best practice examples;
    - To provide further information about the methods of assurance and processes behind the £450m incentive within this CQUIN; and
    - To outline future support available during 2016/17 to help with the implementation of the CQUIN schemes.

2 Where do we want to get to: The vision for staff health and wellbeing?

2.1 Why focus on staff health and wellbeing?

In 2015 Public Health England estimated the cost of sickness absence to the NHS at £2.4bn. Some reports have estimated this to be 27% higher than the UK public sector average, and 46% higher than the average for all sectors.

However, there are many reasons that sickness absence rates in the health sector may be higher than average. Work can often be physically, emotionally and psychologically demanding and the NHS is one of few organisations that work 24 hours a day, 365 days per year. Despite these challenges, there is much the NHS can do as an employer to improve staff health and wellbeing. The main benefits are outlined in the sections below.

2.2 The impact on patient care

The NHS health and well-being review led by Dr Steven Boorman and NICE guidance have outlined the link between staff health and wellbeing and patient care, including improvements in safety, efficiency and patient experience from introducing employer led health and wellbeing schemes.

Over 80% of staff who responded to a survey linked to the review believed that the health and wellbeing of staff had an impact on patient care. Similarly, as a Picker Institute report entitled "*Understanding staff wellbeing, its impact on patient experience and healthcare quality*" identified, well supported staff felt that day-to-day pressures were alleviated.

2.3 Caring for our staff

Staff retention rates are shown to improve when staff feels their employer cares about their health and wellbeing. A report published by the Work Foundation entitled "*The Business Case for Employees Health and Wellbeing"* highlights that many of the psychological factors associated with sickness absence also affect employee retention. Not only does better staff retention mean lower recruitment costs but it also often leads to improved team cohesion and better working environments.

But it's not just about staff retention – as an organisation set up to care for our population's health, the NHS has a responsibility to care for the health of the 1.3million employees who work for the NHS. Our staff spend a large portion of their time at work, which is an opportunity to impact positively on their overall health, wellbeing and happiness.

2.4 The impact on NHS finances

Although the overall cost of sickness absence is estimated at £2.4bn even small reductions in sickness absence can have a large impact across the NHS.

If we reduced sickness absence by **1 day** per person per year then the NHS would save **around £150m**, equivalent to around 6,000 full time staff.

These financial savings do not even take into account the reduced use of agency staff or the costs of recruitment to tackle staff retention issues and so are most likely to understate the overall impact on NHS finances.

The benefits to the NHS and to individual Trusts of a healthier workforce are clear:

- improved **patient safety and experience**;
- improved **staff retention and experience**;
- reinforced public health promotion and **prevention initiatives**;
- setting an **example for other industries** to follow; and
- **reduced costs** through lowering the current £2.4bn cost of sickness absence to the NHS.

3 The role of employers in promoting staff health and wellbeing: The NHS Healthy Workforce Programme

3.1 The NHS Healthy Workforce Programme

The focus of the programme has been on improving health and wellbeing for staff in order to help reduce sickness absence, improve patient and staff experience and provide best practice examples for employer's role in promoting health and wellbeing. Eleven NHS organisations have been working with the programme to test different methods of delivering preventative and early intervention health and wellbeing schemes.

The programme has drawn from existing evidence, best practice examples from across the NHS and the private sector and encouraged the 11 organisations to introduce an improved health and wellbeing offer. This document will look to share some of the learning from their work, which can be found in section 4 and Annex 4.

The programme has three specific aims;

- First, to introduce an improved health and wellbeing offer for staff in these 11 organisations and evidence the impact of the interventions.
- Second, to provide a template for how to improve staff health and wellbeing in NHS organisations and other private sector employers; and
- Third, to ensure that by 2020, every NHS organisation is providing excellent health and wellbeing support to their staff.

There are two broad themes within the programme.

- First, a focus on **improving the culture** within organisations, specifically regarding health and wellbeing.
- Second, introducing an improved set of **preventative and early intervention schemes** for staff.

We will be sharing case studies and learning from the organisations within the programme to help the NHS learn from the work they have already done. The 11 organisations are;

- Birmingham Children's Hospital NHS FT
- Bradford District Care NHS FT
- Epsom & St Helier University Hospitals NHS FT
- Northumbria Healthcare NHS FT
- Nottingham University Hospitals NHS FT
- Rotherham CCG
- Sheffield Teaching Hospitals NHS FT
- University Hospital Southampton NHS FT
- Walton Centre NHS FT
- West Midlands Ambulance NHS FT
- York Teaching Hospitals NHS FT

3.2 Using CQUIN to introduce improvements in Health & Wellbeing

By introducing the CQUIN, equivalent to a £450m incentive payment, we aim to see improvements across the NHS in three specific areas:

- improving the range of support across musculoskeletal, mental health and physical activities;
- improving the uptake of flu vaccinations by frontline healthcare workers; and
- taking action on the food and drink sold on NHS premises.

However, the schemes outlined in the Health & Wellbeing CQUIN do not encompass the entirety of what we know the best employers are doing to promote health and wellbeing support for staff. By introducing the changes outlined in sections 4.1 and 4.2 employers will enhance the impact of making the necessary changes to access the money tied to areas outlined in the CQUIN.

4 How can employers offer health and wellbeing support to staff?

The organisations that are part of the NHS Healthy Workforce Programme are looking to provide support for their staff in two ways. First, by focusing on the organisational culture and second, by introducing employer led health and wellbeing schemes for staff.

4.1 A focus on organisational culture

At the heart of the programme is action to develop the organisational culture, so that it supports health and wellbeing of staff. This includes the following three areas:

- identifying a **Board level director lead** and **senior clinician** to champion this work, ensuring this is a priority for the organisation and that they are making progress. The culture of an organisation often comes from the top, and many of the good examples show the effect of leadership in this area;
- providing **training to line managers** to help them support their staff's health and wellbeing, particularly helping to ensure they are managing staff in a way which is supportive of their mental health as we know that mental health issues are one of the biggest causes of sickness absence in the NHS; and
- ensuring patients and staff are always offered **healthy options** in restaurants, cafes and vending machines on site. NHS England have convened a group of the major food suppliers and are working with them to ensure healthier choices are available.

4.2 Introducing employer led schemes for staff

To supplement the work around developing an organisational culture a range of support offers to individual staff – some of which are universal, with others being targeted on those who might need some support:

- establishing and promoting a local **physical activity and mental health** 'offer' to staff, such as running, yoga classes, free access to mindfulness apps, or competitive sports teams, and promoting healthy travel to work by offering the Cycle to Work scheme so that it is easier for staff to build physical activity into their working day and take better care of their mental health;

- addressing the main causes of sickness absence by providing **additional capacity for staff** to access physiotherapy, so that the length of time that staff are off sick due to MSK issues is reduced. Also introducing mental health talking therapies, as well as smoking cessation and weight management services;

- Improving the **uptake of flu vaccinations** by staff that work in frontline clinical roles so that patients are less likely to catch influenza, and staff are less likely to be off sick;

- providing the **NHS health check at work** for NHS staff aged 40 or over – so that staff are able to access it more easily, and receive local signposting and support, while testing new models of health assessments and health-related incentives; and

- fully implementing the NICE guidelines on workplace health which can be implemented through using Public Health England's **Workplace Wellbeing Charter** (www.wellbeingcharter.org.uk) assessment and accreditation process.

5 National Support

Here we set out how NHS England, Public Health England and NHS Employers will look to support providers to progress against the CQUIN goals over the next year.

- A **regional workshop** ran by NHS Healthy Workforce programme with input from at least one of the organisations working in the programme. This will provide a chance to listen to the work they have done, overcome common challenges and build connections with other Trusts implementing the scheme and will be held at the end of June and beginning of July.

- **Four webinars** throughout the year aligned to key deliverable dates outlined in the guidance providing a place to share emerging best practice for both commissioners and providers. Further details and dates for the webinars and workshops will be communicated during early June, with the first webinar being held in July 2016. The topic areas for the webinars will be;
    1. Indicator 1a: Developing plans & improving outcomes in staff survey
    2. Indicator 1b: making changes to food and drink provided on NHS premises
    3. Indicator 1c: Improving uptake in flu vaccinations
    4. Introducing staff health and wellbeing schemes & encouraging uptake

- **Hosting discussions with the major food suppliers** and franchise holders to the NHS to help Trusts make progress in the four areas outlined in the CQUIN.

- Ensuring **food and drink sold on premises are as healthy as possible** in at least one hospital to push the boundaries of what is possible. We will then share the learning from their journey and the changes that they have made.

- A **national campaign to encourage the uptake of flu vaccinations** in frontline healthcare workers.

- Reviewing of a sample selection of plans to introduce health and wellbeing initiatives within the NHS organisations. This will help support us to **share best practice and ideas** more widely throughout the NHS and inform the webinars and workshops held later in the year.

- **Providing exemplar case studies** from organisations within the Healthy Workforce Programme, the wider NHS and the private sector throughout the year – to be hosted on NHS Employers website http://www.nhsemployers.org/case-studies-and-resources?sort=date_desc.

- If you are **interested in attending one of the workshop events or webinars** please email england.healthyworkforce@nhs.net

6 Annex 1: Overview of health and wellbeing CQUIN

6.1 An overview of the health and wellbeing CQUIN

The CQUIN outlined three areas where NHS England would like providers to make progress in improving their health and wellbeing offer to employees. This builds on the work within the Healthy Workforce Programme over the past six months and looks to introduce some of the learning generated through the programme more widely to other NHS organisations.

6.2 What measures are included in the health and wellbeing CQUIN

Indicator 1a: Introduction of health and wellbeing initiatives (0.25)

Achieving a 5% improvement compared to the 2015 staff survey on q9 a,b,c of the staff survey relating to health and wellbeing, MSK and stress.
Or
Introducing a set of employer led schemes for staff around physical activity, MSK and Mental Health

Indicator 1b: Healthy food for NHS staff, visitors and patients (0.25)

Submitting data on the food suppliers operating on NHS premises and taking action in 4 areas including; banning price promotions, advertisement, and sale at checkouts of food and drink high in fat, salt, sugar and saturates as well as ensuring healthy options are available for staff at night.

Indicator 1c: Improving uptake of flu vaccinations (0.25)

Achieving an uptake of flu vaccinations by frontline healthcare workers of 75% by December 2016

7 Annex 2: Assurance process and review

In the CQUIN published during March 2016 there were several areas that we identified where further clarification would be needed. Within annex 2 we set out the approach for doing this.

Many organisations are starting in different places on health and wellbeing. To help with implementing the three areas outlined in the CQUIN we would recommend that providers collaborate and actively share ideas and progress across Sustainability and Transformation Plan (STP) footprints.

7.1 Indicator 1a: Introducing health and wellbeing schemes

Within the original CQUIN document we outlined that plans would be subject to peer review & that we would provide further clarification about this process.

01st July 2016	Provider to submit plan for introducing & improving health and wellbeing schemes
06th- 14th July 2016	CCGs to review individual plans using Public Health LATs for support
18th- 29st July 2016	NHS Healthy Workforce programme & national experts to review a sample selection of plans
30th July 2016	CCGs to locally agree metrics with providers by which success will be judged
March 2017	CCG assess Provider progress against the metrics agreed in submitted plan

When developing health and wellbeing plans we would encourage the following areas to be covered:

1. Evidence of staff engagement in in influencing the health and wellbeing offer, for example, through drop in sessions or surveys;
2. The content of the schemes and the timeline for implementation throughout the year;
3. Outlining how uptake of the schemes will be maximised to ensure as many staff as possible are benefitting from the improved health and wellbeing offer;
4. The metrics by which success will be judged (to be agreed locally with CCGs) which could cover the implementation of schemes, the number of people accessing schemes and uptake rates.

7.2 Indicator 1b: Introducing healthy food for staff, visitors and patients

We previously outlined that a data collection exercise would be required followed by four changes to food and drink sold on NHS premises. We are now initiating a temporary UNIFY2 return to enable you to submit the data collection outlined in the CQUIN document. Details of the UNIFY2 return can be found at http://nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx with the initial data submission opening at 09.00 Thursday 26th May for submission by 18:00 Thursday 30th June. A second data collection will be submitted during March 2017 to identify if changes have been made to food franchise holders or contract holders operating on NHS premises. Any queries about completion of the UNIFY2 return should be directed to e.cquin@nhs.net.
The process for **data collection** will be as follows;

26th May 2016	UNIFY data collection template published
30th June 2016	UNIFY data collection submitted
30th March 2017	Second UNIFY data collection submitted

In addition to this evidence of the changes made against each of the four areas outlined in indicator 1b will need to be provided. This should take the form of;

- By 31st March 2017 evidence submitted to the local CCG showing that the criteria has been met;
- By 31st March 2017 have discussed the changes or planned changes at a Public Board; and
- By 31st March 2017 a signed agreement between the Trust and any food franchise or contract holder which agrees to keep the changes made beyond 2016/17.

7.3 Indicator 1c: Improving uptake in flu vaccinations

As outlined in the CQUIN documentation, providers will be expected to submit the number of frontline healthcare workers that have received the flu vaccination on the ImmForm website for each month that they vaccinate staff. This is expected to be no different to the existing data collection process in place when submitting data on ImmForm. The final submission date that will count towards CQUIN will be December 2016.

8 Annex 3: Things to consider when introducing employer led schemes

Health and wellbeing is not just about introducing schemes for staff. Just as important is the culture within organisations when focussing on health and wellbeing. Seven key areas to think about when making changes are outlined below.

Leadership and Commitment *from the highest level of your organisation. An executive level and senior clinical lead who are responsible for championing this agenda and for delivering improvements in the health and wellbeing of staff.*

Engagement and co-creation *of initiatives with staff. Staff should be engaged and involved in the design, promotion and delivery of activities to ensure that they have the largest impact possible and to improve the likelihood that there is a strong staff uptake of the offer.*

Communicating the message *to ensure that staff understand the issues, the benefits to them individually and see the new direction clearly*

Wider engagement *with trade unions colleagues, public health colleagues, occupational health colleagues and others to ensure that the right voices are contributing to health and wellbeing.*

Data and metrics *to inform decisions about where to prioritise effort. Data and metrics should be taken to the board to ensure engagement and accountability of senior leaders. In addition to information on sickness absence it could include information about the number of people accessing schemes and uptake rates.*

A **dedicated coordinator** *could be appointed for those larger organisations and a working group set up to support the implementation and introduction of the employer led schemes.*

Easy access and easy to introduce *activities which can be built into the daily routines and working days. For instance, walking and stair use are often easier to encourage staff to take part in than optional activities such as gym classes.*

9 Indicator 1a: Introducing health and wellbeing initiatives

9.1 Promoting physical activity

Developed in conjunction with Public Health England the nine ideas below will help to reduce sedentary behaviour in addition to introducing physical activity schemes.

Push the staircase
*Direct your workforce to the stairs with arrows (priming) and staircase sign-posts at the entrance (*salience*)*

Set healthy habits
Use the power of social norms to set the 'stairs-not-lifts' and other healthy standards at the induction of new employees

Automatically enrol
*Automatically enrol new and current employees in the sports groups that are already available (*default*).*

Promote active travel
Use incentives *to promote active travel using social comparison (*gamification*) or small financial rewards (*lottery*).*

Use commitment contracts
Make your employees commit to their reduced-sedentary promises by having them sign a commitment *contract.*

Promote the norm
*Make your workforce aware of the social sedentary and activity norm, to set a positive example (*social norms*).*

Centralise facilities
Move printers, coffee machines or other regularly used areas further away to allow employees to move with good

Support standing desks
Ask employees to pick their desk type opposed to assigning one and make standing desks available in the workplace

Teach the difference
Teach your workforce the difference between sedentary behaviour and physical activity

9.2 Introducing mental health schemes

Mental health issues account for around 1/3 of sickness absence within the NHS with some estimates suggesting that at some point during their career 15-30% of workers will experience a mental health problem during their working lives.

We know people spend a large part of the day at work and that work often plays an important role towards an individual's mental health. This means that there are many different ways in which employers can take more a more active role in enabling staff to remain well or help provide support those staff with existing mental health issues.

NICE guidance identifies different ways in which employers can take a more active role in promoting mental health and can be found here. We have identified below five different areas that you may consider when implementing an improved mental health offer for staff and have provided case studies later in the document.

9.2.1 The right culture

Control and decision making
Empower individual members of staff to increase the control over their own work

Clear roles and responsibilities
Establishing clear roles, responsibilities and expectations with line managers

9.2.2 Mental Health schemes

Line management training
This focuses on educating managers to be more aware of psychologically healthy and supportive work environments. In addition to this, coaching them to spot signs of poor mental health and learning tips on how their own behaviours towards staff can positively or negatively influence the psychological wellbeing of their staff.

Mindfulness courses
Mindfulness courses focus on an individual's awareness on the present moment. These can either be delivered through face-to-face sessions or online and through various different apps.

Stress management courses
They help provide staff with training to help them improve their personal resilience and ability to deal or reduce the number of stressful situations they find themselves in.

9.3 Improving support to staff with MSK (musculoskeletal) issues

MSK related conditions are one of the two leading causes of sickness absence within the NHS. Nationally, 40% of long-term sickness absence can be attributed to an MSK condition. The 2015 staff survey reported that, on average, 25% of NHS staff suffered from MSK issues due to work related activities in the last 12 months (around 325,000 staff).

Early and reliable access to a physiotherapist has been shown to be one of the most effective forms of intervention to deal with MSK conditions within the workplace. Enabling faster access to people suffering from MSK conditions could optimise the clinical outcomes, reduce preventable deterioration and enable them to stay in work or return to work quicker.

Considering different ways of providing physio
Direct your workforce to the stairs with arrows (priming) and staircase sign-posts at the entrance (salience)

9.3.1 Different referral methods

Self-referral
Staff who self-refer tend to be more proactive in self-managing their condition. Evidence suggests it can be a very effective way to reduce waiting times

Managerial-referral
This may be particularly effective in cases where an individual is off-sick but is unable or has not taken proactive action themselves to seek assistance.

Occupational health referral
Organisations that do not offer physiotherapy service through the occupational health department itself may choose to use the department to manage onward referrals

GP referral
Some individuals may consult their GPs for their MSK conditions. Strong relationships with GPs can help the speed at which staff receive physio support in the workplace.

In addition to improving access to a physiotherapist, NHS organisations may implement initiatives such as pain management workshops, back care workshops and workplace ergonomics.

10 Indicator 1b: Healthier food for NHS staff, visitors and patients

The aim of this indicator is to change the organisational behaviour and culture towards the food and drink sold on NHS premises by focussing more on making healthier food and drink more widely available. It has previously been estimated that around 300,000 NHS staff are obese, with a further 400,000 staff being overweight. One of the main causes of which we know is diet and the consumption of foods high in fat, salt, saturate and sugar.

10.1 Definition of HFSS foods

The aim of this CQUIN is not to establish a complete check-list of healthy or unhealthy foods. However, we would encourage local providers and commissioners to work collaboratively and agree on how each provider will ensure the four outcomes will be met and the evidence required for this.

We would advise that for ease of implementation and to ensure the maximum amount of time can be focussed on making changes that the standards the following definition of foods high in fat, salt, saturates and sugar are used;

1. Any product where there is a high content of fat, salt, saturates or sugar, as indicated by a red box on front of pack nutritional labelling or exceeding the relevant nutritional guidelines (based on a per portion basis) if front of pack nutritional labelling is not present.

More specific information on the gram per 100g/ per portion classifications can be found on page 14 “front of pack nutrition label for pre-packed products” https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300886/2902158_FoP_Nutrition_2014.pdf

10.2 Definition of price promotions

Price promotions will be classified as any temporary price discounting in the price of a product high in fat, saturates, salt or sugar. Common interpretations of a **price promotion** are provided below, although this is not meant to be an exhaustive list;

1. Providing the same quantity of a product for a reduced price (pence off deal);
2. Multi-buy discounting for example buy **one** get **one** free;
3. Free item provided with a purchase (whereby the free item cannot be a product classified as HFSS);
4. Price pack or bonus pack deal (for example 50% for free); and
5. Meal deals (Only applying to those drinks classified under treasury guidelines for the introduction of the upcoming sugar levy).

10.3 Definition of advertising

Common interpretations of advertising on food and drink high in fat, salt, sugar or saturates are the following;

1. Checkout counter dividers
2. Floor graphics
3. End of aisle signage
4. Posters and banners

10.4 Classification of checkout areas

1. Points of purchase including checkouts and self-checkouts
2. Areas immediately behind the checkout

11 Indicator 1c: Improving uptake in flu vaccinations

There are many reasons why it is beneficial for frontline healthcare workers to get immunized. The four main reasons that are commonly used include:

- Anyone can get sick from the flu;
- People with the flu can spread it to others. Patients in hospital can be particularly susceptible to catching it;
- Flu occurs every winter, but the degree of infection is unpredictable so just because the year before was a mild season doesn't mean the following year will be;
- It takes time to build up your immunity, hence the importance to get the flu vaccination as early as possible.

11.1 Eight top tips to maximising uptake of flu vaccinations

NHS Employers provide more information on flu campaigns which can be found here.

Communication
Keep staff updated throughout your campaign, mix up the types of communication and tailor the strategy

Peer Vaccination
Use peer vaccinators, train clinical directors to vaccinate staff, utilise any staff on adapted working duties

Rewards
Use incentives during your campaign

Ensure it is accessible
Set up a mobile flu vaccination clinic, reimburse your staff if they buy their jab externally & hold drop in clinics at events

Myth busting
Use clinical evidence for support and challenge the misconceptions amongst staff

Promote the norm
Make your workforce aware of the positive example, such as by ensuring senior clinical leadership get the vaccination

Balanced flu team
Include staff from all parts of your organisation, get a good skills mix with strong diversity

Support the vaccine
Have a champion to provide leadership at a senior level, seek involvement from the board to the ward and get management to lead by example

12 Annex 4: Case studies

12.1 Staff engagement

University of Sheffield: The campaign took the focus away from sickness absence and onto having a healthy and happy engaged workforce. Top tips include listening to staff about the activities they want and staying focussed on the end result.

Bradford District Care Trust: Top tips include ensuring the agenda is owned by everyone – not just HR, getting board level support and using staff engagement to influence new changes.

12.2 Leadership and management

Coventry and Warwickshire Partnership Trust: The programme followed a train the trainer approach with regards to training staff to delivering on supportive leadership and management behaviours.

NHS Employers: This guidance for line managers will help focus on the important people management behaviours including being empathetic, supportive, personable, positive and recognising success.

12.3 Introducing health and wellbeing schemes

Nottingham University Hospitals NHS Trust: To tackle the challenge of increasing physical inactivity, NUH started a health and wellbeing programme encouraging staff to be active every day. As a result of this, over 3,000 staff have attended the onsite fitness clubs and gym over the last year.

Birmingham Children's Hospital: The programme incorporated resilience workshops, exercise classes, mentally healthy workplace training and awareness campaigns.

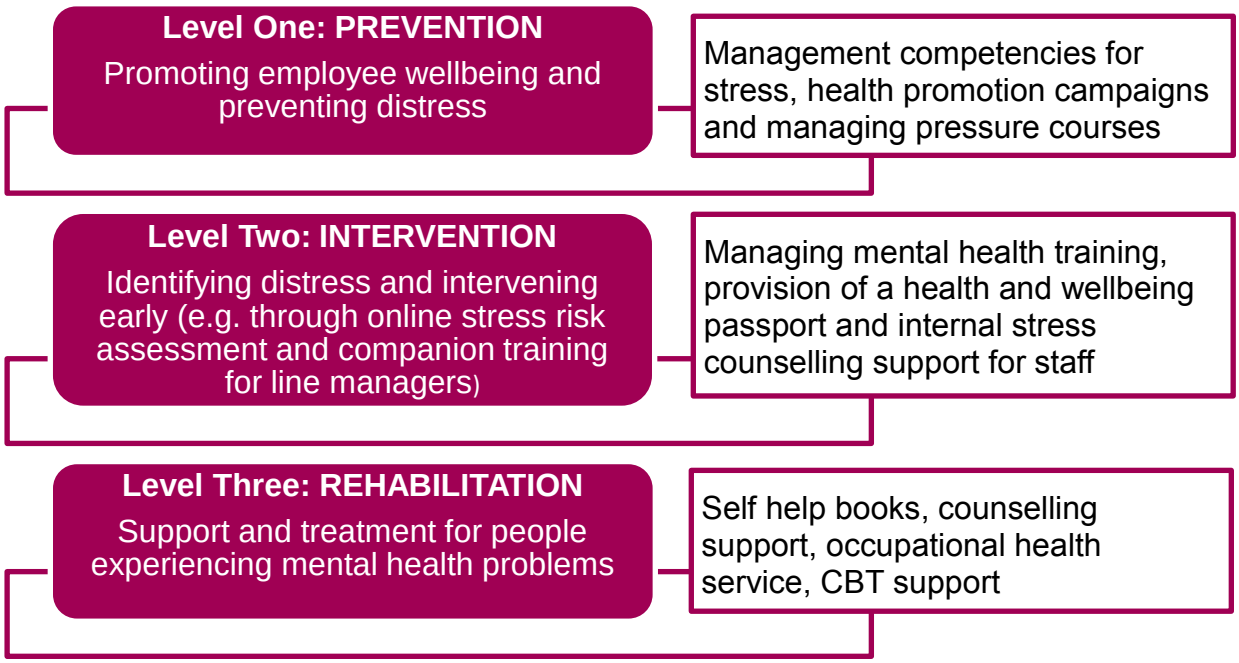
West Midlands Ambulance Service: The main aims of the health and wellbeing strategy were to increase the uptake of health and wellbeing initiatives, gain positive feedback from staff health and wellbeing surveys and reduce sickness absence.

12.4 A focus on mental health: British Telecom (BT)

Overview

BT is one of the world's leading providers of communications solutions and services, operating in 170 countries. The company employs around 101,000 people, of whom some 80% are located in the United Kingdom.

BTs approach has three strands to it and aims to drive a culture of self-help among the workforce and mangers with support available from the "experts" when needed but primarily provided through comprehensive and easy to use materials.



Outcome

The scheme has proved effective in getting people back to work safely with 92% returning to their own role on full duties after intervention.

BT's sick absence rate has decreased from 2.29% (1 April 2013) to 2.11% (31 March 2014) alongside maintenance of employee engagement levels. This percentage reduction when considered across the entire workforce is significant.

The various metrics used to track progress have showed a gradual improvement against a previously rising trend. BT's Wellbeing Index has improved from **3.65** (1 April 2013) to **3.85** (31 March 2014).

13 Annex 5: Health and wellbeing CQUIN Indicators

13.1 CQUIN 1a: Introduction of health and wellbeing initiatives – Option A

Indicator	
Indicator name	Introduction of health and wellbeing initiatives- **Option A**
Indicator weighting (% of CQUIN scheme available)	33.3% of 0.75% (0.25%)
Description of indicator	Commissioners and Providers should choose between Option A or Option B Achieving a 5 percentage point improvement in each of the 3 staff survey questions on health and wellbeing, MSK and stress. Providers will be expected to achieve an improvement of 5% compared to 2015 staff survey results for each of the three questions in the NHS Annual Staff survey outlined below. 1. **Question 9a**: Does your organisation take positive action on health and well-being? *Yes, definitely/ Yes, to some extent/ No* response. 2. **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? *Yes/No* response. 3. **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? *Yes/No* response.
Numerator	NHS staff survey results for the Provider **Question 9a**: 2016 combined percentage of staff who have answered “yes, definitely” or “yes, to some extent” **Question 9b:** 2016 percentage of staff who have answered yes

Indicator	
	Question 9c: 2016 percentage of staff who have answered yes
Denominator	NHS staff survey results for the Provider **Question 9a**: 2015 combined percentage of staff who have answered “yes, definitely” or “yes, to some extent” **Question 9b:** 2015 percentage of staff who have answered yes **Question 9c:** 2015 percentage of staff who have answered yes
Rationale for inclusion	Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. This figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment. As well as the economic benefits that could be achieved, evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients. The *Five Year Forward View* made a commitment ‘to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy’. This CQUIN builds on this promise and the developments made across England during the past year through some of the work being undertaken within NHS England’s Healthy Workforce Programme to help promote health and wellbeing for NHS staff and improve the support that is available for them in order for them to remain healthy & well. A key part of improving health and wellbeing for staff is giving them the opportunity to access schemes and initiatives that promote physical activity, provide them with mental health support and rapid access to physiotherapy where required. The role of board and clinical leadership in creating an environment where health and wellbeing of staff is actively promoted and encouraged.

Indicator	
Data source	The NHS Annual Staff survey. **Question 9a**: Does your organisation take positive action on health and well-being? *Yes, definitely/ Yes, to some extent/ No* response. **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? *Yes/No* response. **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? *Yes/No* response.
Frequency of data collection	Annual release of staff survey results
Organisation responsible for data collection	National NHS staff survey co-ordination centre
Frequency of reporting to commissioner	Publication of 2016 staff survey
Baseline period/date	2015 staff survey data
Baseline value	Individual trust performance against each staff survey question
Final indicator period/date (on which payment is based)	Quarter 4, 2016/17
Final indicator value (payment threshold)	Achievement of the 5% improvement in staff survey results
Final indicator reporting date	Publication of 2016 staff survey – February 2016
Are there rules for any agreed in-year milestones that result in payment?	Yes see milestone requirements below.

Indicator	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	N/A

Supporting Guidance and References

https://www.nice.org.uk/guidance/ng13

Milestones

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 4	Providers should have achieved the following improvements in staff survey scores based on a baseline of 2015 staff survey results; **Question 9a**: A 5% increase in "Yes, definitely" and "Yes, to some extent" based on 2015 performance **Question 9b:** A 5% increase in "No" responses based on 2015 performance **Question 9c:** A 5% increase in "No" responses based on 2015 performance	March 31 2017	100% of the indicator weighting for part 1a

Rules for partial achievement

Partial achievement rules relate to the performance achieved for each question. Only if you have achieved 5% or more for each of the question can you access 100% of the payment for part 1a i.e. 33% of the overall amount available for the CQUIN (0.75%).

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
1% improvement or less	No payment of weighting associated to staff survey results
2% improvement	25% payment of weighting associated to staff survey results
3% improvement	50% payment of weighting associated to staff survey results
4% improvement	75% payment of weighting associated to staff survey results
5% improvement	100% payment of weighting associated to staff survey results

13.2 CQUIN 1a: Introduction of health and wellbeing initiatives – Option B

Indicator	
Indicator name	Introduction of health and wellbeing initiatives- **Option B**
Indicator weighting (% of CQUIN scheme available)	33.3% of 0.75% (0.25%)
Description of indicator	Commissioners and Providers should choose between Option A or Option B The introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues. Providers should develop a plan and ensure the implementation against this plan. This plan will be subject to peer review (further guidance will be issue on the peer review aspect in the next 4-6 weeks). This should cover the following three areas; a) Introducing a range of **physical activity schemes** for staff. Providers would be expected

Indicator	
	to offer physical activity schemes with an emphasis on promoting active travel, building physical activity into working hours and reducing sedentary behaviour. They could also introduce physical activity sessions for staff which could include a range of physical activities such as; team sports, fitness classes, running clubs and team challenges. b) Improving **access to physiotherapy services** for staff. A fast track physiotherapy service for staff suffering from musculoskeletal (MSK) issues to ensure staff who are referred via GPs or Occupational Health can access it in a timely manner without delay; and c) Introducing a range of **mental health initiatives** for staff. Providers would be expected to offer support to staff such as, but not restricted to; stress management courses, line management training, mindfulness courses, counselling services including sleep counselling and mental health first aid training;
Numerator	N/A
Denominator	N/A
Rationale for inclusion	Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. This figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment. As well as the economic benefits that could be achieved, evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients. The *Five Year Forward View* made a commitment 'to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy'. This CQUIN builds on this promise and the developments made across England during the past year through some of the work being undertaken within NHS England's Healthy Workforce Programme to help promote health and wellbeing for NHS staff and improve the support that is available for them in order for them to remain healthy & well. A key part of improving health and wellbeing for staff is giving them the opportunity to access schemes and initiatives that promote physical activity, provide them with mental health support

Indicator	
	and rapid access to physiotherapy where required. The role of board and clinical leadership in creating an environment where health and wellbeing of staff is actively promoted and encouraged.
Data source	Local implementation plan
Frequency of data collection	Quarter 1 – once Quarter 4 - once
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarter 1 – once Quarter 4 - once
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	Quarter 4, 2016/17
Final indicator value (payment threshold)	Introducing the agreed initiatives as set out in their plan
Final indicator reporting date	Introducing the agreed initiatives as set out in their plan
Are there rules for any agreed in-year milestones that result in payment?	Yes see milestone requirements below.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	N/A

Milestones

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Providers should have developed a plan to introduce and actively promote the three initiatives that is peer reviewed and signed off.	July 2016	20% of the indicator weighting for part 1a
Quarter 4	Providers should have implemented their initiatives (as agreed in their signed off plan) and actively promoted these services to staff to encourage uptake of initiatives.	March 31 2017	80% of the indicator weighting for part 1a

13.3 CQUIN 1b: Healthy food for NHS staff, visitors and patients

Indicator	
Indicator name	Healthy food for NHS staff, visitors and patients
Indicator weighting (% of CQUIN scheme available)	33.3% of 0.75% (0.25%)
Description of indicator	**Part a** Providers will be expected achieve a step-change in the health of the food offered on their premises in 2016/17, including: a. The banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS). The majority of HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets;

	b. The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt (HFSS); c. The banning of sugary drinks and foods high in fat, sugar and salt (HFSS) from checkouts; and d. Ensuring that healthy options are available at any point including for those staff working night shifts. CQUIN funds will be paid on delivering the four outcomes above. In many cases providers will be able to achieve these objectives by renegotiating or adjusting existing contracts. **Part b** Providers will also be expected to submit national data collection returns by July based on existing contracts with food and drink suppliers. This will cover any contracts covering restaurants, cafés, shops, food trolleys and vending machines or any other outlet that serves food and drink. The data collected will include the following; the name of the franchise holder, food supplier, type of outlet, start and end dates of existing contracts, remaining length of time on existing contract, value of contract and any other relevant contract clauses. It should also include any available data on sales volumes of sugar sweetened beverages (SSBs).
Numerator	N/A
Denominator	N/A
Rationale for inclusion	PHE's report "Sugar reduction – The evidence for action" published in October 2015 outlined the clear evidence behind focussing on improving the quality of food on offer across the country. Almost 25% of adults in England are obese, with significant numbers also being overweight. Treating obesity and its consequences alone currently costs the NHS £5.1bn every year. Sugar

	intakes of all population groups are above the recommendations, contributing between 12 to 15% of energy tending to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequences. Consumption of sugar and sugar sweetened drinks. It is important for the NHS to start leading the way on tackling some of these issues, starting with the food and drink that is provided & promoted in hospitals.
Data source	**Quarter 1** The responses to the proposed questions below will form part of a national data collection. Providers will submit the responses via UNIFY following locally agreed sign off process by the commissioner. 1) Name of franchise holder 2) Name of supplier or vendor(s) 3) Type of sales outlet (restaurant, café, vending, shop/store, trolley service) 4) Start date of existing supplier contract 5) End date of existing supplier contract 6) Remaining length of contract (time to expiration) with external supplier(s) 7) Total contract value 8) Value of contract for the financial year 2015/16 9) Profit share agreements that are in addition to the contract value (percentage of profit that is received by the NHS Provider from the supplier) 10) Free text box: Contract break clauses

	11) Volume of Sugar Sweetened Beverages sold **Quarter 4** 1) Question: Have you changed your food supplier during 2016/17(Yes/ No) If yes who is your new food supplier?
Frequency of data collection	End of Quarter 1- once only End of Quarter 4- once only
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	End of Quarter 1 End of Quarter 4
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	Quarter 4, 2016/17
Final indicator value (payment threshold)	To be determined locally
Final indicator reporting date	As soon as possible after Q4 2016/17
Are there rules for any agreed in-year milestones that result in payment?	Yes see -milestones requirements below.

Milestones

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	The collection of the 11 data points outlined in **part b.)** and the submission via unify	July 2016	20% of the indicator weighting for part b
Quarter 4	To be paid on delivering the four outcomes outlined in **part a.)**	March 31 2017	80% of the indicator weighting for part a

Rules for partial achievement

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
0 out of 4 changes introduced	No payment
1 out of 4 changes introduced	25% payment of milestone weighting part a.)
2 out of 4 changes introduced	50% payment of milestone weighting part a.)
3 out of 4 changes introduced	75% payment of milestone weighting part a.)
All 4 changes introduced	100% payment of milestone weighting part a.)

13.4 CQUIN 1b: Healthy food for NHS staff, visitors and patients

Indicator	
Indicator name	Improving the uptake of flu vaccinations for frontline clinical staff
Indicator weighting (% of CQUIN scheme available)	33.3% of 0.75% (0.25%)
Description of indicator	Achieving an uptake of flu vaccinations by frontline clinical staff of 75%

Indicator	
Numerator	Number of front line healthcare workers (permanent staff and those on fixed contracts) who have received their flu vaccination by December 31 2016
Denominator	Total number of front line healthcare workers (permanently contracted staff and fixed term contracts)
Rationale for inclusion	Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months when some of their patients will be infected. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season- a much higher incidence than expected in the general population.
Data source	Providers to submit cumulative data monthly over four months on the ImmForm website
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	December 2016
Final indicator period/date (on which payment is based)	December 2016
Final indicator value (payment threshold)	A 75% uptake of the flu vaccination
Final indicator reporting date	As soon as possible after Q4 2016/17
Are there rules for any agreed in-year milestones that result in payment?	N/A
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes - see partial payment section

Rules for partial achievement

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
64% or less	No payment
65% - 74% uptake of flu vaccinations	50% payment
75% or above	100% payment