



# **Interventions to control stress at work in hospital staff**

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# **Interventions to control stress at work in hospital staff**

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This Report describes the application of a risk management approach to dealing with the problem of work-related stress among hospital staff. It describes the application of the risk management cycle from risk assessment through to the evaluation of problem-solving interventions.

The Report is illustrated using material drawn from five case studies carried out within three British National Health Service (NHS) Trusts. The case studies included both direct care and non-direct care staff groups from a variety of hospital-based settings. These groups presented with different problems. Their organisations attempted to address these problems through a variety of interventions. The risk management process was used to gather data on the problems and to guide the design, implementation and evaluation of the interventions. The data gathered throughout the various case studies are used to illustrate the methodology used. A commentary is also provided on the usefulness of the risk management approach in the hospital setting.

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## FOREWORD

Over the last decade it has become clear to those involved in the management of work in Britain, and elsewhere in the developed world, that work-related stress is currently one of the greatest challenges to the health of working people and to the healthiness of their work organisations. Furthermore, there is no evidence that this challenge will not remain considerable in the near future.

Data from a variety of national and trans national surveys of those in work both in Europe and elsewhere in the developed world, have identified stress-related problems as the second most commonly reported cause of work-related ill-health. In Britain, for example, such data are most convincingly drawn from the trailer to the 1992 Labour Force Survey appended by the Health & Safety Executive (Hodgson et al., 1992) and from the subsequent follow-up survey of self-reported work-related ill-health in 1995 (Jones et al., 1998). The data from these two surveys suggested that about 20% of existing reported cases of occupational ill-health (about 500,000 cases) could be accounted for by stress-related illness with an annual incidence of about 92,000 new cases. It was estimated that this resulted in about 6.5 million working days lost to industry and commerce each year. Estimated within the 1995-96 economic framework, the cost to society was £ 3.7 – 3.8 billion.

Fortunately much progress has been made over this decade in relation to the management of work-related stress both in terms of its prevention and in terms of the management of the individual working people who suffer it. Much of what has been achieved scientifically has been framed by developments in health and safety legislation both at the national and European levels. Perhaps one of the most significant advances has been the adaptation of a 'risk management' approach to health and safety problems for dealing with work-related stress. Much of the necessary research and development work behind this approach has been completed by the Institute of Work, Health & Organisations (I-WHO) at the University of Nottingham funded by the Health & Safety Executive. Through a series of case studies, this approach has been applied by I-WHO, in both the private and public sectors. I-WHO at Nottingham has been one of the fore-most bodies in developing such a system, along with TNO in the Netherlands and the Finnish Institute of Occupational Health in Helsinki.

In this work, it has been obvious that some organisations and many managers feel insecure in their knowledge of risk management as applied to work-related stress and lack confidence in exploring its application to their own situation. The Health & Safety Executive has recognised these barriers to action (and to compliance with legal duties) and proposed further education programmes and enhanced guidance. Informative and persuasive case study materials may form an important part of such education and guidance. This research project was an attempt to apply the risk management approach to work-related stress within with three British hospitals and to develop case study materials from that experience. This Report contains a description of the risk management approach illustrated by the case studies.

The Report begins with two introductory chapters dealing first with the nature of work-related stress, both generally and more specifically in the hospital situation, and second with the model of risk management used and its basic steps. The following chapters discuss each of the basic steps in more detail, from a practical point-of-view, and illustrate the issues raised with examples drawn from the case studies. The closing chapters offer an integrative discussion of the case studies and what organisations might learn from them.

The authors of this Report hope that it will prove interesting to the informed line manager, the specialist manager in health and safety, occupational health or human resource management, and trades union representatives. The Report was commissioned to support the production of

sector specific guidance on the management of work stress, and to provide case study examples of the application of risk management. It should be noted that the research aim was not to develop and test a 'manual' for risk management.

That said, however, this Report is intended to provide sufficient information to persuade key individuals within health care settings that dealing with work-related stress in their organisation is both feasible and advisable. We have decided to use a 'conversational' style of English throughout this Report. Often the term 'we' is used to describe the work carried out. It is hoped that this style makes the Report more readable. However, this does not mean that the researchers need to carry out all aspects of the work: we have highlighted the involvement of staff, management and in-house experts wherever appropriate. The use of the word 'we' in our account is not intended to dissuade organisations from attempting to implement the process themselves - provided they have the appropriate skills and expertise to do so. The skills and competencies needed to carry out risk management are discussed in Chapter 9 of this Report.

The risk management approach to tackling the problem of work stress offers a practicable way forward for hospitals to comply with their legal duties with regard to preventing and managing work-related stress.

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## EXECUTIVE SUMMARY

Risk management is a different kind of approach to that which is more traditionally associated with stress management. The risk management approach, as developed by the Institute of Work, Health and Organisations (I-WHO) at the University of Nottingham, is designed to deal with work stress at source. This is in contrast to efforts aimed at tackling work stress by counselling or otherwise helping the troubled individual. In many instances the sources of stress can be tackled through improvements to the design and management of work. As a result, such interventions can have benefits both for individuals and their employing organisations.

This Report provides examples of how sources of work stress were identified and managed in a number of hospital settings. Over the course of two years we worked with five case groups, containing staff involved in a variety of jobs (both direct care and non-direct care). This Report provides an account of the risk management process using these case study examples to illustrate the process and bring it to life. In doing so it provides information about how a number of problems are being tackled in hospital settings. It also highlights the benefits that good management practices can have in terms of working conditions and staff well-being. The evidence from these case studies demonstrates that risk management can be a powerful tool for dealing with sources of work stress.

In this Report, we describe the key steps that were carried out during the risk management case studies. The Report presents a tailored account to demonstrate how risk management works, and can be used within hospital settings. Although not intended to be a manual for risk management, we intend this Report to be a powerful source of ideas and inspiration for those charged with dealing with work stress in the healthcare sector.

Risk assessment was the basis for intervention in all the case studies. Risk assessment was used to identify the size and nature of any problem, and to point to priorities for intervention. Problems with communication, staffing and 'peripheral' workload were among those identified by the various risk assessments.

The Report then describes how we worked with the groups involved to help them develop a response to the risk assessment. This was a challenging part of the process for many organisations. In this Report we describe how organisations went about meeting this challenge – most often through staff consultation - and how they designed interventions that integrated into their everyday management practices. A substantial portion of this Report describes how the interventions were carried out, and the impact they had.

A number of positive interventions and good management practices are described in this Report. Some of the interventions described may appear extremely creative. Some might seem unremarkable. Many interventions were effective. Often, the most positive were those that were built through consultation with employees. For example, a number of interventions that allowed nurses more time to get on with nursing tasks were created, pushed forward, and maintained by the staff themselves. Evaluating the impact of the interventions against a shifting and unpredictable backdrop of change proved the most challenging part of the risk management process. This led to us developing new methods of evaluation that were employed in the case study work. This Report examines the benefits for staff of a variety of interventions.

In closing this Report we isolate the main lessons learned from implementation of the risk management process. There are a number of good management practices already in place within the healthcare sector. Risk management can be used to stimulate new and creative ways of tackling the most difficult problems faced by staff.





# 1. WORK STRESS: PROBLEMS AND INTERVENTIONS

## 1.1 The nature of work stress

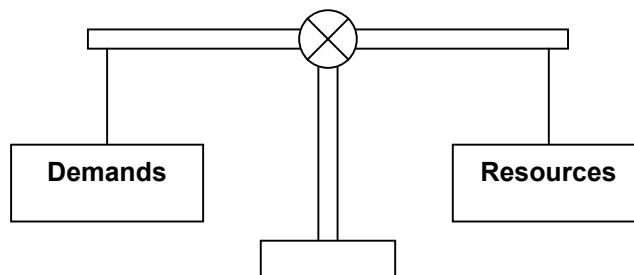
The experience of work-related stress is a threat to the health of working people and to the healthiness of their work organisations. The evidence suggests that this experience is widespread and a major threat to health. In turn, stress is also implicated in many other widespread occupational health problems such as work-related musculoskeletal disorders.

Stress is an unpleasant, disruptive and often disabling emotional experience and one that can have ramifications for psychological and physical health. These are its primary effects; those that focus on the individual. However, through the disruption and impairment of the affected person's work-related behaviour, the experience of stress can also affect the healthiness of work organisations by increasing absenteeism, reducing morale and organisational commitment, impairing both the quality and quantity of work, and the quality of decision making. It may also be a strong contributing factor to accidents at work.

The important question in relation to managing work-related stress must be: what causes this experience? Undoubtedly, individual or personal factors come into the equation, as they do with all health and safety issues, but the cause of work-related stress in the workplace lies in the design and management of work, work environments and organisations. The fundamental objective of all stress management programmes must be to reduce stress at source by dealing with failures in the design and management of work, work environments and organisations. In other words, stress management should promote individual health and organisational healthiness through the design and management of healthy work systems.

The design and management of work impinges on the person by affecting the balance between four aspects of their ability to deal with the pressures of work (i) demand (pressure), (ii) knowledge, skills and ability, (iii) control over working, and (iv) support from others. These are the basic elements in the equation that determine the likelihood of whether a person will experience stress or not. It is the person's awareness of this balance and the way that they 'see' it that counts.

This model of work-related stress is central to most scientific theories and has even found representation in the health and safety legislation in the Scandinavian countries. It has been used to develop guidance on the management of work-related stress by many business, trades union, professional and governmental bodies. It can be represented in terms of a simple balance mechanism (see Figure 1.1). When demands and resources are usually in balance work design and management can be described as healthy. If demands and resources are frequently out of balance the experience of work stress is more likely.



**Figure 1.1: Balance model of work stress: no stress situation**

However, the work factors that play a role in this balance – demands, abilities, control and support - are expressed in a variety of forms in different workplaces. Where they are inadequate (where there are failures of work design or management) they will represent stress-related hazards and have the potential to harm the individual and/or their organisation. Where they are more adequately designed or managed, they may be of no real concern or possibly even a source of satisfaction and a health promoting feature of work.

## 1.2 Sources of work stress

There are various taxonomies of stress-related hazards associated with the design and management of work, work environments and work organisations. The evidence behind these taxonomies, on which there is good agreement in the scientific literature, has been summarised elsewhere (for example, Cox 1993, Cox, Griffiths & Rial-Gonzalez, 2000). What is presented below is a summary based on the work of the I-WHO at the University of Nottingham. This taxonomy was used to shape the current research project and associated case studies. The Health and Safety Executive uses a slightly different, seven category taxonomy in their recent (2001) publication “Tackling work-related stress: A manager’s guide to improving and maintaining employee health and well-being” (HSG 218). These seven categories (culture, demands, control, relationships, change, role and support (etc.)) cover the same issues as described in Table 1.1, using slightly different terminology.

**Table 1.1: Summary of stress-related hazards**

<b>CATEGORY</b>	<b>HAZARDOUS CONDITIONS</b>
<b>CONTENT OF WORK</b>	
Job content	<i>Lack of variety or short work cycles, fragmented or meaningless work, under use of skills, high uncertainty, continuous exposure to people through work.</i>
Workload / work pace	<i>Work overload or under-load, machine pacing, high levels of time pressure, continually subject to deadlines.</i>
Work schedule	<i>Shift working, night shifts, inflexible work schedules, unpredictable hours, long or unsociable hours.</i>
Control	<i>Low participation in decision making, lack of control over workload, pacing, shift working, etc. Lack of control (particularly in the form of lack of participation) is also a context and wider organisational issue.</i>
Environment and Equipment	<i>Inadequate equipment availability, suitability or maintenance; poor environmental conditions such as lack of space, poor lighting, excessive noise.</i>
<b>SOCIAL &amp; ORGANISATIONAL CONTEXT TO WORK</b>	
Organisational culture and function	<i>Poor communication, low levels of support for problem solving and personal development, lack of definition of, or agreement on, organisational objectives.</i>
Interpersonal relationships at work	<i>Social or physical isolation, poor relationships with superiors, interpersonal conflict, lack of social support.</i>
Role in organisation	<i>Role ambiguity, role conflict, and responsibility for people.</i>
Career development	<i>Career stagnation and uncertainty, under promotion or over promotion, poor pay, job insecurity, low social value of work.</i>
Home-work interface	<i>Conflicting demands of work and home, low support at home, dual career problems.</i>

Employers have a duty in law to manage work-related stress. They should conduct an appropriate and adequate assessment of all the risks to the safety and health of their employees, and, where reasonably practicable, take steps to reduce that risk. The emphasis in law is on risk reduction at source - primary prevention - with the focus on the organisation as the generator of the risk. There are also good management reasons why organisations should want to improve their healthiness and reduce absenteeism, improve morale and commitment, and the quantity, quality and innovativeness of their employees' work.

### **1.3 Collaborative work with organisations**

The Institute has adapted the 'typical' risk management approach as used in Britain to deal with the stress-related hazards of work i.e. those inherent in failures of design and management. As far as possible, it uses the everyday language and the concepts of risk management already well known to those working in and managing organisations. This has been a deliberate strategy to make this approach to work-related stress more accessible and readily understandable. More detail on the model that underpins this approach and the basic steps involved is presented in the next chapter (Chapter 2: The Risk Management Approach).

The work of I-WHO has been based on working collaborations with organisations across the public and private sectors. Twelve organisations participated in our most substantial and recent piece of research and development work. The results from this research have been published, along with a detailed description of the methods involved, in a report to the Health and Safety Executive (Cox et al, 2000a). This research and development work involved staff from a number of organisations and work settings, including:

- Chemical manufacturing process operators and technical staff
- Railway station supervisors
- Call centre staff
- Supermarket staff
- Warehouse staff
- Field staff from a large utility company

In negotiating with organisations over their possible participation in this project, it became clear to the Institute that many:

- were insecure in their knowledge of the risk management approach to work-related stress
- lacked confidence in how it might be applied in their situation and to what effect

These barriers to action (and to compliance with legal duties) were among the reasons driving the publication of six case studies from the initial research and development work.

Case studies can be powerful tools, in the context of education and guidance, for developing knowledge and understanding particularly in relation to the application of techniques and methods. The research described in this Report was initiated to address the need for case study material to support education and guidance on managing work-related stress in the healthcare sector.

#### **1.3.1 Case studies in hospital settings**

The available scientific evidence suggests that those who work in the healthcare setting, especially with direct contact with and responsibility for patients and other people, may be particularly at risk from the experience of work-related stress. The primary effects of stress in those that work in healthcare are no less than for those who work in other types of work.

However, the secondary effects are a real challenge to the quality of healthcare provision and may be a factor that determines the overall effectiveness of the healthcare systems.

Work-related stress in healthcare systems is a major challenge to the health of those who work in those systems, to the healthiness of their organisations *and* to the effectiveness of the healthcare that they deliver.

The present research project focused on hospital staff in three British regional hospitals: North NHS Trust (in the North of England), West Central NHS Trust (in central England) and East Central Trust (also in the centre of England). The Institute has worked with those hospitals to identify possible at risk groups and areas (case studies), encompassing all staff groups, and then to work through the complete risk management approach (as described in Chapter 2) from the initial risk assessment to the evaluation and re-assessment that follows intervention.

Chapter 2 describes the risk management principles and procedures that were used with the three hospitals and the subsequent chapters look at each of the steps in the risk management process in more detail illustrating them with data from the case studies. The closing chapters draw together the overall findings and assess the key learning points.

## **2. THE RISK MANAGEMENT APPROACH**

### **2.1 The risk management process**

Risk management in health and safety is systematic, evidence-based problem solving. It starts with the identification of problems and an assessment of the risk that they pose, then uses that information to suggest ways of reducing that risk at source. It then evaluates those risk reduction actions. Evaluation, of course, informs the whole process and should lead to a re-assessment of the original problem and to broader organisational learning.

There are many different risk management methods being used in health and safety to deal with a wide variety of problems. Methods differ depending on the type of problem that they address (e.g. mechanical hazard or microbiological hazard), on the focus of the likely control intervention (e.g. the person working with the hazard, their work system or the culture of their organisation) or on the control strategy to be used (primary prevention at the organisational level, enhanced training or improved occupational health support). Of course, in any real situation, these three factors are likely to be inter-related. Often a mixture of foci and strategies must be used to deal effectively with a hazardous situation in which there are many challenges to health and safety.

To deal with the challenge of work-related stress, I-WHO at Nottingham, funded by the Health & Safety Executive, has adapted 'typical' risk management models and procedures to deal with work-related stress. The rationale for, and outline of, this approach was first described in 1993 (Cox, 1993) and up-dated in 2000 (Cox et al., 2000b). The detail of the methodology, and the questions that arise about its reliability and validity, were addressed in a major report to the Health & Safety Executive also in 2000 (Cox et al., 2000a) that included six illustrative case studies. This Chapter simply provides a brief account of the model used and the principles and procedures that support its application. It describes the framework for the subsequent chapters that present the story of its use in three British hospitals.

### **2.2 The risk management model**

The model underpinning risk management for work-related stress is relatively simple. Before a problem can be addressed, it must be analysed and understood, and an assessment made of the risk that it presents. Much harm can be done, and resources squandered, if precipitative action is taken on the assumption that the problem is obvious and well enough understood. Most problems, even those that present simply, are complex and not always what they seem. Some form of analysis and risk assessment is required.

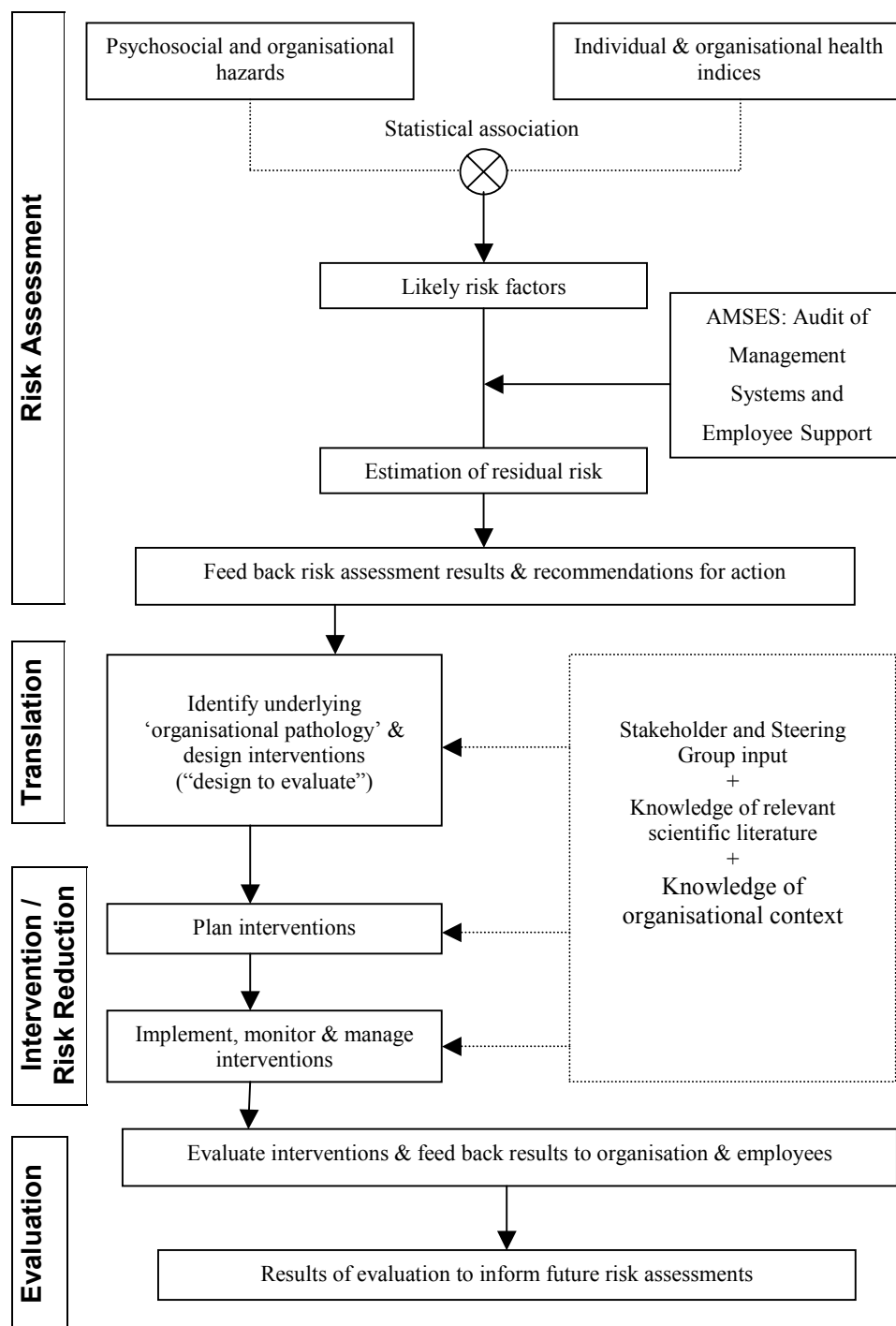
The risk assessment provides information on the nature of the problem, the stress-related hazards and the way they might affect the health of those exposed to them and the healthiness of their organisation. Adequately completed, the risk assessment allows the key features of the problem to be identified - these have been called likely risk factors - and some priority given to them in terms of the nature and size of their possible effects or the number of people exposed. These data can be used to inform the development of an action plan to address the problems at source whenever it is reasonably practicable to do so.

The way in which the information from the risk assessment is discussed, explored and used to develop an action plan has been termed 'translation': the translation of the risk assessment information into a reasonable and practical action plan to reduce risk. Usually, the discussion and exploration of the problems and likely risk facilitates the discovery of any underlying organisational pathology - major problems that may be hidden but give rise to the problems and

likely risk factors. There is a clear analogy here with the general practitioner (GP) exploring the patient's symptoms and discovering an underlying disease. This often makes intervention easier as the underlying organisational pathology can be targeted instead of, or as well as, its symptoms (the problems and likely risk factors).

The development of the action plan, based on the evidence from the risk assessment, involves deciding on: what is being targeted, how and by whom, who else needs to be involved, what the time schedule will be, what resources will be required and how the action plan will be evaluated. If properly handled, planning to reduce risk in relation to work stress is no different from any other management activity. The action plan is then implemented as planned and its progress monitored and reviewed, and the processes involved and their outcomes eventually evaluated.

The evaluation of action plans is an important step, but one that is often overlooked or avoided. Not only does it tell the organisation how well something has worked in reducing stress but also it allows the re-assessment of the whole situation, providing a basis for organisational learning. Essentially it establishes a continuous process for improvement. Managing work-related stress is *not* a one-off activity but part of the on-going cycle of good management of work and the effective management of health and safety. In many ways, good management *is* stress management. This four-step process of risk management, from risk assessment to evaluation is presented in diagrammatic form below (see Figure 2.1). Each of these steps requires a brief description as part of the overall model.



**Figure 2.1: The risk management process**

### 2.2.1 Risk assessment

Analysing possibly stressful situations and assessing the risk that they might pose to the health of individuals or the healthiness of their organisations is not rocket-science. Such an assessment has only to be good enough to provide sufficient appropriate evidence to initiate discussions of stress-related problems at work and provide an informed basis for managing those problems through a risk reduction action plan.



The notion of 'good enough' may cause some people problems in that it suggests something 'second-rate' in everyday usage. Here it is used in its scientific sense and that which is 'good enough' is contrasted with that which is 'ideal' or 'perfect'. The ideal or perfect can be the enemy of that which is 'good enough' and here the search for perfection may unnecessarily delay action to everyone's cost. 'Good enough' is used here to mean fit (and sufficient) for purpose. The purpose of the risk assessment is to inform, guide and support subsequent risk reduction: it is not a purely scientific exercise aimed at publications in esteemed journals.

The risk assessment brings together two things to allow the identification of likely risk factors.

First, it requires the identification of stressful hazards: hazards that have the potential for damaging health through the experience of stress. Stressful hazards are usually situation specific; what is present in one type of work or affects a particular type of worker may not be present in another job or affect a different type of worker. The risk assessment has to consider particular defined work situations (e.g. by examining the workplace, type of worker, work process etc.). It is not an organisation-wide approach. The latter approach is necessarily 'broad brush' that risks missing important details.

The identification of stressful hazards relies on the expert judgement of groups of relevant working people about the adequacy of the design and management of their work. The knowledge and expertise of working people in relation to their jobs is recognised and treated as valuable evidence. This information is treated at the group level and consensus is measured in those expert judgements on working conditions. The method does not seek to catalogue individual views about work.

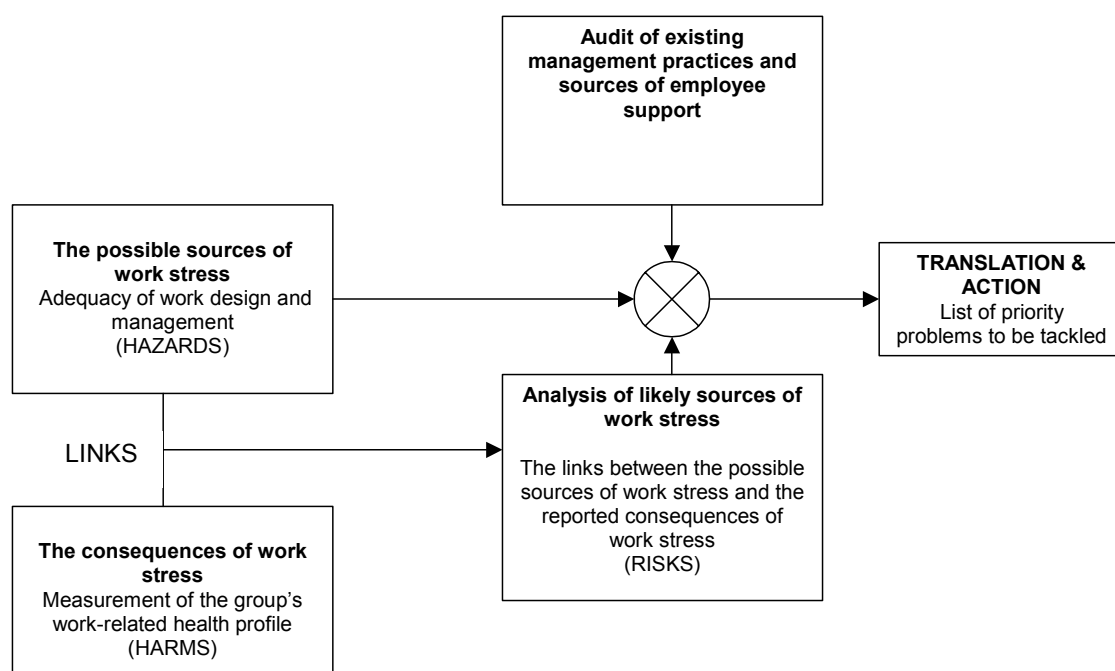
Second, information about the possible outcomes of work-related stress is collected both from the risk assessment and from otherwise available organisational records, such as absence data and occupational health referrals. This information is used to determine which of the stressful hazards actually affects the health of those exposed to them or the healthiness of their organisation. This exercise, relating stressful hazards to their possible effects on health, can be an exercise of logic or can be more formally investigated using simple statistical techniques. Most organisations will use the former approach.

The exercise of logic is straightforward and involves comparing groups or areas that differ in terms of their exposure to, or report of, the stressful hazards in terms of the data on possible health outcomes. What is required here is that the exercise of logic is described and that decisions based on it are justified in terms of the available evidence so that they can be audited at a later stage if necessary.

Bringing together the information on stressful hazards and their possible health effects allows the identification of likely risk factors. These risk factors can be prioritised in terms of the nature of the hazard or the harm it causes, the strength of the relationship between hazard and harm, or the size of the group affected. Similar decisions on priorities are made everyday in other areas of risk assessment.

However, before action can be sensibly planned, it is necessary to analyse what is already in place to deal with work-related stress and its effects on the individual or their organisation. This analysis requires an audit of existing management practices and employee support. This is an examination of initiatives for handling work-related stress and of the support available to employees to help them cope or look after them if they are affected.

This information from the audit together with the risk assessment information allows a notion of the residual risk to be formulated. All this information feeds forward to the process of translation: discussing and exploring the risk assessment data to allow the development of an action plan for risk reduction. The risk assessment strategy is summarised in Figure 2.2.



**Figure 2.2: Risk assessment strategy**

### **2.2.2 Translation: A plan for risk reduction**

The risk assessment information is used as evidence on which to base the planning of the risk reduction activities. In practice, those involved in action planning discuss and explore the results of the risk assessment (the likely risk factors and the problems identified by the majority of staff), developing their understanding of the problems identified. This often leads to the discovery of any *underlying* problems (or ‘organisational pathology’) and this can add to the power of the translation exercise. It helps the planning of risk reduction to know if there are deep problems that are driving the likely risk factors.

Translation involves agreeing what needs to be done, how it will be achieved, by whom and when, whether others need to be involved, what resources are required, and, importantly, how it will be evaluated.

The emphasis here, and in UK and European legislation on health and safety is on primary risk reduction targeted on the organisation as the generator of the risk. However, in practice, it is often also necessary to also consider how support for those affected can be improved or provided.

### **2.2.3 Intervention & risk reduction: Delivery of interventions**

The implementation of the action plan for risk reduction needs to be carefully and thoughtfully managed. It is effectively a change process, and, like all change processes has to be planned and managed to be effective. The progress of the action plan must be systematically monitored and discussed, as well as provision made for it evaluation.

## **2.2.4 Evaluation**

It is essential for any action plan to be evaluated to determine how well and in what respects it has worked. The process of implementation as well as the outcomes of the action plan must be evaluated. Evaluation must consider a wide variety of different types of information and draw it from a number of different but relevant perspectives (e.g. staff, management, stakeholders etc.).

The results of the evaluation should allow the strengths and weaknesses of both the action plan and the implementation process to be assessed. This information must not be treated as an issue of success or failure, praise or blame, but treated more dispassionately. It should inform a re-assessment of the original problem and of the overall risk management process, as well as providing feedback on the outcomes. In this Report we describe both the strategy used to evaluate the interventions and the results of those evaluations for each of the case study groups.

The organisation should use the evaluation to establish a vehicle for continuous improvement and also as the basis for drawing out learning points that may be of use in future risk management projects.

## **2.3 Key principles**

Risk management for work-related stress is not an exercise in stress research: it is focused clearly on intervening to reduce the experience of stress at source. It is an action-led programme. The execution of a risk management project is a professional undertaking that should be subject to common sense with an awareness of the sensitivities of those involved. For those with a recognised professional background, their codes of conduct, ethical principles and advice on and issues of best practice should be brought to bear. Its completion is also framed by the national and European health and safety legislation and by employers' common law duty of care. It is essential that those involved have evidence of their competence and are fully aware of the ethical aspects of this work as well as the legal and scientific aspects.

The risk assessment recognises the validity of the expertise that working people have in relation to their jobs. It draws on their expert judgements at the group level. It works with consensus and seeks to validate consensus judgements against health data. However, the overall risk management process goes further and seeks to involve employees in the prevention of work-related stress and not by requiring them to simply change their perceptions and behaviour. Much of what needs to be done to reduce work stress at source involves implementing good management practices, or organisational development activities. For such changes to be effective, the people involved in them must have a sense of ownership and be involved in the changes that take place.

## **2.4 Concluding comments**

This chapter has outlined the risk management process in sufficient detail for it to act as a framework for the presentation of the case studies. It has described the model underpinning this approach and its basic steps. A much fuller methodological account is already available through an earlier Health & Safety Executive publication (Cox et al, 2000a).

The following chapters deal in more detail with the basic steps - telling the story of how this project unfolded in three hospitals. This should provide the reader with an account of the application of the risk management approach to managing work-related stress in hospital settings. The authors hope that by drawing on the available case study information, this story is both informative and enjoyable.

### 3. CASE STUDY ENVIRONMENTS

The aim of the research was to provide practical examples of how work-related stress could be assessed and managed in hospital settings. The majority of staff involved were those who directly assessed patients' conditions and/or delivered care. This included a variety of groups from qualified nursing staff through to specialist technicians trained in the use of particular assessment techniques. Also included were staff not directly involved in patient assessment or treatment delivery: these staff are an important and significant proportion of a hospital's workforce.

#### 3.1 Staff involved in the project

The variety of staff involved in the project was designed to reflect the diversity of occupations that make up a hospital's workforce. The 'sample' of departments and employees involved was intended to be as broad as the project funding and timescales would allow. As a result, we hope that staff throughout the healthcare sector find this Report to be relevant, useful and informative. This was not a representative survey of stress in hospital staff. Rather it is series of case study examples of the risk management approach to work stress.

Boxes 3.1 and 3.2 give details of the departments and staff involved in the work. Three Trusts were involved. There were five 'case study groups': two departments from North NHS Trust, two from West Central NHS Trust and one from East Central NHS Trust. Some of the case study groups were functional working units (a variety of different groups of staff working in the same department e.g. North NHS Trust's Ear, Nose and Throat (ENT) & Eye Out-patients Department (OPD)) others were specific occupational groups (i.e. one distinct group of staff e.g. qualified nursing staff in North NHS Trust's Children's Services). This variety of case study groups provided a mixture of practical examples for use in this Report.

Several groups of direct care staff were included in the case studies. These are described below in Box 3.1:

<b>Box 3.1</b> <b><i>Direct care staff involved in the project</i></b>	
Qualified nursing staff:	From junior grades (NHS Grade C) through to Nurse Managers (NHS Grades G and H)
Healthcare assistants:	Non-qualified staff delivering patient care (at NHS Grade A and B)
Qualified technical and professional staff:	Audiologists and Orthoptists
Staff combining managerial and clinical workloads:	Senior Grade (NHS F, G and H) grade nursing staff (in East Central NHS Trust)

There were two groups of non-direct care staff involved in the project. These are described in Box 3.2:

**Box 3.2****Non-direct care staff involved in the project**

Support and service workers:

Catering staff

Administration staff:

Clerical and reception / front desk staff

Table 3.1 shows how these various groups of staff were represented in the case study groups. The case studies presented include a variety of different staff working in a variety of different departments and work settings.

**Table 3.1: Departments and employees participating in the research**

	North NHS Trust Children's Services	North NHS Trust ENT&Eye OPD	West Central NHS Trust A&E Dept	West Central NHS Trust Catering Dept	East Central NHS Trust Children's Services
<b>Direct care staff</b>					
Qualified nursing staff	✓	✓	✓		✓
Healthcare Assistants		✓	✓		
Qualified professional 'technical' Staff		✓			
Staff with both a managerial and clinical workload		✓	✓		✓
<b>Non- direct care staff</b>					
Support / Service Workers				✓	
Administration Staff		✓	✓		

**3.2 Case study groups**

This section contains a brief description of each of the case study groups.

**3.2.1 North NHS Trust: Ear, Nose & Throat (ENT) & Eye Out-patients Department (OPD)**

Four distinct groups of staff worked together in this department. The majority of staff were qualified nurses and healthcare assistants (in total a group of around 25 staff). This group worked with consultants running clinics, assessing patients and delivering treatments.

The department contained two sub-departments: an orthoptic department (9 staff) and a audiology department (20 staff). These groups provided support for the clinics run by the department, and had their own caseload (e.g. correcting vision problems and managing patients with balance problems). The department had its own administration / reception desk area (patient notes were kept in the department). Approximately 15 people worked in this area carrying out reception desk and clinic administration work.

### **3.2.2 North NHS Trust: Children's Services**

Approximately 90 qualified nursing staff working in three wards were involved. One ward – the neonatal unit - was based at the Trust's main hospital site. The other two wards (which dealt with older babies and children – referred to in this report as Ward A and Ward B) were based at one of the Trust's 'satellite' sites. During the project these two wards moved to the main hospital site.

The neonatal unit employed approximately 40 staff with the remainder of the group being split roughly equally between the two other wards. Staff worked on a shift work basis, with about 10 staff working on the neonatal unit at any one time. On the other two wards between 4 and 6 qualified nursing staff worked on each ward on each shift.

### **3.2.3 West Central NHS Trust: Accident & Emergency Department**

Nursing staff, healthcare assistants (HCAs) and administration staff from the department were involved in the case study. The majority of the staff were qualified nurses (25 staff), who were supported by 10 HCAs. The department had its own administration section (12 staff).

This was a busy department with a high workload. It was split into two areas – one side of the department dealt with minor injuries (such as cuts, burns and fractures), while the other side dealt with more serious problems (e.g. heart attacks, major traumas). Staff worked shifts and their work was 'rotated' so that they spent some time on each side of the department. Around 10 nursing and HCA staff worked on each shift. Administration staff worked on a front desk reception area or in a small office just behind it: a small number of these staff provided administration support on night shifts.

### **3.2.4 West Central NHS Trust: Catering Department**

This department prepared meals for the whole hospital. It also provided a dining room service for staff and visitors. In total, it employed around 40 catering staff. The majority of the staff worked in food preparation areas - either cooking, preparing ingredients, or cleaning around food preparation areas.

The remainder of the department's staff worked either in the dining room (serving customers and preparing some items of food) or in the central washing up area (where crockery and utensils returned from the wards and dining room were cleaned).

### **3.2.5 East Central NHS Trust: Children's Services (F,G, & H Grade staff)**

The Children's Services department in this Trust was large. It was made up of more than 15 wards (in comparison to the three in North NHS Trust). This case study was designed to look at managing problems for staff that had a significant managerial workload in addition to their clinical work.

Approximately 80 staff were involved in this project. The majority were staff working at F grade. The next biggest group was G grade staff (who had responsibility for the management of wards). There was also a small number of H grade staff that provided operational support and advice for G grade staff.

This case study focused on the managerial aspects of the work done by these staff. It also looked at how the managerial part of the job 'interfaced' with clinical work.



## 4. ANALYSING THE PROBLEM: RISK ASSESSMENT

This section describes the part of the risk management process that identifies the need for problem-solving interventions: the risk assessment. Risk assessment draws upon employees' experiences and judgement of their working conditions and measures of their well-being to identify the likely sources of work stress. It is also tailored to reflect the size, and the nature of the work they do, and the composition of the assessment group. Details of how this is done are given in this chapter – the case study examples are used to show that a flexible approach is needed.

### 4.1 Risk assessment: Objectives, evidence and deliverables

The risk assessment had a number of objectives – each requiring evidence to be gathered. These are described below:

- **Objective:** To identify problems with the way work is designed, organised and managed: the possible sources of stress  
**Evidence required:** Evidence about problems with the design and management of work: the potential sources of stress, or hazards
- **Objective:** To measure the well-being of staff and the 'healthiness' of their department or organisation: the possible consequences of stress  
**Evidence required:** Evidence of the well-being of the group - is there stress-related problem and what is it?
- **Objective:** To examine the adequacy and benefits of existing management practices  
**Evidence required:** Evidence about existing or planned management practices that might help to solve any problems or support employees
- **Objective:** To identify which problems with the work are linked to poor staff well-being  
**Evidence required:** Evidence about the likely sources of stress: what is it about the job that might be affecting the well-being of staff: the risk factors

These reflect those pieces of evidence described in the framework outlined in Chapter 2.

These aspects of a risk assessment are context-dependent. Evidence gathering may vary between groups. However, the underpinning logic, the principles and procedure remain constant. The case studies demonstrate how the risk assessment can be adapted to gather good enough evidence in a variety of settings.

### 4.2 First steps: Principles, planning and practicalities

In planning the risk assessment a number of guiding principles and practical issues are important. For each of the case study groups involved, these were applied so that the risk assessment could be executed in the most appropriate way.

#### 4.2.1 Principles

During this work we have found it extremely important to work within a number of well-defined guiding principles (see Table 4.1). These keep the risk assessment on track. They guard against a number of problems. For example they help prevent misconceptions about the aims



and objectives of the risk assessment (e.g. that it is about stress management training or counselling provision). These principles should be applied throughout the project. They are especially important to ‘set the ball rolling’ correctly and to establish good practice early on.

**Table 4.1: Key principles of risk assessment**

<b>Working with defined groups</b>	Each risk assessment was carried out within a defined group – either a department or profession
<b>Focus on work not individuals</b>	Risk assessments were executed in order to identify the aspects of work giving rise to stress – not the individuals experiencing stress
<b>Focus on ‘big issues’</b>	The focus was on problems that staff agree on, rather than individual complaints
<b>Use of reliable measures</b>	All methods of data collection were designed to be reliable and valid
<b>Confidentiality of information</b>	Confidentiality of information given by individuals was guaranteed. Individual information was stored securely and not disclosed
<b>Risk reduction as a goal</b>	The risk assessment was designed with risk reduction in mind. Risk assessment tools were designed to provide sufficient detail and context-specific information to allow for intervention design

#### **4.2.2 The accessibility of the group**

The risk assessments were planned to ensure that minimal disruption was caused. This is particularly important in healthcare settings where, in extreme cases, patient care might be interrupted by over-intrusive data collection. At the very least, intrusive data collection will do little to encourage staff to become enthusiastically involved in the risk assessment.

#### **4.2.3 The size of the group**

Risk assessment needs to be workable for various sizes of groups. Larger groups can support the use of questionnaire data, while for smaller groups more qualitative approaches (e.g. interviews) yield more useful information. For example, we drew upon qualitative methods for staff in the small administration group in the ENT & Eye OPD in North NHS Trust. For the larger patient assessment and treatment delivery group in the department, we were able to use a questionnaire as the primary evidence gathering tool. Even for small groups quantitative health data are useful. Short questionnaires were used to gather data on well-being for even the smallest groups involved in this project. An assessment of the size of the group, and of any sub-groups within it

(e.g. dining room staff within the Catering department) was used to guide the planning of the risk assessment activities.

#### **4.2.4 Management issues**

At the start of the risk assessment we worked with a key contact in each group to establish a Steering Group that would help to run each case study. This group was charged with overseeing and facilitating each risk management project. This group guided and gave authority to each risk assessment. Its membership was designed to enable it to have authority and credibility. The steering groups represented all interests relating to work stress and employee health in the assessment group (i.e. key stakeholders). Typically, management, staff representatives (in some cases union representatives), occupational health, health and safety and human resources specialists formed the Steering Groups. For example the Catering Steering Group consisted of staff from the dining room, kitchen and cleaning / washing areas. The groups were kept sufficiently small to manage and function well (i.e. up to seven or eight people).

The Steering Group drove the project forward. Often a project ‘champion’ took on the ‘overseeing’ role of ensuring things progressed smoothly and stayed on track. Health and safety specialists, occupational health specialists, and employee representatives (e.g. trades union officials) were particularly effective in this role. As far as possible we worked to empower the group to manage and execute as much of the project as possible (see also Section 9 for discussion of the skills and competencies required to carry out the risk management work).

#### **4.2.5 Publicity and marketing**

Publicity is crucial to making the risk management project work. Without it people can feel uninvolved and may become wary and suspicious about what is going on. A variety of strategies were used in the case study groups, many of which used effective communication systems already in place within each group (e.g. regular team meetings, or communication books). For example in East Central NHS Trust we used the regular sisters’ workshops to publicise the risk assessment and inform staff about its benefits. An initial informal assessment of communication systems was made to allow this to happen.

Since the risk management approach to dealing with the problem of work-related stress is so new, many staff were unfamiliar with the project and were unsure what it would mean to them. Consequently as many methods as possible were used to publicise the project. Posters, memos, ward / unit meetings and team briefings were all used.

##### ***Box 4.1: Publicity materials***

###### **Publicity materials used in the North NHS Trust ENT & Eye OPD**

- Poster to announce the project: ‘this is what it is’ and ‘these are the benefits’
- Briefing at two ward meetings before the risk assessment (these contained information about what staff would be asked to participate in( interviews and questionnaire completion) and covered topics such as confidentiality and timescales)

###### **Publicity materials used in East Central NHS Trust**

- Sisters’ meetings – with information cascaded down to other grades of staff at ward meetings
- Individual, addressed memo to each member of staff involved
- An article in the new staff newsletter

Two different titles were chosen for the project. In all cases this decision was made by the Steering Groups. Three groups used the title “The Work and Well-Being Project”, the other two used the name “Well at Work Project”. All groups felt that it was best to avoid the direct use of the word ‘stress’: it was felt that it might lead to misconceptions about the nature of the project (i.e. that it might be about stress counselling or the identification of ‘stressed’ employees). They also felt that “Work and Well-Being” adequately reflected the nature of the issues that staff would be asked to comment on.

#### **4.2.6 Managing staff involvement**

In order to keep staff involved, informed, and enthused, we used ‘project champions’ in each of the case studies. This was someone who was trusted and known by the majority of staff. At East Central NHS Trust the senior nurse for staff development took on this role, in North NHS Trust ENT & Eye OPD we had four different champions – one for each of the groups of staff involved in the project.

The project champions helped to encourage people to participate in all aspects of the project e.g. completing questionnaires or getting involved in the interviews. Project publicity also helped to encourage staff to get involved. High questionnaire return rates and involvement in interviews are important to make the project work – having someone ‘on the ground’ to facilitate this made a big difference in all of the case studies.

We gave the project champions an extremely detailed briefing about the project. This enabled them to keep staff ‘on the ground’ informed as the project progressed. Taking time to explain the project to staff always helped. We used this strategy (successfully) to tackle low return rates in busy departments, like Accident & Emergency, or where staff were not familiar with questionnaires and how they might be used (e.g. the Catering Department)

#### **4.2.7 Ethical principles**

There were a number of ethical principles that were followed during the risk assessment work. These are outlined in detail in the BPS Guidelines for Ethical Conduct (2000). Ethical principles such as informed consent and client confidentiality are an integral part of the risk assessment procedure. These were adhered to throughout the risk management process.

### **4.3 Risk assessment procedure: The 5 steps**

This sequence demonstrates the order in which the evidence was gathered. The procedure is designed in this way to help the evidence build into a risk assessment. A detailed description of the methods used for gathering evidence during this process is given in Section 4.5.

The risk assessment procedure contains a number of standard steps. Each step involves evidence gathering. The procedure enabled us to gather the four pieces of evidence needed for the risk assessment. These were:

- The possible sources of work stress
- The likely consequences of work stress
- An analysis of the likely sources of work stress
- An audit of existing management practices and sources of employee support

An account of the collection of this data, illustrated by the case studies is given in Boxes 4.11 to 4.26.

Risk assessment needs to be flexible and is tailored to meet the needs of the group of staff involved. The design and management of work, and the nature of working conditions, differs between jobs, workplaces and organisations. Different groups have different problems that manifest themselves in different ways. The risk assessment procedure was tailored to reflect this. This section presents an overview of the steps that need to be undertaken in order to carry out a good enough risk assessment.

#### **4.3.1 The five-step risk assessment procedure**

The first two steps are designed to gather information to build a model of the work and health of the assessment group. This information can be used as the basis for the risk assessment itself by establishing logical associations between the stress-related hazards and employee health, in which case Step 3 is omitted. In the case studies we used the information to support the design and use of an assessment survey in Step 3. This survey can be used to quantify the group's exposure to specific stress-related hazards (which would be established from Steps 1 and 2) and to assess its health.

##### **Step 1: Familiarisation**

We spent some time 'getting to know' each workplace. This involved informal chats, looking at organisational documents (organisational charts, job descriptions, absence summaries, results of other staff surveys etc.) and informal interviews with managers and key stakeholders. It was also possible to spend one day shadowing Catering staff, though this was not the case in departments such as Accident and Emergency. Arrangements for project management and publicity (see Section 4.2.5) were also made at this stage.

##### **Step 2: Work analysis interviews**

This step builds on the information collected during familiarisation. Work analysis interviews are conducted with the assessment group. Depending on the size of the group all or some staff may be interviewed. The objective of the interviews is to identify the likely stress-related problems. This information can then be used to design an assessment survey (Step 3) or can be interpreted in its own right. For small groups of staff these can give the bulk of the information needed to complete the risk assessment. For larger groups of staff, they are used to provide information for the assessment survey. Detailed information about how these interviews were conducted and used is given in section 4.5.1.

##### **Step 3: Assessment survey**

This step involved designing a questionnaire to survey all members of the assessment group about stress-related problems and their consequences (i.e. their health). The survey provided quantifiable data on the antecedents and consequences of work stress. It contains both tailored measures of work design (see Section 4.5.1) and standard measures of well-being (see Section 4.5.2). Surveys were usually presented in three parts.

- **Section 1:**  
Background information (age, gender, grade, ward, specialty etc.). This can be important if particular problems affect particular grades of staff, or if staff work in different wards or departments with different problems
- **Section 2:**  
Questions about the possible sources of work stress
- **Section 3:**  
Measures of the possible consequences of work stress

Questionnaire cover sheets and publicity were used to explain the purpose of the project and the principles (e.g. confidentiality).

Details of what these measures were and of how they were designed, used and interpreted are given in Sections 4.5. It may not always be possible to use a questionnaire survey. During this project we looked at some alternative approaches. A discussion of this issue can be found in Section 4.3.3.

#### ***Step 4: Audit of management systems and employee support (AMSES)***

This step of the risk assessment aims to assess what the organisation is already doing – or is planning to do – to deal with work stress. It looks at policies and procedures for dealing with work stress, and arrangements for dealing with stress-related problems. It also aims to identify examples of good management practices. In practice this can be carried out alongside the work analysis interviews (Step 2) and the questionnaire survey (Step 3). The data gathering activities used are described in Section 4.5.4.

#### ***Step 5: Data analysis and interpretation***

At this stage the evidence is brought together and analysed. We looked at:

- The health profile of the group
- The problems with the design and management of work: the stress-related problems reported by the group
- The likely risk factors and any risk groups
- The adequacy of existing management practices

The analysis and interpretation of these different pieces of information is described throughout the section on evidence gathering (Section 4.5).

#### ***4.3.2 Timescales***

The risk assessment can be carried out relatively quickly. Here is a brief resume of the time scales as they applied to the case studies contained in this Report.

Marketing and publicity usually ran for a week or two before the project began. Depending on demands on services and access to staff, the familiarisation and interviews were generally accomplished in one or two weeks.

Where surveys were used these were developed over a few days before being examined by the Steering Group. Once amended they were usually in the field for two weeks. Analysis and interpretation of the data, and report writing took two to three weeks.

With adequate co-operation from those involved, it was usually possible to complete a survey-based risk assessment (from marketing through to feedback of assessment results) in six to eight weeks. However, circumstances may mean that this is not always possible.

#### ***4.3.3 A Comment on methods: Interview data and questionnaire data***

To support the risk assessment we chose the methods that best fitted each group. The main choice was whether or not to use a questionnaire survey. We discuss this issue in this section of the chapter.

The tools and measures used in a risk assessment must be flexible. This means that the risk assessment can be adapted to meet the specific needs and context of the group under consideration.

We used the opportunity in some studies to gather both questionnaire and extensive interview data. This enabled us to compare the validity and utility of both approaches. In practice, both approaches gave very similar information. Quantitative data on well-being is useful, even from small groups. It allows for normative comparisons. Where the group is large, questionnaires give everyone the chance to have a say. For example it was not practicable to interview all the staff in the Accident & Emergency department of West Central NHS Trust. And, of course, the more people who have their say, the more likely the information is to be representative of the views of the group as a whole (the ethos of risk assessment is the identification of consensus problems that group agree on). Questionnaires also provides quantitative data on the sources of work stress. As we describe in Chapter 5, this can help with the identification of priorities.

Agreement on problems and their impact can be evaluated using either a questionnaire or interviews. Both used together give depth and detail to the results. If an assessment survey is not to be used, the information from the interviews will form the core risk assessment data to be interpreted in Step 4. If this is the case, they must also provide information on the association between these stress-related hazards and health by asking direct questions about how work problems may affect employee health (e.g. fatigue, anxiety, musculoskeletal pain) and organisational health (e.g. job satisfaction, intention to leave).

Problems identified in risk assessment surveys tended to tally with the issues most commonly raised as problems in the interviews. In larger groups questionnaires helped to quantify the size of the problem and were more practicable, since it was not possible to interview large numbers of staff. As this was a research and development project we attempted to use both methods. In other situations this may not be possible and the method most suitable and practicable for the group being assessed will need to be identified.

#### **4.4 Following the risk assessment process**

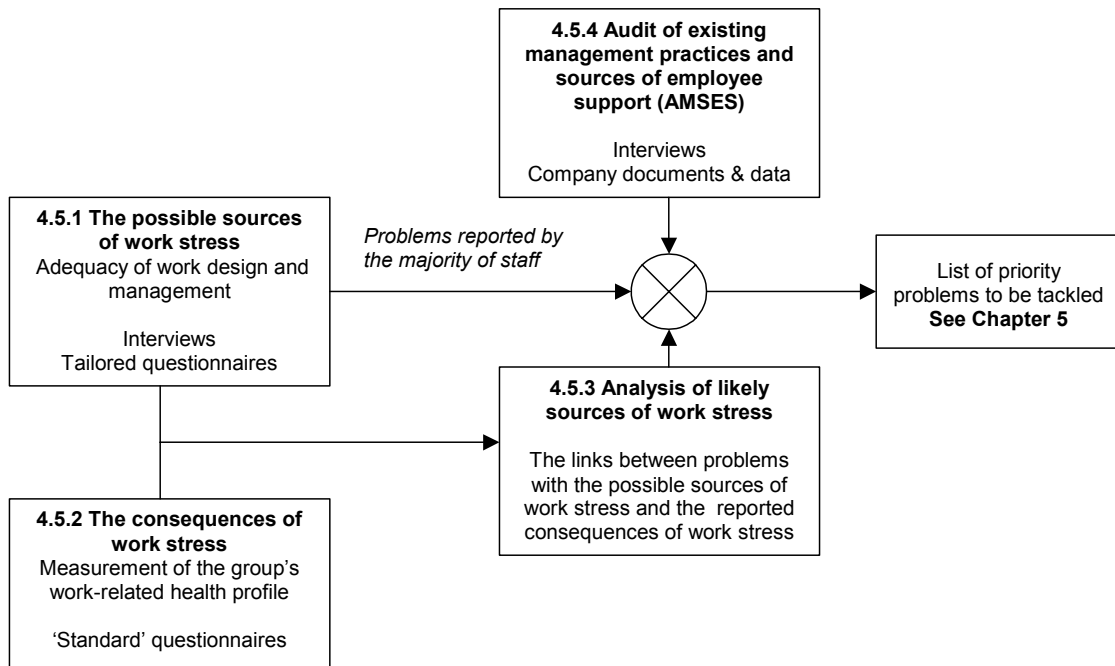
This chapter is the lengthiest and perhaps the most complex part of this Report. The risk assessment process described in Section 4.3.1 describes the activities involved in a 'typical' risk assessment. This describes what the process looks like when it is carried out.

Section 4.5 describes how the evidence needed to complete the risk assessment is gathered and analysed throughout the process. The evidence collected as described in Section 4.5 hangs onto the framework of the five-step risk assessment process described in Section 4.3.1.

Evidence gathering is the core part of the risk assessment process. The risk assessment process and its activities support the collection of evidence. Completing the risk assessment involved bringing the data together (see Figure 4.1) to draw conclusions about the problems and their impact. Section 4.5 makes explicit reference to the risk assessment procedure described in Section 4.3.1. We hope that this makes it clear how the risk assessment procedure dove-tails with the evidence gathering activities outlined in Section 4.5.

#### **4.5 Risk assessment: Evidence gathering**

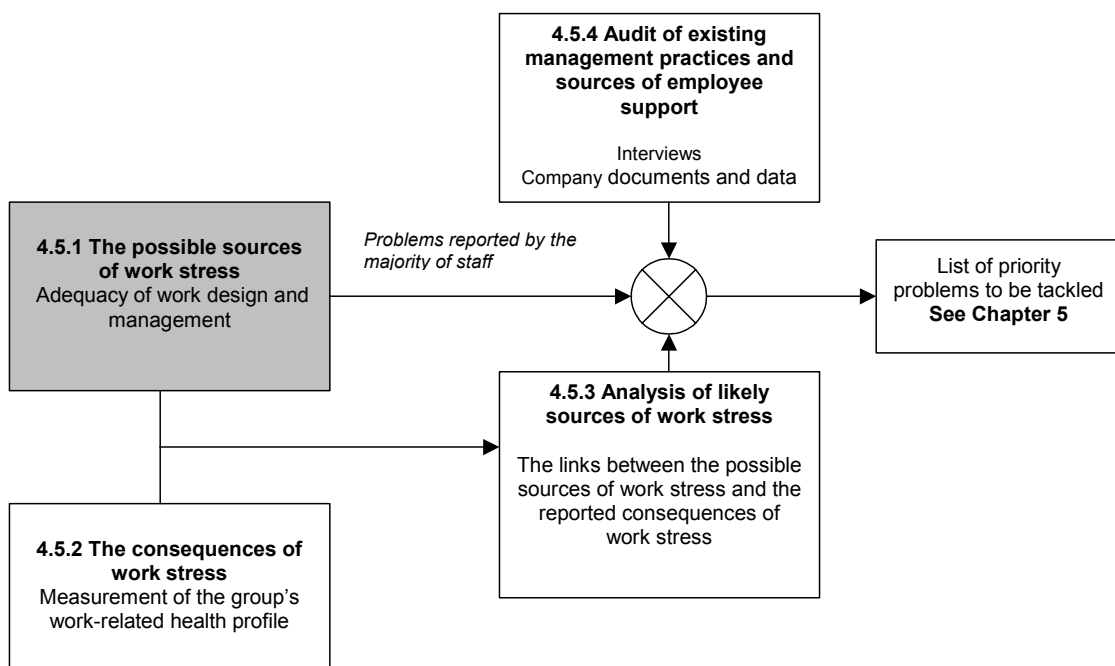
In this section we describe how each of the four pieces of evidence required for the risk assessment was gathered. Together these four pieces of evidence make up the risk assessment process. Figure 4.1 shows how these pieces of evidence 'fit' together.



**Figure 4.1: The risk assessment data collection strategy**

In each box we have identified the section of this chapter that describes, in detail, how the evidence was gathered. For example, Section 4.5.1 describes the measurement of the possible sources of work stress. To follow the process described in this section, Figure 4.1 should be used as a point of reference. We have inserted this figure at each point in our description of the evidence gathering process: the box that is shaded shows the evidence gathering that is being discussed. Once discussed, each box is marked with a tick (✓).

**4.5.1 The possible sources of work stress: Work design and management**



For the reasons given in Chapter 2, an assessment of the adequacy of work design and management is tailored to the needs and context of each group. For example, it does not make sense to ask nurses in children's services the same questions about their jobs as catering staff. Their jobs are certain to be very different and each group is likely to experience its own, different problems. That was why this aspect of the risk assessment required the most 'tailoring'.

### ***Familiarisation***

As a first step we familiarised ourselves with the work and its setting. We did this by inspecting job descriptions, visiting the workplace and where possible observing the work of those involved. We also looked at documents like organisational charts, workload statistics (such as clinic sizes in ENT & Eye OPD and the number of meals prepared and sold by the Catering department). Informal chats with staff and interviews with management were also valuable source of information at this stage. Familiarisation provided us with the background information we needed to construct and conduct work analysis interviews with staff.

### ***Work analysis interviews***

Building on the information collected during familiarisation, work analysis interviews were conducted with employees and managers. The key objective was the identification of all the major stress-related hazards associated with the design and management. This information was used to develop a model of the design and management of work and the nature of working conditions and then to design the assessment survey (Step 3), which quantified employee exposure to stress-related hazards and employee health.

The interviews were conducted with employees and managers from the group being assessed. They were designed to explore potential stress-related hazards, and their effects on employee health and on health-related and organisational behaviour. It was important that they were confidential and undertaken in a 'safe' and open climate, and that this was communicated to all employees from an early stage. We made sure that each interviewee understood the purpose and nature of the interview and had consented to participate in it. Their participation was requested as 'experts' in the stress-related hazards of their work.

A structured sample of the assessment group was interviewed, containing representatives from all sub-departments, grades, professions and levels. Depending on the size and variability of roles in the assessment group, we carried out anywhere between 10 and 20 interviews for each of the case study groups.

The content of the interviews was semi-structured, allowing the volunteers to talk about their work in their own words but with some form of structure to the discussion. This approach is less formal than a structured list of pre-set questions, but still provides the interviewer with a guide of topics to be covered. The kind of topics covered and questions asked are summarised in Box 4.2. We also went through a list of various aspects of work and asked the interviewee if any of them cause problems (e.g. task content, workload and pace, working hours, communication and leadership, etc. – see *Table 1.1*). The interviews were designed to end on a positive note, asking about the good aspects of work and what interventions might be used to make the situation better.

Rather than focus on the individual employee, the questions asked during the interview were related to the common experience and behaviour of the work group. The questions asked employees to make 'expert' judgements on their work and that of their colleagues in the assessment group. The aim was to elicit employees' judgements about which aspects of work were problematic for the group rather than which aspects of work the interviewee felt unhappy about.



**Box 4.2**

***Example questions asked during a work analysis interview:***

- What is your job title?
- What are your general duties (describe a typical day)?
- What are the main problems faced by you and your colleagues at work?  
[With further questions about specific, potential problems based on Table 1.1 e.g. 'Tell me about the way management communicates with staff. How well does this work? Are there any problems with this aspect of the job?]
- How do these [the problems] effect the health of you and your colleagues?
- Are there any health problems in your work group?
- What are the good things about your work?

Supplemented with open 'probe' questions such as:

- 'Can you tell me more about that please?'
- 'What do you mean by that?'
- 'Could you tell me about that in a little more detail?'

Boxes 4.3 to 4.5 give some examples of the types of issues explored during the work analysis interviews.

**Box 4.3:**  
***A question of time***

Interviewer: “Are time pressures a problem for you in your job?”  
Nurse: “Yes, a big problem.”  
Interviewer: “Can you tell me more about some of these problems.”  
Nurse: “Well, it's part of the job to deliver a total package of care to the child. Not just making sure they are safe, or getting better by taking care of medications and observation. I'd like to be able to take more time talking to children. But the number of kids we have to look after means we don't get the time to just sit and talk to them, and find out how they are feeling, or to re-assure them. It makes it less satisfying, I feel less proud of my work. You don't feel as if you are delivering all the care you can.”

Example taken from North NHS Trust Children's Services

**Box 4.4:**  
***Having a 'life' as well as a job***

Interviewer: “You work shifts. Are there any problems with the way shifts are managed?”  
Nurse: “None with the length of shifts or anything like that. But its just that we don't find out what shifts we are doing for the week until a couple of days before. That's very frustrating - you can't plan, or have a social life - and then you can't unwind properly.”

Example taken from West Central NHS Trust Accident and Emergency Department

Similar responses were given by a number of employees. We concluded that a question about the amount of advance notice of working hours should be included in the assessment survey.

**Box 4.5:**  
***The trolley dash***

Interviewer: “What about equipment. Do you have all that you need to do the job?”  
Catering assistant: “Generally, yes. But we are very short of trolleys. Especially around dinner time - there's a mad dash to get your hands on the few we have got. I just end up wasting time looking for one. Sometimes I go without and just carry things myself. Which I shouldn't really.”

Example taken from West Central NHS Catering Department

This seemed to be a problem for the cooks and cleaning staff in the Catering department. It came up time after time in interviews. We decided to ask about the availability of trolleys in the assessment survey.

### **Questionnaire items**

For each of the case study groups we used the information gathered in the work analysis interviews and the familiarisation to design a questionnaire measure of exposure to potential sources of work stress. This questionnaire measure asked employees to make expert judgements on the adequacy of specific working conditions. The questionnaire items were designed to cover all the problem aspects of work identified during familiarisation and work analysis interviews as briefly and concisely as possible.

Employees evaluated the adequacy of each aspect of their work by ticking a box on a scale. We used two types of scales. The first asked staff to indicate how often each aspect of the design and management of work was 'good enough' i.e. never good enough, rarely good enough, often good enough, or good enough all the time. Some examples of questionnaire items are given below – these related to the examples of interview questions given earlier.

**Box 4.6**

***A question of time.....***

Once you have carried out basic priority care tasks, [how often] do you have enough time to deliver additional patient care (e.g. talking to a child)?

North NHS Trust Children's Services

**Box 4.7**

***Having a life as well as a job.....***

[How often] Are you notified of your working hours far enough in advance?

West Central NHS Trust Accident & Emergency Department

**Box 4.8**

***The trolley dash.....***

[How often].....Do you have enough equipment (e.g. trolleys) to carry heavy or awkward equipment?

West Central NHS Trust Catering Department

In some cases we also used simpler scales. The example in Box 4.9 is taken from the questionnaire used in East Central NHS Trust Children's Services. It asked staff to indicate whether there are adequate arrangements in place to help them deal with their administrative workload.

**Box 4.9**

***The adequate / inadequate scale***

<b>Work Characteristic</b>	Is this aspect of your work (please tick):	
	<b>Adequate</b>	<b>Inadequate</b>
Frequency of 'office days' or slots of time in which you can work on administrative tasks		

In practice these and other scales provide very similar information. We worked with each project Steering Group and the staff involved to identify the most suitable and appropriate for each case study. We also tried simple, two point scales like the one above – these seemed to work well.

It is impossible in the space provided to list all the items used in the various case studies. However, to give a flavour of them Table 4.2 provides some examples taken from the various aspects of the design and management of work that we investigated.

**Table 4.2: Examples of questions about work design**

<b>Work Characteristic</b>	<b>Taken from</b>	<b>Example question [How often.....]</b>
<b>Job content</b>	West Central NHS Trust Catering Department	Do work sheets (the lists of jobs you have to do) make the job varied enough?
	North NHS Trust Children's Services	Do you have enough time to carry out informal observations of patients (i.e. 'to keep an eye of them', rather than taking blood pressure readings etc.)?
<b>Workload / work pace</b>	North NHS Trust ENT & Eye OPD	Is enough time allocated to see each patient during clinics?
<b>Work schedule and organisation</b>	West Central NHS Trust A&E	Are you notified of your working hours far enough in advance?
	North NHS Trust ENT & Eye OPD	Do you find yourself working extra hours (e.g. to finish jobs, because clinics have over – run etc.)?
<b>Control and participation</b>	North NHS Trust Children's Services	Do you have enough say in decisions about how many patients are admitted onto the ward?
<b>Organisational culture and function</b>	East Central NHS Trust Children's Services	[is] Communication and co-operation with other wards in the service e.g. about the movement of staff [adequate or inadequate]
	North NHS Trust Children's Services	Do you get enough advice and support when you start to do nursing tasks that are new to you?
<b>Interpersonal relationships at work</b>	West Central NHS Trust Children's Services	Do you get enough help to do the job from your colleagues in your area of the Catering department?
<b>Nature of the role</b>	West Central NHS Trust A & E Department	Do medical staff that ask you to carry out patient assessments and treatments demonstrate a clear enough understanding of the boundaries of your skills and responsibilities?
<b>Career development</b>	North NHS Trust ENT & Eye OPD	Are there enough opportunities for you to progress to a better job within ENT / Eye OPD, or some other part of the Trust?
<b>Home-work interface</b>	North NHS Trust Children's Services	Is the off-duty rota flexible enough?

### ***Interpreting the data: Consensus***

The data from questionnaires and interviews was used to identify and describe the major stress-related hazards for the assessment group. This did not involve listing every individual complaint, but just those problems that were identified as being major problems.

The level of consensus or agreement on the presence of a stressor (e.g. the proportion of staff reporting an aspect of their work to be never or rarely good enough, or inadequate) was used to

achieve this. A starting point would be to consider those stress-related hazards that are agreed by the majority of employees (>50%) as being problematic. Similarly, the aspects of work reported as satisfactory or good by >50% of employees were presented as features to maintain or strengthen. We were also careful to examine for the presence of local problems within the group that may not have been reported by a large proportion of the group as a whole. For example in North NHS Trust Children's Services, noise was a major problem in the Neonatal Unit, but not in the other two wards.

An example of what these data 'looked like' for East Central NHS Trust Children's Services is given in Box 4.10. Summaries of the results for the various case study groups are given in Boxes 4.11 to 4.17.

**Box 4.10**

***Problems in East Central NHS Trust Children's Services***

Generally, this group of staff was satisfied with many aspects of work. However there were some 'clusters' of problems. For example (i) dealing with managerial and administrative tasks, (ii) training and development arrangements and (iii) communication systems.

	% of <b>all staff</b> reporting it to be inadequate or a problem
<b>Workload / Work pace</b>	
Amount of time available to tackle long or complex managerial / planning tasks that require concentrated thought	86
Frequency of 'office days' or slots of time in which you can work on administrative tasks	71
Administrative support in your ward / area (e.g. to answer the telephone, door buzzers etc.)	71
<b>Training &amp; Development</b>	
Availability of funding to support your study / training and development	74
Amount of feedback from staff who have been on training courses	67
Availability of study time / time for training	66
Speed with which new ideas are allowed to develop, gain approval, and then put into practice	66
<b>Communication</b>	
Availability of information on a continuous basis, about how the ward is performing e.g. against its budget	79
Communication and co-operation with other wards in the service e.g. about the movement of staff	69

**Box 4.11**

***Positives and problems in East Central NHS Trust Children's Services***

In general staff indicated that a large number of aspects of their work were well-designed and managed. A number of positive aspects about the nature of the work, and the working environment were identified within the Children's Services. The group as a whole indicated that there were strong working relationships between colleagues, facilitating a supportive environment for emotional, clinical and managerial issues. The quality and availability of advice within the department was regarded as a positive aspect of work. The degree of autonomy within Children's Services was highly regarded; respondents noted adequate levels of control over the management of both their personal time and that of their staff. Clarity of roles and targets was also reported to be a positive aspect of work by the group as a whole. These findings reflected good management practices.

However, a number of issues relating to the design of work were identified as problematic to the whole group, specifically the amount of time to complete complex managerial tasks and the availability of support to complete these tasks. Issues regarding both funding and time available for study were also highlighted as inadequate aspects of work. The absence of continuous communication regarding the wards performance was an issue for most staff. Problems were also identified in the amount of communication between wards and the subsequent level of understanding of each other's job roles and ward requirements. Concerns were also noted at the work-home interface, with the group as a whole indicating the impact of their work on their home life was a problem, and further that the amount of work that they have to take home was a problem.

Some problems were specific to F grade staff including the absence of opportunities to take breaks during a typical shift, and the clarity of written communications. G and H grade staff reported that the amount of time available to discuss the future and management of their ward with consultants was problematic. G and H grade staff also reported an inadequate level of understanding of their roles by other staff.

In boxes 4.12 to 4.17 we present a brief summary of the results gathered from the case study groups. These case study examples illustrate that while real problems need to be recognised, the good things about the job should not be ignored. It is clear that healthier groups reported more of these sources of satisfaction. Many groups of staff reported that, despite its problems, the job was varied, interesting and positively challenging. We worked to ensure that these strong aspects of work design were maintained or strengthened further during risk reduction.

**Box 4.12**

***ENT & Eye OPD care delivery staff: a group with few problems***

Nursing, orthoptic and audiology staff reported a large number of aspects of the job to be positive and satisfactory. These included variety of treatments and assessments they were involved in, the level of control they had over the way they delivered care, and being adequately equipped and trained to do the job. Relationships with management were strong - staff reported communication to be clear and regular (e.g. through regular team meetings), and consultation to be real and effective. They also reported that management were knowledgeable and aware of the issues associated with working in the department. Section 4.5.2 shows how these strong aspects of work design were reflected in the strong health profile of the group.

However, some problems were reported. Nursing and orthoptic staff reported that a major problem concerned access to patient records, and poor communication with patient administration staff. There were problems in patient administration (see Box 4.13) that impacted on nursing and other staff. Many staff indicated problems with the volume of paperwork and lack of help with administrative tasks (e.g. locating and filing test results). Staff also said that clinic time was pressured leading to a lack of time to see each patient and a lack of flexibility in the length of appointments. Treatment work was often interrupted by telephone calls. In a small department, staff absence impacted on those remaining: covering for absent staff or carrying out tasks assigned to others and a lack of qualified staff were all reported to be problems. In terms of the working environment several issues were related to the physical size and design of the department. These included the temperature (staff reported it to be hot and stuffy), lack of space and excessive noise. Although working relationships within the department were generally good, there were problems with: a lack of appreciation and recognition from consultants and their staff, aggressive or abusive patients (and a perceived lack of training in how to deal with them) and patients not understanding the appointments system.

Audiology and orthoptic staff reported many of the aspects of their work to be adequate. These were similar to those reported by nursing staff. A handful of problems were reported by audiology staff that included: a lack of appreciation and recognition from consultants and their staff, providing cover for the work of staff who were absent, interruptions by phone calls from the public, working extra hours, and a lack of space and sound-proofing in treatment and examination rooms. The main problems for orthoptic staff concerned access to patients' records and clinic administration. Like nursing staff, they also reported problems with a lack of appreciation and recognition from consultants and their staff, a lack of flexibility in the length of appointment times, and a lack of time when being given extra tasks to do.



**Box 4.13**

***ENT / Eye OPD administration staff: A group under pressure***

Administration staff were experiencing a number of problems. Staff turnover was high, and the job was skilled and demanding. Lack of training and guidance on various aspects of the job (especially computer systems) were raised as severe problems. Most regarded their work environment as cramped, hot, poorly lit and inadequately laid out.

With a high turnover of staff, those remaining reported being under heavy time pressures and often dealt with more than one person's workload. Clinics were busy and booking systems complex. Many staff reported it was difficult to deal with such complex jobs in the hustle and bustle of the department, especially in the face of a stream of interruptions. Most of the time there were simply too few staff to cover for staff on training courses, and people had to muddle through as best they could.

Staff also reported that their problems were not adequately understood by other parts of the department, and that this lack of understanding was making a difficult situation worse. However, even in the face of these difficulties, staff reported that there were a number of good things about their job. These included the varied and interesting nature of the work, the clarity of their role and priorities, communication with line managers and being able to get good advice and support from colleagues.

**Box 4.14**

***North NHS Trust Children's Services***

The nursing staff were positive about many aspects of their work. They felt adequately appreciated by ward managers, patients' parents and their colleagues. Their job appeared to be varied, rewarding (in the sense they could care for a patient over a long period and see their condition improve) and interesting (they were faced with a range of presenting conditions requiring different care plans and skills). They also reported that their views were asked for and respected when decisions were made about care. Support from colleagues was said to be good, with their being a good 'mix' of skills on the wards. Performance appraisal was seen as useful and frequent enough. Important information was freely available and communication was frequent (e.g. through useful, participative, and informative and regular ward meetings).

Despite these encouraging findings, some aspects of work were judged to be rarely, or never good enough by large numbers of staff. One aspect of work identified as a problem was recognition and feedback from higher up in the organisation. The work was pressured and the dependency levels of patients meant that sometimes nurses did not feel that they were delivering the total care package (e.g. talking to children and parents about their concerns as well as ensuring they were safe and comfortable). The level of paperwork was also seen as a problem.

At the time of the risk assessment, the service was using many agency staff to cover staff absence, sickness and vacancies in the establishment. Given the specialised nature of much of the work, many staff indicated that supervising temporary staff was increasing the pressure on their time. There was also a perceived shortage of housekeeping or support staff (staff who cleaned and prepared cots, dealt with stock etc.). Many nurses felt that much of their time was being taken up doing housekeeping tasks as a result. There also appeared to be a problem in the working relationship between medical and nursing staff: it was reported that medical staff often took for granted that nurses would carry out 'extended role' tasks (e.g. setting up an intravenous drip).

Nurses also reported a lack of support to help them deal with the cultural diversity of patients and their families, and a lack of staff with specific responsibilities for organising children's play. In terms of support many said there was a lack of support for staff that had been involved in distressing or upsetting situations. There were also some severe problems with the physical working environment (such as the temperature and ventilation) and problems related to the availability and storage of equipment. There were some issues (e.g. problems with noise levels) that were particular problems in certain wards (i.e. the neonatal unit).

**Box 4.15**

***West Central NHS Trust Accident & Emergency Staff***

***The balance of challenge, support and involvement***

By its very nature, accident and emergency (A & E) nursing is stretching and unpredictable. At times it is hectic. Often the stakes are very high. In this environment proper work design and management is needed to help staff deal with the challenges they face. In this department it was unsurprising that nursing staff (including HCAs) reported their job to provide adequate variety, opportunities for decision making and room for the development of skills. Staff reported that they worked well as a team and reported being well supported by their colleagues and managers when it came to getting the job done. The majority of staff reported that they were adequately trained to do their job. Most indicated that colleagues were reasonable in their requests for help. What also came across strongly was that when faced with problems or uncertainty, staff felt their colleagues were good sources of advice and support. The majority said their job allowed them to make decisions and this was rewarding - but that policies, procedures and the boundaries of their roles were clear. Most were happy with the length of their shifts. Departmental meetings, although sometimes infrequent, and shift handovers, were said to be useful and informative. Many said that daytime security arrangements were good, and that the triage system worked well. The department also appeared to be well-equipped.

Both treatment delivery and administration staff reported problems with their workload, time pressures, interruptions and lack of help at busy times. Problems working with staff outside of the department also seemed to be important – the most prominent of these involved difficulties in getting patients beds on the wards. There was also a cluster of problems around communication and consultation within the department: staff reported problems with management's responses to their ideas, and a lack of consultation about change, as well as problems with communication from the Trust's senior management. As with many A&E departments, staff reported problems with abuse and assault from patients – they also reported needing more training to deal with these situations. Support for staff involved in distressing and upsetting situations was also highlighted as a problem. The majority of those in the department reported low staffing as a problem. Many staff reported problems dealing with shift work because they were informed of their rota only a few days before it began.

Other problems identified included: covering the work of absent staff; a lack of time to reflect on the care given to patients; a lack of training (e.g. information and training on new developments in research and patient care techniques and a lack of opportunities to attend specialist A&E courses); and a lack of space in which to hold private conversation with patients and relatives

The department's administration staff also indicated some of the same sources of satisfaction as nursing staff. They also indicated that they worked to clear procedures. However, administration staff reported problems with several aspects of communication (lack of appreciation and recognition from other staff in the department, infrequent departmental meetings and a lack of consultation about changes - also inadequate communications with other departments and various levels of management). There were specific problems with grading. Staff felt pressured by other staff not allowing them enough time to complete tasks - with tasks not being allocated efficiently enough and staffing levels failing to reflect patient numbers. A number of problems with the physical working environment were also reported: lack of space, uncomfortable desks and workstations, unsuitable layout of equipment and furniture, uncomfortable noise levels, and a lack of ventilation. Some aspects of training and advice also presented problems (e.g. a lack of guidance when taking on new jobs, about priorities, on how to operate and use computer systems or on how to best organise and manage time at work).

**Box 4.16*****West Central NHS Trust Catering Department***

The Catering staff were a diverse group and there were a number of issues that pertained to particular areas of the department. While highlighting these to the organisation we focus here on some of the common problems and positives that were reported by the majority of staff returning questionnaires.

Staff reported that their jobs allowed them to have control over the way they went about completing their jobs. For example, cooks could modify recipes according to feedback from the wards. Staff in the washing up areas were able to decide themselves how they worked as team to tackle the large amounts of cleaning that needed to be done after mealtimes. Some areas of the department had introduced formal work rotas that meant that staff carried out a variety of different tasks within their job during the day. This made the work more varied than it otherwise might have been. However, within these rotas there was room for staff to develop their own approach to getting the job done: the completion of tasks was monitored, but the methods employed were largely left to the discretion of staff.

Working relationships between line management and staff were reported to be strong – most staff worked in small teams with a team leader, and many staff had worked in the department for a number of years and knew their colleagues well. For the vast majority, their work required them to work closely with colleagues to get the job done.

***Good aspects of the job***

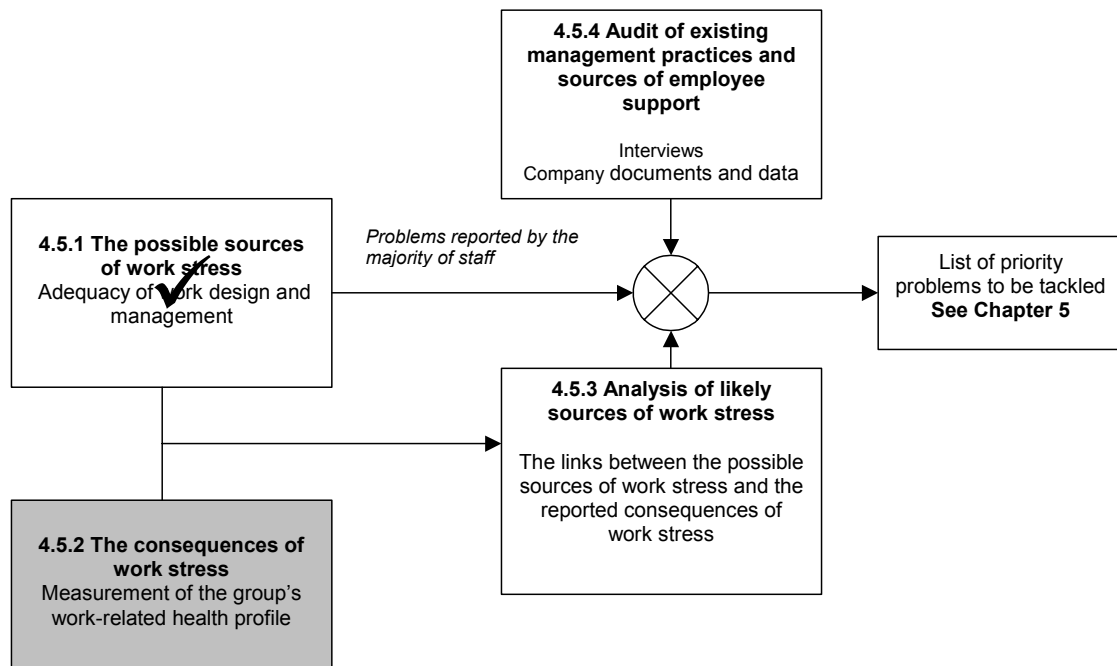
- Good levels of control over working methods
- Having a reasonable amount of responsibility for getting the work done
- Team leaders having a good knowledge of the job
- Good support from managers and colleagues and a friendly working atmosphere
- The availability of important information
- Job rotation and therefore variety

In terms of problems, several ‘clusters’ of issues were reported across the department. There were some problems that affected some areas – for example cooks reported that consultation about recent changes to equipment in their work area had been poor – but not others. These findings were presented to the organisation, but the focus of the risk assessment was on the broader issues reported by the majority of staff. These are summarised below.

***Problems reported by the majority of staff***

- Workload and time pressures around mealtimes – this affected different sections in different ways, but peaks in workload were identified as a major problem
- Poorly trained cover staff: it was reported that this had a big impact since staff worked in small teams and often had to help or supervise inexperienced or untrained staff
- Different parts of the department (e.g. the dining room and kitchen) not working well together
- A lack of consultation about changes (e.g. to stock replenishment procedures) and their impact
- Problems with the repair of some work equipment (e.g. the industrial dishwashers)
- Trolleys not being available to move heavy or awkward pieces of equipment – this was a major issue for many staff who reported that valuable time was often taken up looking for trolleys and that sometimes they had to move heavy objects without using trolleys

## 4.5.2 The consequences of work stress



As we have already said, measuring the emotional state that is ‘stress’ is not easy. Fortunately, it is not necessary for the purposes of risk assessment. It is enough to measure the likely consequences of stress – the problems with well-being that may be linked to the experience of stress. These are different in different situations. In a fluid labour market, people who believe their job is poorly designed and managed might move to another organisation. In a more difficult labour market they might stay with the organisation, but with the consequences of stress manifesting themselves rather differently (e.g. through higher absence, poor well-being, or low job satisfaction). This is one of the reasons why risk assessment is important: the causes and consequences of stress are different in different workplaces.

We looked at five possible consequences of work stress in the risk assessment. These can be explored with reliable and valid measures. These five possible consequences of work stress were:

- Feeling ‘worn out’ (tired, emotional, ‘mixed-up’ in one’s thinking) and in some cases ‘tense’ (nervous, anxious, jittery, uptight)
- High absence
- Low job satisfaction
- Intention to leave the job, or the hospital
- Musculoskeletal pain (an explanation of how this relates to work stress is given later in this section)

We looked at the data from these measures to produce a ‘health profile’ for each of the groups involved. We also inspected organisational data e.g. absence summaries and actual turnover to gauge the healthiness of the assessment group.

### **Interpreting the ‘health profile’**

The ‘raw’ health profile provided by the assessment was interpreted to find out if whether work stress is a problem for the group (e.g. if 30% of the nurses want to leave their job, is this a problem?). These data are interpreted by comparing them with pre-existing and appropriate normative groups. For example, are the group more ‘worn out’ than the norm? Are they less

satisfied with their job overall? Organisational norms were also used: for some measures the organisation was asked to define its own desired norm. For example, some groups decided that even a low level of absence or staff turnover represented a problem. This gives some indication as to whether work stress is a problem affecting the group. In this section, we describe how such data were interpreted.

### **The measures used**

#### **Feeling worn-out & exhausted**

Feelings of being worn-out were measured using the worn out scale of the General Well-Being Questionnaire<sup>1</sup>. By completing a set of twelve items (two examples are given below) a score of between 0 and 48 was produced for each person. However, the measure **is not** an individual diagnostic tool and individual scores were not inspected. Rather, an average was taken for groups of employees. As stated in Chapter 2, the objective is to make an assessment of the health of the group. The use of data on specific individuals is inappropriate and unnecessary for a risk assessment. Using these measures as individual diagnostic tools on individuals may also be unethical and potentially damaging.

#### **Box 4.17**

##### **Example items from the General Well-Being Questionnaire (worn out scale)**

<b>Over the last six months, how often have you.....</b>	All the Time	Often	Some Times	Rarely	Never
1. Become easily bored?	4	3	2	1	0
2. Become easily annoyed or irritated?	4	3	2	1	0

Data obtained from a carefully structured sample of the general population suggests that on average people score around 16-17 on this measure. Average scores of 18 and upwards indicate that a group is more worn out than the national average. Average scores higher than 20-21 indicate a relatively high level of worn out symptoms.

#### **Feeling tense & anxious**

Feelings of being tense (nervous, anxious, 'uptight') were also measured in jobs where the pressures and stakes were particularly high (in this study we used this measure for staff working in the A&E department). The questions reflect different aspects of well-being but are phrased in the same way as those used in the worn out measure. The national average score for this scale is around 8 or 9. Average scores of above 10 or 11 suggest that work may be having an adverse impact on staff well-being.

#### **Overall job satisfaction**

It has been extensively shown that the design and management of work, through the experience of stress, can influence job satisfaction. Staff were asked to comment on their overall levels of job satisfaction by circling a point on a five-point scale like the one overleaf.

<sup>1</sup> The General well-being questionnaire is a 24 item self report measure of symptoms of general malaise. Full details of the scale itself and its development can be found in Cox, T. and Griffiths, A. (1995) The nature and measurement of work stress: Theory and practice, in N. Corlett and J. Wilson (eds.), *Evaluation of Human Work: A Practical Ergonomics Methodology* (London: Taylor and Francis), 783-803.

0	1	2	3	4
<b>Not at all satisfied</b>			<b>Very satisfied</b>	

Across a range of industries and employee groups, at least 55-60% of the workforce tend to report being either satisfied or very satisfied with their job (i.e. they circle '3' or '4' on this scale). We found that job satisfaction was relatively high across the case study groups involved in this project. Most reported having varied and interesting jobs. This suggested that the baseline for interpreting job satisfaction in the healthcare sector may be quite high. The 'norm' from the case studies we carried out was around 60-70% of staff reporting satisfaction with their jobs.

### ***Intention to leave the job or the organisation***

An employee experiencing work stress may well believe that less stressful work can be found elsewhere: either in another part of the hospital or in another hospital. Actual turnover is determined by a number of factors (e.g. the state of the labour market) that are challenging to quantify and control for. Therefore we also included a measure of 'intention to leave' in the case studies. An example of this is shown in Figure 4.2.

Which of the following statements most accurately reflects your views about **leaving or staying in your job ?**  
(please tick the appropriate box)

I would leave [my department] **and** the [hospital] as soon as the opportunity arose

I would leave [my department] as soon as the opportunity arose, **but** would like to continue to work within the Trust / hospital

I wish to **continue** to work in [my department]

**If you are considering leaving, please say why**  
(write in the shaded area below)

**Figure 4.2: A measure of intention to leave**

The interpretation of this measure is dependent on the group involved. Relatively small levels of turnover can be a problem for departments experiencing difficulties recruiting new staff, or where there is a skills shortage. For example, around 30% of staff from one of the wards in Children's Services in North NHS Trust reported that they wanted to leave the service. Management immediately identified this as potentially problematic. This level of 'intention to leave' is not seen as a problem for most private sector organisations. Similarly, other groups involved in this study tended to interpret 20-25% intention to leave as a healthy figure. Intention to leave also gives an early indication of the potential size of the problem that could be encountered if the labour market were to open up. Assessing intention to leave allows action to be taken before real problems occur.

### ***The report of musculoskeletal pain***

There is a growing body of research evidence demonstrating that work stress is related to the experience of musculoskeletal pain. Stressful jobs may exert more load on the body (for example when people lift things incorrectly to get things done quickly because they are under pressure). Work stress may also lead to tension in the muscles – thus increasing 'wear and tear'

on the working muscles. It may also be linked to impairments in the body's ability to repair its muscles and joints after exertion. For these and other reasons, musculoskeletal pain is included in the risk assessment as a measure of the possible consequences of work stress. In the case studies we used a straightforward set of measures. An example is given in Figure 4.3.

**MUSCLE OR JOINT PAIN RELATED TO YOUR WORK**

Have you experienced any **physical discomfort or pain** in any part of your body (for example, in your hands, wrists, arms, back, neck, knees, etc.) **over the last 12 months** ? Please only mention those problems that you think **were caused or made worse by your work** (rather than those caused simply by other activities, arthritic pain, age etc.).

**Have you experienced work - related muscle or joint pain over the last 12 months?**

Yes  No

Please tick the appropriate box

---

If you answered **Yes** to this question, please answer the question below

**Where was the pain?**  
(tick as many boxes as is appropriate)

Neck    Shoulders    Upper back    Upper Arms    Lower Arms    Wrists  
 Hands    Lower Back    Hips    Thighs    Knees    Lower legs

**Which aspects of the job do you think caused, or made worse, this pain?**

**Figure 4.3: A measure of work-related musculoskeletal pain**

Organisational figures can also be used (e.g. occupational health referrals). However, many people with musculoskeletal problems do not seek help through organisational resources, and self-report measures may be the only way of obtaining such information. In the event the incidence of such pain was usually unremarkable among the case study groups involved in this research.

### ***Organisational data***

Organisational data can be a useful source of information about employee well-being. Absence data and turnover rates were collected from the case study groups. To ensure the confidentiality of information, absence was not matched to individual questionnaire responses. However, it was used to give an overall view of the well-being of the group. Other data examined included accident rates, mistakes, complaints and workload data (where available). Generally, this was used to gauge the well-being of the group. Where possible it was also used to evaluate interventions.

Organisational data is often referred to as 'hard' data, and sometimes as being superior to 'soft' self-report questionnaire data. However, there are numerous problems with using organisational data. Actual turnover can be affected by the state of the labour market: when there are few jobs available people are less likely to leave even in the face of problematical working conditions. However, they may still express the desire to leave. Absence figures are not only affected by



stress – they may be affected by the nature of absence policies and procedures and by the proliferation of common diseases (such as common colds). Absence data may also not be collected properly. We have found that the best solution is to draw on data from a variety of sources in order to obtain a balanced evaluation of the evidence.

### ***Health profiles of the case study groups***

As expected, the health profiles for the case study groups were different. Some were healthy on a variety of measures (e.g. the ENT & Eye OPD patient assessment and treatment delivery staff). Others less so. None of the groups was ‘unhealthy’ across the full range of measures. This pattern of results shows the importance of assessing employee well-being using different measures. It also shows that the consequences of stress manifest themselves in different ways in different environments (see Section 9.2.2). Box 4.18 gives a detailed example of what such a health profile looked like.

**Box 4.18*****ENT & EYE OPD treatment delivery staff: An all-round healthy group***

Worn-out scores were broadly in line with national averages. There were no real major differences between the three groups of staff involved (see below). Positive findings emerged for the remainder of the measures. Few staff wanted to leave the department or the Trust, and most were either satisfied, or very satisfied with their job. Self-reported absence was unremarkable. This positive health profile reflected the positive evaluations of working conditions that made by staff (see Box 4.12).

For a group with this kind of health profile, the appropriate response to the risk assessment is to maintain the good practices that contribute to good health, while addressing any problems. It concerns making a healthier group even healthier. Within this health profile the only minor problem was evident in the worn out scores which were a fraction above national averages. Consequently we looked for problems that were linked to high worn out scores. How this was done is described in Section 4.5.3, and the rationale for identifying priorities is described in Section 5.1.2.

	Average Range	Whole Group	Nursing / HCA	Audiology Staff	Orthoptic Staff
WORN-OUT	16-17	17.4	17.3	16.5	18.9

	Average Range	Whole Group	Nursing / HCA	Audiology Staff	Orthoptic Staff
MUSCULOSKELETAL PAIN % Reporting work-related pain	40-50%	22%	21%	31%	11%
ABSENCE Self-report of absence (days/year)	6	8	7	8	8
INTENTION TO LEAVE % Wanting to leave the department	30%	17%	16%	23%	0%
JOB SATISFACTION % Satisfied, or very satisfied overall	40-50%	71%	74%	69%	67%

Two strong patterns emerged in the data gathered across the case studies. Direct care staff were generally very satisfied with their job overall, even where they were experiencing problems with their well-being (e.g. in the Accident and Emergency Department, the two Children's Services groups). This was also the case for staff in the Catering department. Second, some case study groups reported positive results across a range of measures.

Even within departments, we found some differences in the health profiles of different groups of staff. We examined the well being of distinct sub-groups of staff, to help to identify any local difficulties. An example of this approach is given in Box 4.19.

**Box 4.19**

***A Group reporting problems: ENT & Eye OPD Administration staff***

Worn-out scores were above normative levels. Additionally, only 13% of staff wished to continue to work in the department, reflecting the fact that only 33% of staff were satisfied with their job overall. Actual staff turnover was high. This was a problem. However, on the positive side only 33% of the group reported work-related musculoskeletal pain. Absence was generally moderate (at around 10 days per year).

Analysing this health profile separately from that of the nursing and technical staff was important. It revealed issues that may otherwise have been concealed by the positive results obtained from nursing and technical staff.

There were a number of groups who reported satisfaction with their job, and who indicated they wanted to continue with the same job in the ward or department. However, often they also reported problems with their well-being. These were committed staff who found their job satisfying – but who also reported that the job was wearing them out. Perhaps surprisingly, absence was fairly low within these groups.

**Box 4.20**

***Accident & Emergency: A satisfying but 'wearing' job***

Accident & Emergency direct care staff reported few problems in terms of their satisfaction with the organisation. Most staff wished to continue to work in the department, and most were either satisfied, or very satisfied with their job overall. The incidence of work-related musculoskeletal pain was also encouragingly low. However, worn out and tense scores (see below) were higher than the national average. These scores indicated that staff reported feeling more worn out and tense than most. Absence was also higher than average at 11 days per year. The focus for this group was to examine the likely reasons for the high worn-out and tense scores and, to a lesser degree, absence.

	Average Range	Nursing / HCA
WORN-OUT	16-17	22.3
TENSE	6-8	10.5

**Box 4.21**

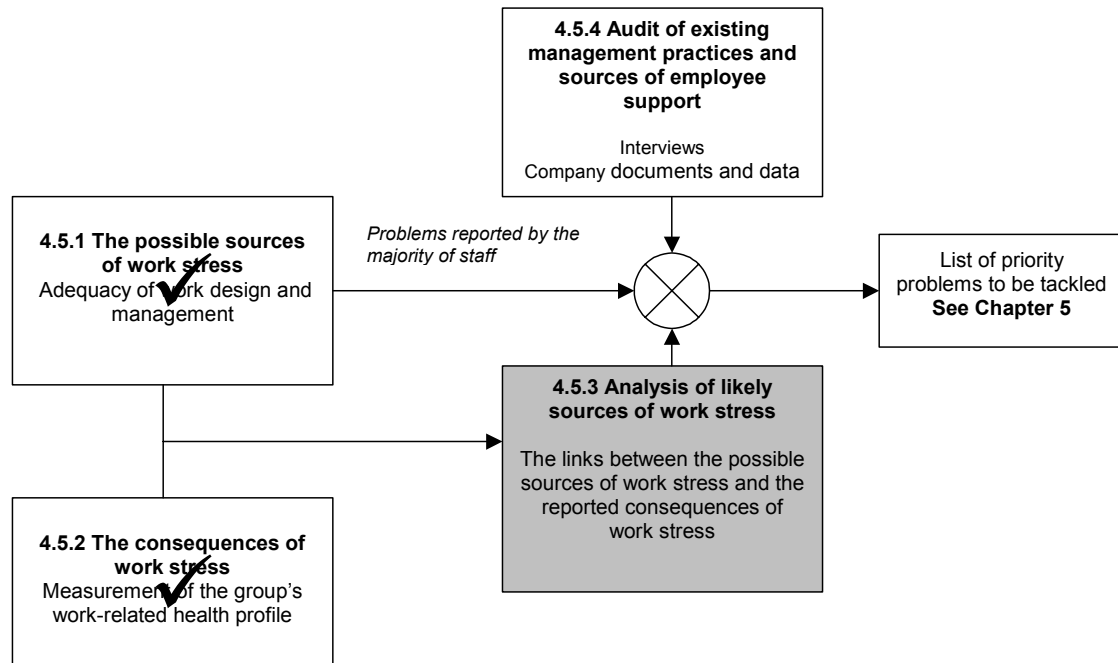
***Other satisfying but wearing jobs.....***

The health profile of F, G and H grade staff in East Central NHS Trust Children's Services showed a similar pattern to that found in Accident and Emergency staff. Worn out scores were higher than normative scores. However, absence was moderate to low. Only 28% of the group reported work-related musculoskeletal pain. 60% were either satisfied, or very satisfied with their job overall. 67% of the group wished to continue to work in Children's Services. However, 42% of the higher (G and H) grade staff indicated they intended to leave the service if the opportunity arose. In summary, high worn-out scores and, for higher grades, intention to leave the service appeared to be the two areas of concern.

Children's Services' nursing staff in North NHS Trust reported some problems in terms of their well-being. Worn out scores were higher than normative scores, but absence was moderate (at around 8 days per year). Only 32% of the group reported work-related musculoskeletal pain. Again, the vast majority were satisfied with their work overall, and most wished to continue to work in the department. However, one ward manager was concerned about the fact that around 30% of staff wanted to leave the ward. Though not an especially high figure the manager indicated that recruitment was a problem, and that even lower levels of intention to leave were desirable.

Catering staff in West Central NHS Trust reported high job satisfaction. Few wanted to leave the department. Absence and work-related musculoskeletal pain were in line with normative data on the various measures. However, staff reported feeling slightly more worn out (symptoms of feeling tired, exhausted etc.) than would normally be expected. The high worn out scores suggested that there was a 'health and safety' case for tackling the sources of work stress.

### 4.5.3 Likely sources of work stress: Problems with the job linked to poor health



This stage of our analysis combined data from the health profile and the identification of potential sources of work stress in order to establish the likely risks. Here, we were exploring the associations, or links, between the major work problems reported by the group and aspects of their health. Simple statistical analysis was used to establish these associations. We used Odds Ratios<sup>2</sup>. A brief summary of how these work is given below.

An Odds Ratio is a statistic which:

*indicates the likelihood of having a particular negative health outcome in the group of employees who judge a work characteristic to be problematic  
relative to .....  
those who are not reporting the work characteristic as problematic.*

The use of Odds Ratios fits the principles of the risk assessment for work stress: they allow associations to be examined at the level of the whole group rather than at the level of the individual. Two examples are given on the following pages.

<sup>2</sup> Sections on odds ratios statistics can be found in many statistical texts. A very accessible account of their use and interpretation can be found in Wang, M., Eddy, J.M., & Fitzhugh, E.C (1995). Application of odds ratio and logistic models in epidemiology and health research. *Health Values*, 19, 59-62.

**Odds Ratio Example 1:**  
**East Central NHS Trust Children’s Services**  
**Problems with communication and co-operation**

	High worn out score	Low worn out score
Communication and co-operation with other wards in the service is <b>inadequate</b>	26	14
Communication and co-operation with other wards in the service is <b>adequate</b>	1	10

The odds ratio was calculated by looking at whether those who reported the problem (in this case poor communication and co-operation with other wards in the service) also tended to be those with the poor health ‘outcome’ (in this case high worn out scores). If there was a link between the two we expected the people who reported the problem to also report high worn out scores (there were 26 such people in this group). Similarly there were 10 people who reported that communication and co-operation was *adequate* and who also reported *low* worn out scores. Therefore 36 people in the group reported data that suggested there was a link between the problem and worn out scores (compared to 15 people who did not). We tested whether this was significant by calculating the odds ratio:

$$\text{Odds ratio} = 26 \times 10 \text{ divided by } 14 \times 1 = 18.6$$

This indicated that the *group* of employees who reported inadequate communication and co-operation between wards were nearly 19 times more likely to have a high worn out score than those people in the *group* who reported that the communication and co-operation between wards was adequate. The significance of the odds ratio itself was also examined – we used the statistical package SPSS (version 10) to do this.

**Odds Ratio Example 2:**  
**North NHS Trust ENT / Eye OPD**  
**Problems with interruptions**

	High worn out score	Low worn out score
Amount of uninterrupted time to get on with the job is <b>rarely / never good enough</b>	13	6
Amount of uninterrupted time to get on with the job is <b>often or always good enough</b>	8	13

If there was a link between this problem and high worn out scores, we would expect the people who reported the problem to have also reported high worn out scores (there were 13 such people in this group). Similarly there were 13 people who reported that the amount of uninterrupted time was adequate and who also reported *low* worn out scores. Therefore 26 people in the group reported data that suggested there was a link between the problem and worn out scores (compared to 14 people who did not).

We tested whether this is significant by calculating the odds ratio:

$$\text{Odds ratio} = 13 \times 13 \text{ divided by } 8 \times 6 = 3.6$$

This indicated that the *group* of employees reporting that they never or rarely have enough uninterrupted time were nearly 4 times as likely to have a high worn out score than those people in the *group* who reported that they often or always had enough uninterrupted time. Again the significance of this figure was tested using SPSS.

The odds ratio analysis was focused. It focused on identifying the links between work and the group's health problems – not all aspects of their well-being. Table 4.3 shows the health problems for which risk factor analysis was carried out.

**Table 4.3: Health problems for which risk factors were analysed**

		Worn out	Musculo-skeletal pain	Absence	Intention to leave	Job satisfaction
North NHS Trust ENT&Eye OPD	Direct care	✓ <sup>a</sup>				
	Non-direct care	✓			✓	✓
North NHS Trust Children's Services		✓	✓ <sup>b</sup>	✓ <sup>b</sup>	✓ <sup>b</sup>	
West Central NHS Trust A&E Dept	Direct care	✓*		✓		
	Non-direct care	✓				
West Central NHS Trust Catering Dept		✓	✓			
East Central NHS Trust Children's Services		✓			✓	

- ✓ = Problems identified in the health profile
- \* = Tense scores were also higher than the norm
- <sup>a</sup> = Although worn out scores were not particularly high for the group, they were sometimes the only indicator that gave any cause for concern
- <sup>b</sup> = Only in one or two wards

### **Likely risk groups**

We also examined the risk assessment data to see if there were any particular groups at risk. This was done by taking each likely risk factor, and identifying from the odds ratio which group was reporting both poor health and the stress-related hazard. We then analysed this group's biography and work details. When those employees reporting both the stress-related hazard and the poor health belonged to an identifiable sub-group, it suggested that membership of that group contributed to the risk. For example, in East Central NHS Trust those staff reporting both a high worn-out score and problems with communication and co-operation between wards tended to be F grade staff. This made sense because F grade staff were most likely, most often to be tasked with organising the movement of staff between wards.

The risk factors for the various case study groups are summarised in boxes 4.22 to 4.26.

**Box 4.22**

***Risk factors Accident & Emergency***

In this department a few, small clusters of issues were clearly presenting a problem to staff. The slow movement of patients to wards, and lack of help at busy times were two problems that were linked to high worn-out scores among staff. These two problems were linked: not being able to move patients into wards meant that the department became busier, with more patients requiring care. Also linked to high worn out scores were two very different issues. Staff who indicated that their off-duty was not prepared far enough in advance, and those who said that they frequently had to cover the work of absent staff also tended to those who reported high worn-out scores. A number of issues associated with time pressures and training were linked to high tense scores. There seemed to be a small, but significant proportion of staff (around a third) reporting these problems. Staff who felt they needed more training in some aspects of patient care tended to report being more tense. These staff also had higher levels of absence.

**Box 4.23**

***Risk factors ENT & Eye OPD Staff***

A clear cluster of risk factors emerged for the treatment delivery staff. Most were linked to the time pressures associated with working in busy clinics (that many staff believed were over-booked). There were also a number of aspects of the job that increased the demands on staff already working under time pressures. In this group we just examined the risk factors for high worn-out scores. Three risk factors were directly linked to time pressures. Staff who reported that they worked to unrealistic time limits (e.g. not having enough time scheduled for each patient in a clinic) tended to report high worn out scores. Staff with higher worn out scores also tended to be those who indicated that they did not have adequate time to deal with any 'extra' tasks that cropped up during a clinic (e.g. questions from a confused patient after a consultation), and those who didn't feel that they could control the pace at which they carried out their work.

Three other risk factors were linked with these issues: (i) the lack of help provided for staff working on particularly busy clinics (ii) problems with 'avoidable' interruptions (e.g. from phone calls while attempting to give treatments, or being called to locate patient records or test results), and (iii) with irrelevant and repetitive paperwork. One other risk factor was identified. Staff who indicated they had not received adequate training for dealing with violent or aggressive patients tended to report higher worn out scores. For most of these problems it was nursing staff (rather than technical staff) who were at risk.

The situation was somewhat more complex for administration staff in the department. For these staff there were a number of different risk factors covering a range of problems with job satisfaction well-being and intention to leave. These included: a number of problems related to lack of appreciation, recognition and support from a number of sources (managers, other professions and the public). A further cluster of issues related to time pressures and avoidable interruptions - for example when dealing with a patient at the registration desk, other staff intervening to ask for information or patient records. There were major concerns over staff training and development (e.g. over the availability of training on the department's IT systems), and the physical working environment. There were a number of issues related to communication, and lack of understanding from other staff in ENT / Eye OPD.



**Box 4.24**

***Risk factors Catering Department staff***

When compared to the other case study groups, the catering group provided a unique profile of risk factors. The main risk factors for the reporting of high worn-out scores were related to the physical demands of the job i.e. the amount of lifting, bending and stretching involved in the job. These tangible demands can wear people out. A perception that stress is being placed on the body can also be a stressor for staff.

Job stagnation was also a risk factor: staff who felt their opportunities to progress were limited reported higher worn-out scores. Around a third of staff reported problems with working alone for long periods: this social isolation was a risk factor within this group.

**Box 4.25**

***Risk factors North NHS Trust Children's Services***

High worn out scores were the focus of the analysis of risk. Although lesser problems than the worn out scores, risk factors for high absence and work-related musculoskeletal pain were also investigated.

A number of environmental issues appeared to be linked to high worn out scores. The lack of ventilation, uncomfortable temperatures, and lack of storage space for equipment not in use were all linked to high worn out scores and were reported by a significant number of staff. Communication with, and appreciation from, senior management within the service were also risk factors.

A small number of staff reported problems with the amount of say and control they had over patient care decisions. These problems were linked to high absence.

Risk factors for musculoskeletal pain included unsuitable layout of equipment and furniture and repeated lifting. Both were problems reported by a significant number of staff. The frequent monitoring and supervision of bank staff was also linked to the report of musculoskeletal pain.

**Box 4.26**

***Risk factors East Central NHS Trust Children's Services***

High worn out scores and intention to leave the organisation were the focus of the analysis of risk. Although intention to leave was not extremely high it was investigated because of the highly competitive labour market associated with the recruitment of highly skilled staff.

A number of problems linked to high worn out scores related to the balance that could be achieved between the clinical and managerial workload e.g. the amount of time available for managerial and administrative tasks. A cluster of risk factors related to communication issues – such as the communication and co-operation between wards and the availability of the information required to run the ward e.g. its budget status.

Other broader communication problems were also risk factors – such as a lack of information about impending developments that could affect the running of the ward, and the unintentional 'masking' of important information among large amounts of written communications.

A number of issues relating to control were also risk factors linked to high worn out scores. These included: having inadequate control over the staffing of the ward, a lack of control over the way they managed their own time, the instability of the skill mix within their ward, and inadequate say in decisions about the way the ward was run. Infrequent opportunities for meetings with ward staff was also a risk factor.

Problems with some aspects of support were risk factors: lack of advice and support regarding clinical issues, and infrequent meetings with others at a similar grade, and consultants, were also risks.

Although problems with achieving a balance between the managerial and clinical aspects of the job were also risk factors for intention to leave, the pattern of risk factors linked to this problem was somewhat different.

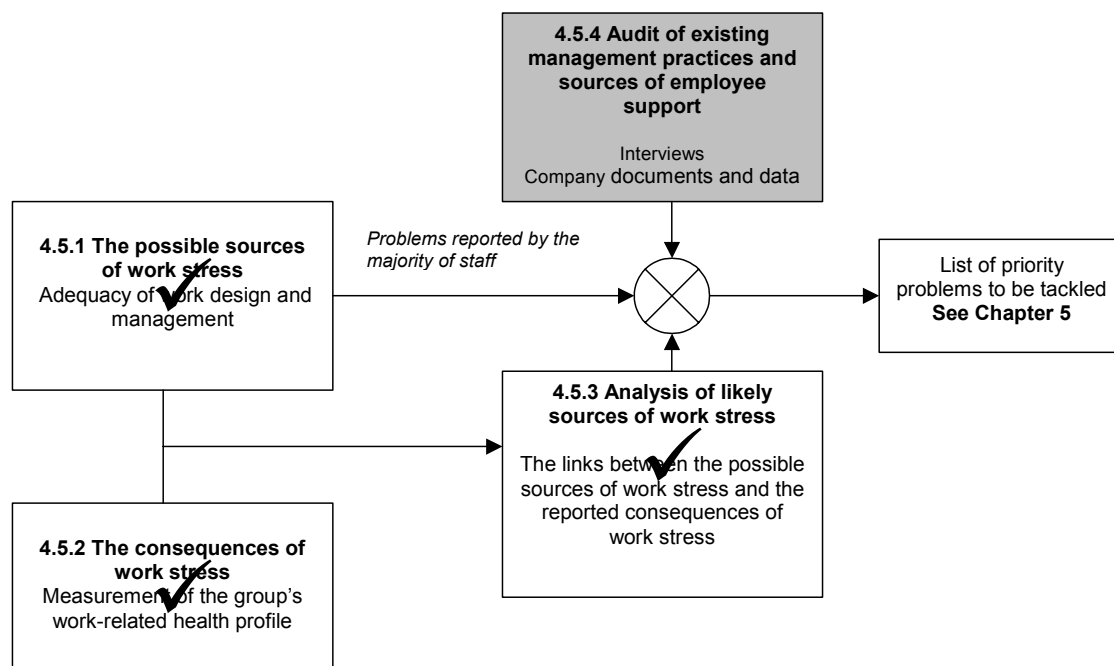
There was a cluster of risk factors linked to the speed and quality of problem-solving. Inadequate sharing of good ideas and good practice between wards and across the service was a risk factor. As was the problem that new ideas not being allowed to develop, gain approval, and be put into practice quickly enough.

Unsurprisingly, problems with training and development were associated with intention to leave: lack of funding and lack of advice to staff to help them plan and manage their personal development were risks. Those staff who indicated they were not given enough opportunities to develop their roles and responsibilities, or who believed the appraisal process was not working well for them, were also more likely to leave: there were a significant number of staff reporting such problems.

Those who reported problems with their working relationship with management were also more likely to want to leave: lack of praise, recognition, and support from management were all identified as risk factors. Inadequate support for staff who had been involved in distressing or upsetting situations was also a risk factor, as was a lack of support staff in the wards.

A smaller proportion of staff reported problems with advice and support on clinical issues and a lack of emotional support from their colleagues. These were also risk factors for intention to leave.

#### 4.5.4 Audit of management systems and employee support (AMSES)



The AMSES was designed to provide an account of existing management practices within the departments involved, and the policies and arrangements for providing support for staff. Many of these features may serve to protect and promote staff well-being, and tackle work-related problems. These were carried out largely through interviews with key stakeholders (e.g. Health and Safety staff, representatives from Human Resources, Occupational Health specialists, Union Representatives, senior managers etc.). The AMSES also involved the collection of organisational data e.g. workload figures, absence data, training documents, policies and procedures etc.

Detailed results on these AMSES are not provided in this Report. The key findings are summarised in Section 5.4. They show that the Trusts involved had many systems in place that promoted and protected employee well-being, and strengthened the design and management of work.

The findings from the AMSES are useful in a number of ways. First they help to bolster the results of the risk assessment by providing another source of information about problems and their impact. For example, trends in absence figures can be informative. Second the AMSES can be used during intervention design. It highlights resources that might be available to Steering Groups to help them manage problems (e.g. training courses run ‘in house’ by the hospital). These resources can often be mobilised during risk management. It also points up any ‘gaps’ in existing management practices, that might otherwise have gone un-noticed.

#### 4.6 Responses to the risk assessment

The groups involved responded favourably to the risk assessment. The results were viewed as sensible and informative. It was often commented upon that the risk assessment was particularly useful in that it identified problems using evidence. The identification of priorities was a key issue for the groups involved: they wanted not only to know what the problems were, but how ‘big’ they were, and which were the most important. As you will have seen from this section the risk assessment provides this information.

The risk assessment results enabled to groups to see a way forward. Since the assessment was tailored to the needs and context of each of the case study groups, the risk assessment results were expressed in the local language of work. This made the risk assessment real and tangible – with there being little need for further investigation to clarify issues. The results themselves ‘pointed’ to the possible interventions: all groups found this to be an extremely useful feature of the risk assessment. How the hospitals viewed the risk management process as whole is described in Chapter 9.



## **5. TRANSLATION: DESIGNING INTERVENTIONS TO TACKLE THE PROBLEMS**

This section describes how the results of the risk assessment can be translated into actions. This translation phase is important: it involves identifying the priorities, investigating options for action, assessing the resource implications of various courses of action, and planning the implementation of change. These decision-making processes are described in this section. They form an important ‘bridge’ between the results of the risk assessment and problem-solving interventions.

### **5.1 Objectives of translation**

A bridge between the risk assessment results is needed since it is not always obvious what action should and could be taken as a result of the risk assessment. The translation process was designed to achieve a number of objectives. These were:

- To assess the need for a response
- To prioritise those problems where a response was needed
- To examine existing and impending plans for action
- To devise and justify a response
- To set the response into motion

To show how these objectives were achieved we describe how the risk assessment results were interpreted, prioritised and simplified. We then describe a number of ways of using the simplified results to devise a number of options for action. We then describe how these options can be evaluated alongside existing plans for change. Finally, we describe how plans are made for implementing the interventions themselves.

#### **5.1.1 *Is action needed?***

The first step in translation involved answering a simple question: does anything need to be done? The need for action was identified by looking at the three sets of results coming out of the risk assessment:

- The health profile of the group indicated the need for intervention. Was the group unhealthy in some way? For example, was the group ‘worn out’ enough for action to be considered?
- Were there problems that many staff agreed on? If so, these might need to be tackled.
- Were there any problems strongly linked to any problems with the group’s health profile (risk factors). These problems might also need to be tackled.

If there are problems with the health profile of the group, there is clearly a health and safety argument for intervention. The same rationale applies to risk factors - after all they are the problems reported by staff that are linked to poor well-being.

If staff agree that there are a number of problems with work design and management - but the group is healthy - there is still a case for intervention. In this instance it is good management practice to intervene to improve work design if it is reasonably practicable to do so.

All groups involved in the study agreed that some actions should be taken. Some groups made a small number of changes. Others were more radical. Naturally, the response needed to fit the results of the risk assessment.

Most changes were built into existing management strategies and systems. For example, in many cases a number of interventions that had already been planned became much higher priorities once the assessment results were known.

### 5.1.2 Prioritising the big issues

In all our case studies, some problems were more important than others. A first step in translation involved picking out the priorities from the risk assessment results. For these issues, actions would need to be, at least, considered – and usually implemented. As a starting point for discussion we highlighted two sets of issues as priorities.

- The major problems - problems identified by the majority of the assessment group, or the majority of a sub-group of it (e.g. the majority of staff on a particular ward)
- The likely risk factors (i.e. problems that were also associated with poor health)

These issues can quickly and easily identified (see Section 4.0). An example is given in Box 5.1. They all point to the aspects of the job that could be improved by intervention. The question of whether intervention is reasonably practicable comes later.

**Box 5.1**

***Simplified version of the Accident & Emergency priority list***

	<b>Problem reported by the majority of staff</b>	<b>Risk factor</b>
Lack of advance notice about the off-duty	YES	YES
Covering the work of absent staff	YES	YES
Lack of qualified staff	YES	NO
Interruptions and admin work	YES	NO

### 5.1.3 Facilitating the translation process: Help needed

Research and practical experience strongly suggests that those interventions that are designed with the involvement of staff are the most likely to be effective in the long-term. However, lessons can be learned from interventions tried in other settings. And discussions might need to be directed to ensure they focus on designing interventions - and that they are not ‘side-tracked’ by other issues. Therefore, part of the researchers’ role in this project was to work with the case study groups to facilitate the design of interventions.

We believe that this facilitation can also be carried out 'in-house'. Many organisations have shown this to be the case. For the in-house approach to work, it may be useful to have someone in the role of a 'critical friend' or facilitator, to help the process along. The facilitator can ask questions about proposed interventions in order to test their adequacy and further their development. It is useful if the facilitator is not someone who works directly with the group, but knows enough about what they do to make a useful contribution.

Our role as facilitators involved us asking a lot of questions. This helped those involved to explore the options and to plan specific actions. Some examples are given below:

- ‘Is this a problem that could be tackled?’
- ‘Is problem A more important than problem B?’
- ‘Might these problems be linked together in some way?’
- ‘What are the costs of this intervention?’
- ‘What are the chances that this intervention will survive?’
- ‘What do you need to do to make this happen?’

These questions were used, as appropriate, at different points in the intervention design process (see Section 5.3).

Different groups requested different levels of help from the research team. We offered the Steering Groups a number of alternatives. These ranged from a monitoring and advisory role (as in West Central NHS Trust Catering Department) to the running of specific problem-solving workshops (as in West Central NHS Trust A&E and North NHS Trust Children’s Services). However, it should be noted that where help is needed it need not be driven by expert knowledge of work stress.

#### **5.1.4 Organising and managing staff involvement in intervention design**

Staff involvement in problem solving is important. It encourages enthusiasm, and creativity and can yield extremely effective interventions. We managed this in several ways. Consultation with project Steering Groups was used to identify the least disruptive and most appropriate method of managing involvement for each group. The approaches adopted by each of the case study groups and the level of facilitation each needed are shown in Table 5.1.

**Table 5.1: Intervention design strategies**

	<b>Method of translating results</b>	<b>Level of facilitation</b>
<b>ENT &amp; Eye OPD</b>	Steering group meetings supported by staff input from 'time out' sessions	Moderate
<b>North NHS Trust Children’s Services</b>	Problem-solving workshops	High
<b>Accident &amp; Emergency Department</b>	Meetings with management and staff representatives	High
<b>Catering department</b>	Self managed steering group meetings and management actions	Low
<b>East Central NHS Trust Children’s Services</b>	Workshops and staff meetings	Moderate

For the sake of simplicity, the various types of groups described in Table 5.1 are referred to as 'problem-solving groups' throughout the remainder of this chapter.



## **5.2 Types of intervention considered**

We use a broad definition when we talk about interventions. Interventions can be anything that has the potential to impact upon the work and well-being of employees. These fall into three categories:

- Interventions that are a planned and specific response to the risk assessment results
- Interventions that are part of existing management plans for change – but that directly relevant to solving problems identified by the risk assessment
- Changes that occur within, or outside the organisation that are unrelated to the risk assessment, and perhaps entirely out of the control of those involved in the risk management work (e.g. North NHS Trust Children's Services moved location during the project). These can also change the context of other interventions

In practice, the intervention packages implemented in the groups were a mixture of all of the above. However, during translation, discussions focused on the first two types of intervention.

## **5.3 Turning the results into action**

This section describes how the various case study groups went about turning a list of priorities into a list of actions. We worked with problem solving groups through a six-step decision-making process.

### **5.3.1 *Six steps to intervention design***

These six steps involved us, as facilitators, asking a structured series of questions that helped to keep discussions on track. The questions guided discussions through the problems towards a plan of action. The translation of the assessment results into a concrete intervention action plan often seemed daunting for the problem solving groups. However, after the feedback of the assessment results, it is important that staff feel they 'own' the results and the intervention design process. Research suggests that a high degree of employee and management involvement in intervention design leads to successful interventions. We 'walked through' the translation process with the problem-solving groups and this often helped to ease their anxieties.

We have developed a number of decision making aids that can be used to give structure to the intervention design process. In practice these aids are a series of exploratory questions which structure and focus steering group discussions. In this way the discussion of the assessment results is channelled towards the aim of producing a series of reasonably practicable interventions. The process helps to ensure that the interventions tackle the problems identified. It also helped to prevent the development of long, daunting lists of priority problems. Throughout the process we used flipcharts and 'post-it' notes to collect and display ideas. Minutes of meetings were produced and distributed to ensure the process was documented and that no information from the problem solving process was lost. The six steps were as follows:

**Box 5.2*****The 'Six Step' approach to intervention design***

Steps 1-3 form the 'ideas phase'

*Step 1: The identification of underlying issues/ organisational pathology*

*Step 2: Making decisions about what can be achieved*

*Step 3: Select the appropriate and practicable intervention strategy*

Steps 3-6 form the 'action planning phase'

*Step 4: Identify the agency and target*

*Step 5: Planning implementation*

*Step 6: Setting timescales and milestones*

The first three steps are designed to help construct a manageable list of problems that can be addressed by intervention. Table 5.2 summarises how this process focused the risk assessment information from a potentially long list of problems to a small package of interventions. The process is described in more detail below.

**Table 5.2: Average number of problems and issues faced at each step of the translation process**

<b>Identification of priorities</b>	<b>15-20 problems</b>
Step 1: Identification of underlying issues	5-7 underlying issues
Step 2: Issues that 'can be tackled'	4-6
Step 3: Interventions needed	4-6

### ***Step 1: The Identification of underlying issues***

Initial discussions focused on identifying the priority problems identified by the assessment. Once a list of priorities had been established (see section 5.1.2), the group was directed to look for any underlying factors that may be driving clusters of problems. For example, it may have been that a lack of communication between nursing and medical staff was the underlying problem driving difficulties in communication, the understanding of roles and responsibilities, and appreciation and recognition.

Our previous risk reduction work (Cox et al., 2000a) has shown this step to be a crucial part of the intervention design phase for three reasons. First, it reduced the list of problems to be dealt with to a manageable size. Second, it provided an economical basis for interventions: a long initial list of problems may be addressed by means of only a few interventions. Third, by designing interventions that address underlying issues, the difficulties that feed and maintain a series of problems can be addressed. This strategy may therefore reduce the possibility of similar, related problems re-occurring in the future.

It was important that this step was not rushed since its outcomes determined the direction of the intervention design discussions. It had a major impact on the nature and success of the

interventions. Even when a list of underlying issues was agreed it often proved useful to refer back to the original list of problems to ensure that discussions stayed on track.

For example, in one ward in Children's Services in North NHS Trust issues relating to time pressures and workload were inextricably linked to two factors: lack of housekeeping staff and the ward working at three members of staff short of its ideal allocation. In East Central NHS Trust, Children's Services a lack of dedicated office time underpinned a host of problems experienced by staff with managerial responsibilities.

### **Step 2: Making decisions about what can be achieved**

This step involved examining the underlying problems and asking fundamental questions about whether it was possible to make improvements. The group was asked to consider what was reasonable (for example, in terms of the available resources and time) and what was practicable (for example, whether interventions could be introduced and maintained). This further reduced the list of issues identified in Step 1 to a list of those problems for which the group believed that reasonably practicable intervention was viable. Some general options for intervention were considered at this time. For example, some groups looked at whether staffing increases are viable or whether other options were more realistic.

#### **Box 5.3**

##### ***Managing patient workload in North NHS Trust Children's Services – some tough choices***

There were a number of problems related to patient workload across all three wards. The problem was particularly acute for nurses working in a ward with a high turnover of patients. Given financial constraints on the ward substantial increases in the numbers of qualified staff was not thought to be an option. However, the group identified that qualified staff were carrying out support tasks (e.g. making feeds and changing beds). Increasing support staff was thought to be a more workable and cost-effective option.

Documenting this step of the process proved especially important. If the group decided not to act then that decision needed to be appropriately justified and accounted for. We encouraged problem-solving groups to inform staff of all their decisions.

At this stage the group also used the AMSES to identify whether any interventions are already in place, or planned, that may tackle the problems identified in the assessment. For example, West Central NHS Trust Accident and Emergency department were in the process of recruiting an administrative co-ordinator to take away some of the basic administrative tasks such as booking X-rays and finding beds, from treatment delivery staff.

At the end of this stage the list of problems to be tackled tended to be reduced further: the problem-solving groups also decided that there were some problems that could not be tackled at that time. In the discussions we facilitated, we ensured that all avenues were explored before this conclusion was accepted.

Chapter 6 describes, in full, the interventions. Many were low cost. Most were intended to be cost beneficial i.e. they were intended to result in improved staff well-being, reduced turnover, improved patient care. A forward-looking view of the potential cost savings of interventions was taken by most of the Steering Groups. For example, many groups were keen to tackle problems related to the turnover of staff: the effort of recruitment and the loss of expertise would have represented a cost to the department.

**Box 5.4**

***Interventions: Costs and benefits***

Some costs that were considered

- Salaries
- Equipment
- Disruption to service
- Disruption to staff and the service
- Time and effort (for many interventions these were the main investment)

Some benefits that were considered

- Reduction in turnover (and loss of expertise and reduced recruitment problems and associated costs)
- Improved service (e.g. fewer mistakes)
- Less absence (and fewer difficulties with cover)
- Healthier workforce
- Enhanced protection for staff
- Better use of existing resources

**Box 5.5**

***Staffing the dining room in the Catering Department: Cost management***

The risk assessment identified a problem with staffing and help at busy times. In the dining room this was around the mid-day meal. It was decided that the resources available to recruit new staff would be best used by recruiting part-time staff to work around the mid-day period (2-3 hours per day).

***Step 3: Select the appropriate and practicable intervention strategy***

At this stage decisions were made about the type of intervention that would be most suitable for tackling each problem. At this point the problem-solving groups were encouraged to look at possible interventions in some detail. Costs and benefit discussions continued through this phase.

Problem solving groups began to identify the type of intervention that might be used. Discussions began by examining whether problems could be tackled at source by modifying the design and management. As with any other health and safety issue, prevention was the preferred option. It was the one explored first by the steering group. This often resulted in a further debate around costs and benefits.

If the group felt that prevention was not reasonably practicable (e.g. because of the cost or disruption involved), the possibility of implementing interventions aimed at managing the impact of problems was investigated. If this was not possible then ideas for putting a systems in place for helping staff affected by the problem were discussed. These three levels of intervention are described in Box 5.6.

**Box 5.6*****Three levels of intervention considered******Prevention - tackle the problem at source***

Examples: in East Central NHS Trust Children's Services it was felt that by 'enforcing' office days more time would become available for staff to deal with their managerial workload. In North NHS Trust Children's Services, an increase in the number of support staff would reduce the amount of support work nursing staff had to do, thus relieving the workload on staff. In the Catering Department more trolleys could be bought to save staff time and effort during busy times.

***Secondary prevention - provide resources to help staff deal with the problem***

Examples: in North NHS Trust training was provided for staff to deal with abuse and aggression from the public in ENT & Eye OPD. Although other interventions that might help to prevent aggression (e.g. ways of communicating waiting times to patients) were considered, the problem-solving group felt that some incidents might still occur and staff should be appropriately equipped to deal with them.

***Rehabilitation - help for staff affected by the problem***

This type of intervention should be designed to 'kick in' when prevention and secondary prevention fail, or when it is not possible to prevent exposure to the stressor. Only in a few situations is it the preferred intervention strategy. For example, a 'bereavement care' policy was put in place within the neonatal unit in North NHS Trust's Children's Services. Unfortunately it is not always possible to prevent staff from being involved in such situations - the intervention was designed to manage the impact on staff.

Problem-solving groups seemed to benefit most from facilitation during this step. We asked them many questions to draw out ideas and explore options. It was at this point that we discussed interventions used elsewhere. However, we were careful to present these as examples of what could be done as a stimulus for discussion, *not* as prescriptive solutions.

**Box 5.7*****Facilitating Step 3: Some of the questions we kept asking:***

- 'Can you tackle the source of this problem?'
- 'What are the options?'
- 'How workable is this option (sometimes including a discussion of costs and benefits)?'
- 'What are the advantages and disadvantages of this?'
- 'This is what was done elsewhere.....is there anything you could draw from this?'

At the end of this stage we encouraged each group to list the underlying issues and to come up with a list of the interventions designed to tackle each of them. Although this list could be modified it provided a platform for moving to Step 4. The underlying issues identified for each case study group are listed in Chapter 6 – these were the basis for intervention.

#### **Step 4: Identify the agency and target**

At this stage the problem-solving-group was encouraged to plan how the intervention was to be implemented. Decisions were made about who would be implementing (the agency) and who would be receiving (the target) each intervention. These decisions represented the first steps towards planning the logistics of the implementation of the interventions.

##### **Box 5.8**

##### ***Identifying agency and target***

In East Central NHS Trust Children's Services a review of office hours and office hour arrangements was thought to be a good way of 'freeing up' time for G Grade staff to deal with their managerial workload. In this case the Senior Nurse for Training Development said that she would undertake the review and would work with the service nurse manager to ensure its implementation. The target of the intervention was the group of G Grade staff who were allocated dedicated 'office hours' time.

#### **Step 5: Planning implementation**

This part of the intervention design process required the problem solving groups group to identify the mechanisms by which the intervention would be implemented. Decisions were made by mapping the intervention process i.e. deciding who would be doing what and when. This part of the process also involved establishing responsibilities and bringing key people 'on board'. Using the plans devised, interventions began to be implemented at this stage.

##### **Box 5.9**

##### ***Making plans in Accident & Emergency***

In West Central NHS Trust Accident & Emergency department the group decided to resurrect fortnightly departmental meetings to improve communications. A senior nurse volunteered to organise the agenda and invite administration and support staff to attend. It was also decided that minutes would be kept by one of the senior nurses (on a turn-taking basis) and placed on noticeboards.

#### **Step 6: Setting timescales and milestones**

Sometimes, the problem solving groups and the Steering Group set up realistic timescales and milestones to ensure that interventions were implemented as planned. Procedures were set up for monitoring progress, and the evaluation was planned (see Section 7).

### **5.4 Examples of good management practice**

The job satisfaction reported by a number of groups of staff was one of the strongest findings to come out of our work. Even in groups experiencing some problems there was evidence of strong work design and good management practices. It is important that these are highlighted in this Report.

Good management practices are powerful stress management interventions. Section 4 highlighted the fact that the ENT / Eye OPD was a particularly 'healthy' department. Similarly

the other groups involved all demonstrated good health on some criteria. It was most likely that good management practices contributed to these findings. The AMSES used in the risk assessment is used to gather this information. When planning interventions it was important to recognise these good practices – and often to make plans for maintaining and strengthening them. New interventions needed to fit around them. New interventions were sometimes implemented in a way that mirrored past successes. Existing management practices were sometimes developed further to tackle some of the problems identified. Some of the pre-existing good management practices are listed below:

- Regular and relevant staff meetings, with real participation in decision-making
- Structured staff development programmes and grading reviews
- Structured and purposeful staff consultation (e.g. problem solving workshops)
- Job rotation to ensure skill use (e.g. between the ENT and Eye sections of the ENT & Eye OPD) and to manage the physical load of the work (e.g. in the Catering department)
- A culture that supports strong management communications with staff and in many instances encourages active involvement in problem solving
- Experienced help and advice being readily available (e.g. mentoring and perceptorship systems)
- Giving staff responsibility and freedom to make decisions (in line with their skills and capabilities)
- In-house training and education
- Flexible rostering

We used this information within problem-solving groups to shape intervention design. But we also used it across and between problem-solving groups to facilitate the sharing of good practice and to provide other groups with inspiration and ideas. Existing good management practices represent interventions in themselves. Section 9.1.3 discusses these good management practices in some detail.

## **5.5 Comments on translation**

Translation was one of the most challenging aspects of the risk management process. However, with some guidance the case study groups were able to make progress. Often, a discussion of existing management plans stimulated progress. For example, recruitment was already on the management agenda in a number of case studies. The risk assessment acted as a catalyst for moving such plans forward. But by pointing out what was already planned and how that fitted into the response, addressing the rest of the issues appeared less daunting. We used this tactic in some of the case studies to break any ‘deadlocks’ in discussions that occurred.

Making progress during translation was about fostering sensible creativity. It was helped along by someone asking questions and challenging ideas – not ‘specialist help’. Health and safety and occupational health representatives, and staff and employee representatives were involved in translation discussions and were often able to stimulate progress in the problem-solving groups.

## 6. INTERVENTIONS: TACKLING THE PROBLEMS

This chapter gives full and detailed accounts of the intervention packages implemented in the case study settings. The bulk of this chapter is given over to a detailed account of what happened in each of the case study groups. Although there are some common themes, a wide variety of interventions is reported. The chapter describes these interventions and an account of their impact is given in Chapter 8. However, the inclusion of an intervention in this chapter does not constitute a recommendation for its use elsewhere.

### 6.1 Purpose of this chapter

This chapter is an account of what was done to solve problems in the case study environments. It is included to show what the case study groups did to improve the design and management of work. It is broad and inclusive – many different interventions are described. We intend this chapter to provide a flavour of what could be done in an organisation. It describes a very important part of the risk management process as experienced by the case study groups – it is a key part of their ‘stories’.

Although the reader may wish to draw inspiration from its contents, this chapter is not intended as a catalogue of ‘off the shelf’ interventions to try. Nor does the inclusion of an intervention in this chapter indicate that it was successful. This information is provided in Chapter 8.

### 6.2 Drivers of change

The interventions described came about in three ways (see Section 5.2). Some interventions were a direct response to the risk assessment. Others were ideas that had been previously discussed or were about to be implemented - sometimes they were adjusted in the light of the risk assessment. In the latter case the risk assessment sometimes acted as a catalyst for their implementation. Other changes included those unrelated to the risk assessment results. All three types of interventions and changes are reported in this chapter.

This distinction is real, but in a sense unimportant. What matters is whether the interventions make a positive difference. A response to a risk assessment can be integrated into existing management plans for change, and this is shown clearly in our case studies. Risk reduction interventions need not be disruptive.

Some readers may expect stress management interventions to be somewhat ‘different’, or maybe even revolutionary, when compared to everyday management practices. However, primary prevention is about good management practice. It is about well designed, organised and managed work in well designed, organised and managed workplaces. This is clearly reflected in the nature of the interventions implemented. Most are simply are examples of imaginative good management practice.

It is also worth noting that the interventions took place in real functioning organisations. These organisations are changing all the time, as are the demands placed on them and the context they function within. This environment brings about change. For example new policies and procedures or treatment protocols may have an impact on the way people work. Staffing levels may be disrupted, or other events may provide a turbulent backdrop for the interventions. We decided to treat these in the same way as interventions in themselves and attempted to evaluate their impact. This achieved two things. First, it allowed us to investigate the impact of these events on staff. Second, it allowed us to better understand the impact of planned interventions



that took place against this shifting backdrop. We briefly describe these important background events in this chapter – see ‘Background Changes’ and ‘Additional Information’ for each of the case study groups.

### **6.3 Interventions implemented in the case studies**

The next five sub-sections of this chapter describe the interventions implemented by each of the case study groups. In each section the underlying problems and organisational ‘pathology’ (identified in translation and summarised in the shaded boxes presented throughout this chapter) are listed with the interventions intended to tackle them. A brief commentary on the backdrop against which the interventions were implemented is also given for each case study.

#### **6.3.1 North NHS Trust: ENT & Eye OPD**

**ENT & Eye OPD Underlying Issue 1:**  
Poor co-operation and mutual understanding between treatment delivery staff and administration staff

To improve the situation two interventions were implemented. First, a Staff Forum was re-established. Senior staff from each section of the department met each week to discuss problems that had arisen during the previous week, and to plan for the week ahead.

Second, teambuilding sessions were started so that staff from all sections of the department could meet with each other on a monthly basis. Two to three staff from each section attended these sessions on a rotational basis. Minutes were taken and distributed to all staff. A significant number of staff had taken part in these meetings at the time of the evaluation. In addition, a series of ‘short-term’ secondments was also planned. These would involve staff working in other sections of the department for a half a day to give them a ‘feel’ for the work done by other staff. Staff turnover in the patient administration section meant that this could not be implemented until after our evaluation work was complete.

**ENT & Eye OPD Underlying Issue 2:**  
Increased workload and lack of control due to interruptions and demands to do administrative tasks

Nurses’ administrative workload was recognised as a long-standing problem in the department. To address it a departmental clerk was appointed to work with the nursing staff on a part-time basis. The clerk took on jobs such as filing and locating tests results, clinic bookings and stock ordering. She also dealt with various types of telephone calls.

In the audiology department a new ‘one-week’ rota was implemented. This rota organised each person’s work for the month ahead (instead of staff being allocated tasks on a day-to-day basis) and included a half of a day a week set aside for administrative work. During this time staff had no clinical workload. This allowed for planned administrative time. The rota also included dedicated time set aside for personal development and training – in the risk assessment staff indicated that there were not enough opportunities for personal development.

To tackle the problems with workload and administrative tasks in audiology an assistant technical officer (ATO) was appointed. The ATO’s job was to help with the jobs in the department that did not require high levels of specialist technical knowledge (e.g. some of the hearing aid repairs) and to help more qualified staff to complete their administrative tasks. It was hoped that this would ease both the clinical workload and the administrative burden placed on the more qualified and experienced staff in the department.

**ENT & Eye OPD Underlying Issue 3:**  
Demands to work late to cover clinics running late

During intervention design discussions it was felt that some nursing staff were working more 'lates' (staying behind after scheduled work hours to cover clinics) than others. To even things out all nursing staff were 'scheduled' to work one 'late' per week to cover any clinics than ran past 5pm.

**ENT & Eye OPD Underlying Issue 4:**  
Large clinic sizes

As new consultants were appointed decisions were made in Clinical Governance meetings that clinic sizes on the ENT side of the department would be reduced and 'capped'. Consultants backed this change by adhering to the guidelines. Statistics held by the department indicated that these new clinics typically ran with 12-15 patients per clinic. Other more established clinics continued to run with 20-25 patients per clinic. This intervention was seen as being particularly important for nursing staff.

The impact was predicted to be minimal for audiology staff since the number of tests they carried out came from a variety of clinics – most of which were still large. There had been no significant reduction in clinic sizes on the 'eye side' of the department where orthoptic department staff supported clinics. There was also some concern that while smaller clinics would mean there would be fewer patients to deal with at the reception desk, patient administration staff would find it more difficult to find appointment slots for patients.

**ENT & Eye OPD Underlying Issue 5:**  
Lack of information being given to patients about clinic running times /  
patient appointments being managed ineffectively

This problem was not one that could easily be eliminated, so the group devised an intervention to 'manage' the problem. One member of nursing staff worked as 'clinic liaison nurse' during clinics on the ENT side of the department. This nurse was based in the waiting area and inspected patients' notes to see if time could be saved by sending them for tests (e.g. for a hearing tests in Audiology) before they saw a medical consultant. This nurse also kept patients informed about how clinics were running, and offered explanations as to why they might be running late. The intervention was also designed to be beneficial for patient administration staff in that it meant there was one less clinic for which they had to organise notes – removing these notes from the patient administration area also freed-up room in a crowded area.

**ENT & Eye OPD Underlying issue 6**  
Aggression from patients

As a response the finding that staff were concerned about aggression from patients, and their lack of training for dealing with it, staff were encouraged to attend in-house training on managing violence and aggression. Staff meetings and appraisals were used make staff aware of the training and management actively encouraged staff to attend. Clearly, a number of the other interventions listed above were also aimed at reducing the frustrations felt by some patients during clinics.

**ENT & Eye OPD Underlying Issue 7**  
Difficulties in obtaining information from administration staff

To address this problem, patient administration clerks were allocated to a named consultant i.e. each clerk was allocated to work with a particular consultant. Before this change each consultant's clinics were organised by a number of different clerks – an informal system largely governed by who was available at any given time to help run the clinic. It was felt that having a specific, 'named' administrative clerk to approach would help other staff in the department to deal with questions more quickly. It was thought that this would be of particular benefit for orthoptic and nursing staff. The intervention was also intended to make the administrative clerks' work less complex and frustrating: clerks could 'own' a clinic and manage its bookings and administration, rather than having to deal with clinics that had been organised by a number of different people.

A number of other interventions were implemented within the patient administration department to improve the situation and these are detailed below.

**Administration: ENT & Eye OPD Underlying Issue 1**  
Poor access to computer systems training

The computer system used to manage appointments, clinics and patient records was central to the work carried out by patient administration staff. To address the problem of training, two interventions were implemented. A member of administration staff was trained to deliver training on the patient administration computer system (PAS) and a schedule of training was devised, with training delivered to each member of staff during the intervention period. Although directed at patient administration staff, it was expected that this intervention (if successful) would have 'knock-on' effects for other staff: questions could be answered more quickly and accurately by administration staff who had a good knowledge of the operation and capabilities of PAS.

**Administration: ENT & Eye OPD Underlying Issue 2**  
Poor management communications and consultation

While communication in the rest of the department was strong, a number of problems were identified within patient administration and remedial action was taken. First, a new patient administration manager post was created and filled. Before this intervention the section had been without a manager who was based within the department (supervisors took responsibility for overseeing the section with management actually being based in another part of the hospital). This extra post was designed to give the section direction, and a driving force for making improvements. It was also designed to provide staff with more managerial support on a day-to-day basis and a clear and visible management presence.

Along with the new management positions, regular staff meetings were instigated. These took place approximately every two weeks and were a forum for staff to discuss issues as well as being an opportunity for management to communicate important information.

**Administration: ENT & Eye OPD Underlying Issue 3**  
Missing notes

A major problem for all staff in the department was that of missing notes. Interventions were targeted to improve the organisation of notes. A number of additional staff were employed on short-term temporary contracts to solve particular problems with notes e.g. to locate missing notes (or parts of notes) and to tidy-up and re-organise the storage of notes. A system of tracer

cards was also implemented – when staff removed notes, or discovered that notes were missing they filled out a tracer card. This helped staff to keep track of the location of notes.

These interventions were also intended to improve the situation for other groups of staff in the department: treatment delivery staff needed complete sets of notes to be available on time in order to deliver proper care. A problem identified by many of them during the risk assessment was that much of their time was taken up locating missing notes and this did nothing to improve relationships between patient administration staff and the rest of the department.

### ***Background changes***

While the interventions were in place a number of other changes occurred in the department. To ease the workload on senior staff and to increase access to management, a second high-grade nurse (nursing sister) was appointed by up-grading an existing member of staff. Clinical Governance (multidisciplinary meetings designed to discuss the development of patient care techniques and to facilitate their implementation) also began to take effect, and many staff became involved in this. A number of developments within the orthoptic department were driven by Clinical Governance, with staff in the department having a particularly active role in the process. There was still high staff turnover in patient administration and this meant that some of the changes that had been implemented in this section were undermined.

A significant change occurred in the audiology department during the intervention period. The technology used in the provision of hearing aids was significantly up-graded. New computer systems were used in the assessment of patients during hearing tests. New digital hearing aids were introduced – hearing aids that needed to be programmed (using a computer) according to patients' needs. This change had a major impact on the delivery of care to patients. Staff received intensive training in the use of this new technology, and had begun to use it for the majority of their work during the intervention period. This was a period of major change for these staff.

Many nursing staff were also involved in working towards achieving accreditation of good practice and innovation (Nurse Development Unit Accreditation) for the department by, for example, organising seminars and training. One other change also impacted on audiology staff during this period: they were asked to leave patients' notes e.g. the results of tests in boxes outside of consulting rooms during clinics. Some staff felt that although this speeded up clinics and helped to secure patient confidentiality, it had a detrimental effect on working relationships between audiologists and medical consultants.

### ***Additional information***

To tackle problems with the physical working environment management had begun to make long-term plans to renovate and extend the department. In the interim some short-term changes were planned but not implemented until after the evaluation. These included the addition of temporary buildings ('portacabins') to ease the space problems in patient administration. Because of the long-term plans little action was taken around these issues in response to the risk assessment.

### **6.3.2 North NHS Trust Children's Services**

**North NHS Trust Children's Services Underlying Issue 1:**  
The high dependency of patients (that led to high workload for staff) coupled with a high 'peripheral' workload

The interventions implemented as a response to this problem were designed to reduce the support work carried out by nursing staff (who were already busy dealing with patients who required lots of care and attention). Additional support (housekeeping) staff were appointed. These staff took on a number of tasks to support the medical care given to children (e.g. cleaning cots, preparing feeds, organising linen and stock on the ward, making drinks for parents etc.). For some time, nursing staff had been taking on many of these jobs. In the neonatal unit support staff's hours were adjusted so that they also worked a late shift. This provided additional housekeeping support outside of traditional working hours.

In addition, the neonatal unit appointed an extra clerk to work into the evening visiting times (a very busy time for dealing with visitors requiring access to the ward). Again this was designed to ease the workload, interruptions and time pressures on nursing staff – and to leave them more time to deliver care to patients. Ward B also recruited an extra clerk.

It was recognised that delivering care to high dependency babies was extremely taxing for staff. In the neonatal unit the decision was taken to manage the allocation of staff so that they worked in the high dependency 'intensive care' area of the ward for no more than two months, before being moved to work on the less intensive special care area of the ward (for the next two months, and so on).

**North NHS Trust Children's Services Underlying Issue 2:**  
Gaps in the establishment and the use of temporary cover staff

Just after the assessment, two of the three wards (Wards A and B) were in a position to recruit the students they had been training into qualified nursing posts. After the completion of their training, several students were actively encouraged to apply for permanent posts, and were subsequently recruited into qualified nurses' posts. This filled gaps in the establishment within the ward, without the need to find staff in a very competitive labour market. As a consequence there was less need to use bank nurses: during the risk assessment the supervision of bank nurses had been reported to be significant drain on nursing staff's time.

On the occasions that bank nurses were needed, fewer were needed and the unit could be more selective, using only the most experienced bank staff as cover. Consequently, these wards had more staff working on each shift. The situation in the third ward, the neonatal unit was somewhat different – although extra efforts were made to use only the most experienced bank and cover staff, several experienced permanent members of staff left the department. Furthermore, workload statistics showed that there had been an increase in the number of high dependency patients admitted to the neonatal unit. Combined, these two changes had major implications for staff workload and for the success and evaluation of interventions (see Section 8.3.3).

**North NHS Trust Children's Services Underlying Issue 3:**  
Lack of recognition from, and communication with, senior management

As a response to this problem, the service nurse manager indicated that he would make more frequent visits to the wards and, when possible and appropriate, attend ward meetings. Also as part of the move of wards A and B to the main hospital site (see below) his office was re-located within one of the wards (Ward A).

**North NHS Trust Children's Services Underlying Issue 4:**  
Lack of support for staff involved in distressing or upsetting situations

The neonatal unit instigated a training programme to make staff aware of all aspects of bereavement care – from caring for parents through to the management of their own reactions and well-being.

***Background to the changes***

Around the time that the risk assessment results were reported a decision was made to relocate two of the wards (Wards A and B) from one of the Trust's 'satellite sites' to its main site. The new ward environments were quite different to the old ones, and information from the assessment was used to look at how the new environment should be adapted. One of the aims of the move was to tackle one of the major underlying problems identified by staff:

**North NHS Trust Children's Services Underlying Issue 5:**  
Poor physical working environment in two of the wards

The wards at the new site had much more natural light and were bigger. They also had more large, dedicated areas for the storage of equipment not in use. The new wards also had a large staff room and a separate room that was used only for preparing milk feeds for children. Being on the main site the wards were also closer to many services that they used frequently e.g. main pharmacy, blood testing facilities, access to porters, surgeons etc. This had the potential to address one of the other underlying issues identified in the risk assessment:

**North NHS Trust Children's Services Underlying Issue 6:**  
Delays in testing and obtaining test results

Because of the impending move, problems with the physical work environment and testing procedures were not tackled directly. However, the results of the risk assessment helped to ensure the new wards were suitable.

The neonatal unit also instigated a number of Neonatal Development Groups – these were groups of staff who met on a regular basis to research and make recommendations for practice on a number of patient care issues e.g. pain management for babies. The management of noise in the unit e.g. the instigation of quiet periods during which babies could sleep, was a recommendation from one of the groups that directly addressed an issue identified in the risk assessment. To address some specific training issues in the unit, a practice development nurse was appointed to assess training needs in the unit and to co-ordinate the delivery of training.

One other change also occurred in the neonatal unit. Just before the evaluation, staff were offered the option of working longer (12 hour) but less frequent shifts. This was designed to allow staff to have longer periods of time away from the unit within their work schedule.

***Additional information***

Several ideas for reducing the amount of paperwork were discussed by problem solving groups e.g. photocopying information and replacing forms, but these were not progressed because of problems and obstruction in gaining approval for changes.

**North NHS Trust Children's Services Underlying Issue 7:**  
Working relationships with medical staff

Some efforts were also made to improve the working relationship with medical staff – ward managers contributed to the induction programme for medical staff (junior doctors), and highlighted the nature of extended role tasks (i.e. that they were carried out at the discretion of appropriately trained medical staff) and that nursing staff had different levels of skills. Ward meetings were also used to discuss and agree best practice on the use of extended role tasks – up to this point there had been no overall discussion and agreement about how extended role tasks should be managed. In the neonatal unit, consultants were asked to record any positive comments about staff in ward’s communication book.

Some specific problems with team working were being experienced by staff in the neonatal unit – although staff worked in teams, these teams rarely had team meetings because of shift patterns, pressure of work etc.. The Steering Group decided to address this problem by scheduling team meetings to occur on essential training days. To facilitate this, training days were organised so that the whole of a team received essential training on the same day. This intervention was just getting underway at the time of the evaluation. The other two wards also indicated that ward meetings were not happening as frequently as they should and renewed efforts were made to set dates well in advance and to schedule meetings so that, over the course of a couple of months, most staff would be on site when at least one meeting occurred.

The management of the neonatal unit was in a state of flux during the intervention period. The ward manager was successful in obtaining a secondment to another post within the hospital and a member of senior nursing staff ‘acted up’ to cover the role. There was some uncertainty about the long-term management situation during this time.

### **6.3.3 West Central NHS Trust Accident & Emergency Department**

#### **Accident and Emergency Underlying Issue 1:**

Multiple demands on nursing staff’s time – workload, interruptions and time pressures

To reduce interruptions and peripheral administrative tasks the group decided to introduce an administrative co-ordinator into the department. The cost of the intervention was drawn from the administration budget. The administrative co-ordinator’s job involved dealing with the administration and organising jobs that had traditionally carried out by nursing staff. These included finding beds for patients, chasing up notes and test results, and organising patient paperwork and records. The co-ordinator also dealt with telephone calls at the nursing station in the middle of the department.

Other interventions were also implemented to reduce the number of demands on nursing staff’s time. An ECG (electrocardiogram – a device to measure heart activity, used frequently to assess patients in the department) technician was based on the wards to carry out ECGs when nursing staff were busy. A community psychiatric nurse and a community liaison nurse also moved their base into the ward. These staff were then on hand to deal with long a complex cases presented by patients who needed after-care arranged for them (e.g. a place in a residential home) before they could leave the department.

#### **Accident and Emergency Underlying Issue 2:**

Infrequent meetings and discussions about key issues

As a response to the problems reported with communication in the department, several interventions were implemented swiftly. Fortnightly departmental meetings were introduced. Staff were encouraged to put forward items for the agenda, and management raised issues that required discussion and consultation. Staff from all sections of the department (including administration) were invited to attend. Each section presented an agenda item to allow them to raise and discuss any issues.

**Accident and Emergency Underlying Issue 3:**  
Information not reaching everyone in the department equally

As part of the response designed to address this problem, a communication folder was placed at the nursing station. Any member of staff could add important pieces of information into the folder e.g. about changes in policies or procedures, information about study days etc. Because staff worked shifts, and not all staff could attend meetings, it was felt that written communications were also needed. A similar approach was taken by the administration group: a 'Staff Information Book' was introduced. The book contained a section for each member of staff – each person's section of the folder was updated (by inserting memos or written communications) whenever important information needed to be communicated.

**Accident and Emergency Underlying Issue 4:**  
A lack of regular research-based training

Around the time of the risk assessment two members of the department's existing staff were close to becoming nurse practitioners (nursing staff trained to do some jobs traditionally carried out by medical staff). Once qualified, these nurse practitioners set up a series of short training sessions that were run on Tuesday lunchtimes. These covered a range of topics and moved beyond basic training to also look at new developments in research and practice. The sessions were publicised in staff meetings and through the communication folder.

**Accident and Emergency Underlying Issue 5:**  
Low staffing

Low staffing was a recognised problem in the department before the risk assessment. As a response a number of qualified staff were recruited. This was at no extra cost since it brought staffing levels up to 'establishment' – a staffing level that was already budgeted for. However it was difficult to recruit staff at higher grades, and more junior grades were brought into the department. Management from within the department took the initiative with recruitment, and drove the recruitment of staff. The nurse practitioner role was also 'activated' during the intervention period. The department had two nurse practitioners who were able to deal with many minor injuries without calling upon a doctor.

**Accident and Emergency Underlying Issue 6:**  
Inadequate notice about the off-duty

In response to this problem, a senior member of nursing staff was assigned the task of organising the off-duty rota with the goal of getting it running six weeks in advance. Previously the rota had not been the responsibility of one person: the job had been done by various senior members of staff.

The vast majority of these interventions were focused on nursing staff, but some had implications and potential benefits for administration staff. The specific response to the risk assessment for administration staff was more modest. However, there were some interventions that were targeted specifically at this group.

**Administration: Accident and Emergency Underlying Issue 1:**  
Lack of communication within the administration section

In an effort to remedy this problem a series of monthly team meetings was instigated in the section. The manager of the administration section organised and chaired these meetings.



**Administration: Accident and Emergency Underlying Issue 2:**  
Perceived inappropriate grading of jobs

In an effort to address grading issues the administration manager worked with a number of staff to make a case for their re-grading to higher paid grades. Several staff presented a successful case based on the complexities of their jobs and the position of responsibility they held (e.g. their jobs requiring them to manage other, more junior, staff).

***Background to the changes***

The group was experiencing a number of problems related to the movement of stabilised patients into wards. Many staff believed that this had not improved over the intervention period. During the intervention period the department was re-furnished, with the movement of some treatment areas and the creation of extra space for paediatric beds and rooms for use by relatives. Remotely monitored beds were introduced in resus areas (machines that took physiological measures fed back information to computers located at the central nursing station on the ward). The resus area was also divided into a series of cubicles (before beds were divided by curtains). Private areas for discussion with relatives were also introduced, along with a new viewing room (for bereaved relatives).

In the administration section, a new computer system for the management of appointments was installed. This was intended to make patient information more easier to manage and obtain – training to support its implementation took place over the intervention period. Also in the administration area, new security cameras were installed.

***Additional information***

The problem-solving group looked at a number of ways of improving the support offered to staff. The hospital already offered counselling services, but there was also some discussion about a departmental policy for allowing staff time to discuss their experiences after dealing with a bereavement, or introducing de-briefing sessions. However, these ideas were not progressed. Efforts were also made to adjust staffing levels by having a ‘managed rota’ whereby one member of staff worked from the middle of one shift to the middle of the next, so as to provide the department with one extra member of staff at busy times. However, there were some problems in managing the implementation of this and it was being reviewed when we evaluated the interventions. At the time of the evaluation, training for staff to help them deal with assault and abuse by patients was being discussed with security staff.

**6.3.4 West Central NHS Trust Catering Department**

**Catering Underlying Issue 1:**  
Poor communication, consultation and co-operation between different sections  
of the department

The group felt that the key to improving communications was to strengthen the links between different sections through their team leaders. Monthly team leader meetings were introduced. These involved team leaders from the various parts of the department (about eight staff) and management from within the department. The meeting agendas were driven by staff and could cover any issue that needed to be addressed. Prior to this intervention there was no formal way for staff from different sections to come together and discuss issues. In addition, when a vacancy arose in one section of the department (the central washing up area) a team leader was appointed to fill the role. Prior to the appointment, this large section of the department did not have a team leader, and reported feeling isolated and uninvolved. One of the team leaders in the dining room was appointed to a new post of restaurant supervisor. This was designed to give

staff a clear idea of how decisions were made and a single point of reference – before the appointment the section was run by three team leaders.

**Catering Underlying Issue 2:**  
Lack of equipment for moving heavy equipment

This was one of the simplest interventions for the group to agree and implement: several new trolleys were purchased for use throughout the department. The cost of this intervention was relatively low (a few hundred pounds).

**Catering Underlying Issue 3:**  
Inadequate training of temporary cover ('bank') staff

The department used part-time bank staff to cover for absences and holidays in the department. Just after the risk assessment the 'bank' of temporary cover staff was depleted. A training programme was devised for new members of staff and new bank staff. A structured programme of training was introduced whereby new permanent and bank staff spent several days being trained in each section of the department. While they were being trained they were not given any work to do: instead their time at work was dedicated to training on the key parts of the job. One section of the department (the cooking area) did not use bank staff and was affected by staff shortages. Due to the short supply of cooks in the labour market, three of the department's own catering staff were offered the opportunity to train as cooks. This provided the department with three extra cooks: the posts they vacated elsewhere in the department could be easily filled.

**Catering Underlying Issue 4:**  
Low staffing and high workload around mealtimes

To tackle the problem of low staffing at busy times, different interventions were used in deferent parts of the department: most interventions involved juggling existing staff resources to increase staffing around busy (meal) times. When a vacancy arose in the dining room, the staffing budget was used to recruit two part-time staff to work around the dinnertime period, rather than one full-time member of staff. Existing resources were also 'shuffled' within the kitchen area so that some staff started work earlier (e.g. on vegetable preparation), and more staff were available of busy days, to lessen pressure to get things done around mealtimes. One further change was also introduced to help ease the load at mealtimes – the telephone in the kitchen and dining room areas was 'diverted' so that it was answered by a member of secretarial staff.

### ***Background information***

In addition to these interventions two other positive changes occurred in the area. The maintenance department based a technician in and around the department. This was likely to have some impact on the underlying problem of slow equipment repairs. The department also decided to begin using plastic, rather than porcelain, plates, cups and saucers. These were lighter and eased the physical demands of cleaning large amounts of this equipment.

### **6.3.5 East Central NHS Trust Children's Services**

**East Central NHS Trust Children's Services Underlying Issue 1:**  
Lack of dedicated time for administration tasks / problems in balancing the managerial and clinical role

As a first step towards tackling this problem, it was decided that a review of office days (days set aside for administrative work when staff had no clinical workload) was required and that

staff should have a say in deciding what was needed. This intervention took place over a number of weeks. Staff were asked to keep a diary about the amount of time they spent on administrative tasks. These diaries were collated by nurse manager and proposals for the allocation of office time were drawn up after consultation with staff. After the review, many staff were allocated one office day per week and were given guidance as to how they could manage ward staffing to ensure that they did not have a clinical caseload on those days.

Another response to this problem was to place computer facilities on every ward. Many staff had indicated in the risk assessment that the lack of computers facilities impacted on their time i.e. they had to seek out facilities in other wards, or take work home to complete it.

Many wards also appointed a new member of staff in a 'housekeeping' role. This member of staff dealt with the 'support' work that was often undertaken by trained nurses e.g. making up beds, getting drinks for relatives, monitoring stocks of equipment etc.

**East Central NHS Trust Children's Services Underlying Issue 2:**  
Gaps in the study leave policy relating to arrangements for feedback and responses to requests for study leave

As a response to this problem the study leave policy was updated with new timescales for decisions on study leave. It was also adjusted to tighten the arrangements for providing feedback – staff were not allowed to request study leave until they had delivered feedback from the previous training course they had attended. To support these interventions, an article about training was published in the service's newsletter – this article detailed expenditure on training and described the new system for obtaining study leave. To get 'better value' from training, a list of staff attending training course was published in each newsletter (with their contact details). Using the list, staff with an interest in a topic could contact an appropriately trained member of staff for advice across a range of issues.

**East Central NHS Trust Children's Services Underlying Issue 3:**  
Inadequate communication and co-operation between wards (in solving problems and lack of sharing of good practice)

Several interventions were implemented to increase the cohesion between wards. 'OPEN Forums' were set up to allow staff to meet with each other and management to discuss issues that concerned the unit as a whole. These happened once a month and were open to all members of staff in the service, with an agenda driven by staff suggestions. Regular, focused workshops were also continued. These brought together staff working at the same grade to tackle issues affecting their group and to discuss the development of the service. These workshops ran every couple of months for F grade staff and (separately) for G grade staff. They were facilitated by senior nursing staff from within the service.

Other interventions implemented in relation to this problem included: the introduction of a staff newsletter (produced every couple of months by staff with contributions from staff about developments in the various wards, training courses etc.), and the introduction of email and IT facilities (e.g. an intranet) into the wards.

**East Central NHS Trust Children's Services Underlying Issue 4:**  
Unwieldy problem-solving systems and slow development of practice

**East Central NHS Trust Children's Services Underlying Issue 5:**  
Lack of participation in the planning and development of the service

At the time of the risk assessment, F and G grade staff were working in a number of problem-solving groups – each tasked with dealing with particular issues facing the service (e.g. the replacement of old equipment). However, it was felt these led to slow progress since they relied on meetings being organised between groups of staff working on different aspects of particular problems. The groups rarely talked to each other. These groups required approval from senior management to progress their ideas. In an attempt to move things more quickly these problem-solving groups were suspended and a Shared Governance model of problem solving was devised.

Shared Governance involved the setting up of a small number of ‘councils’ with broad responsibilities for organising and co-ordinating development work. Staff would then be ‘recruited’ to work on issues as directed by the councils. Those involved were allocated time to work on projects. The system of councils was introduced to increase participation in decision-making, reduce duplication of effort and speed up the development of ideas and improvements to the service. At the time of the evaluation, the intervention was in its early stages: the first councils were being established.

**East Central NHS Trust Children’s Services Underlying Issue 6:**  
Lack of control over important ward management decisions (e.g. budgeting, recruitment, management of staff)

Increasing the control that senior nurses had over the running of ‘their’ ward was a medium-to-long terms goal for the service. However, during the intervention period a number of interventions took place. First, initial steps were taken to hand over the management of ward budgets with many staff attending budget management training (as part of a longer-term training programme that included modules on the management and recruitment of staff). Second, the recruitment of some staff was ‘handed over’ to the wards e.g. advertising for applicants, writing the job description and being involved in the selection of ward housekeepers. Third, funds allocated for the re-decoration and refurbishment of wards were handed over to ward managers to spend as they deemed appropriate. Senior management within the service also indicated that, on a day-to-day basis, efforts were being made to change the management approach to allow for more local decisions to be made at the ward level.

**East Central NHS Trust Children’s Services Underlying Issue 7:**  
Poor working relationships between levels of management

A number of the interventions already described were intended to address this issue. The regular staff workshops were seen as important in this respect. The introduction of office days was also intended to allow ward staff more time to dedicate to management activities.

Furthermore, guidance was written to help staff who were charged with overseeing the running of several wards (this happened outside of daytime (9am-5pm) hours when the service’s senior managers were not in the department). This covered a range of issues that needed to be dealt with by whoever was ‘acting up’ e.g. it described procedures for dealing with child protection issues, detailed who needed to be contacted when problems arose, and presented the essence of complex procedures in an accessible way. In practice this was a folder containing a set of laminated sheets that contained all the information needed when ‘acting up’. It was hoped that this would lead to the smoother running of the department (e.g. the movement of staff to wards affected by staff absence), more ‘standardised’ decision-making and, by having all the information they needed at their fingertips, ease the pressure on staff who were acting up.

## **East Central NHS Trust Children's Services Underlying Issue 8:**

### **Inadequate investment in equipment and ward decoration**

Soon after the risk assessment decisions were made to invest heavily in new equipment for the service. A large number of new syringe pumps were purchased – problems with the existing equipment were well-recognised. As already mentioned, significant funds were also made available for the purchase of computer equipment to be used on the wards. Substantial funds were also made available specifically for ward re-decoration and refurbishment (up to £5,000): the spending of this money was controlled at the ward level.

#### ***Background to the changes***

During the relatively short space of time between the risk assessment and the evaluation, the background to the interventions was relatively stable. One important change however, was the appointment of an acting senior nurse manager when the previous manager left. Staff reported that this had created some uncertainty and that there were differences in the 'style' of management as a result (the new manager was perceived to have a more open management style).

In the wider context of the hospital organisation some broad changes were being made to the roles and responsibilities of the most qualified and experienced nursing staff. The thrust of these changes was to move more responsibility to ward managers and away from senior management. These changes were intended to allow senior staff (G Grade staff) more control over the running of 'their' wards.

During the intervention period staffing levels continued to be a problem in some wards. The situation varied from ward to ward. Some wards were having problems recruiting the specialist staff they needed. Other wards were functioning at their full establishment.

#### **6.4 A commentary on interventions**

The examples given in Section 6.3 illustrate the variety of interventions implemented. Many are examples of good, creative management practices. Very few required massive expenditure: most costs were met inside existing budgets. However, in some cases expenditure was necessary and justifiable.

There are some common threads running throughout these interventions. These are discussed in more detail in Chapter 9. However, it is worth commenting that few groups simply accepted that high workload was 'a fact of life' for hospital staff. Many sought to better manage the workload placed on staff by allowing them to use their skills to the fullest (e.g. the introduction of administration workers and support staff). And for most of the interventions there was evidence of a creative use of the talents of staff (e.g. nurse practitioner training sessions) that made the most of existing, or already budgeted for, resources.

## **7. EVALUATING THE INTERVENTIONS (I): RE-ASSESSING THE SITUATION**

This chapter describes how the interventions described in Chapter 6 were evaluated. Both the way the interventions were implemented (the intervention process) and their outcomes were evaluated. In this section we describe how the effectiveness of the interventions was evaluated by gathering information on the work and well-being of employees, and their direct evaluations of the interventions themselves. The evaluation methods employed were designed to recognise, and work within, the complex social setting of the work environment. The evaluation of interventions in real and functioning organisations is challenging. To meet the challenges we developed and used new methods of evaluation. One of the explicit aims of this research was to explore the use of new and accessible methods of evaluation. Therefore we use this section to explain how this evaluation work was performed, before describing the results of the evaluation work in Chapter 8.

### **7.1 Aims of the evaluation**

We set a number of criteria against which the interventions were evaluated. We then devised measures to assess the effectiveness of the interventions. The evaluation work had three objectives:

- To see if people were aware of, or involved in the interventions – this was to evaluate whether interventions had been implemented as intended – and whether they had reached as many people as was intended
- To make an assessment of the intervention process i.e. were the interventions designed and implemented as effectively as they could have been? Were there any problems with implementing them?
- To assess whether the interventions had in any way tackled the problems identified in the risk assessment i.e. had they eased the problems at all?

In the evaluation work we also attempted to take into account the background to the changes (e.g. problems with staff turnover, site re-location etc.). These events are sometimes unpredictable, but often important. These can impact on staff and on the delivery and impact of the interventions themselves.

### **7.2 Evaluation tools**

We used four sets of evaluation tools:

- Interviews with key stakeholders (managers, staff influential in delivering or receiving interventions etc.)
- Interviews with staff
- Questionnaire measures (including any measures of work and well-being used in the risk assessment)
- Organisational data

Each of these tools all have their advantages and disadvantages (see Table 7.1). Whenever possible, a combination of these was used to gather rich data on the impact of the interventions. As with the risk assessment, gathering data in a number of different ways helps to build a

stronger body of evidence. Organisational data and records were used wherever possible. Using a variety of measures also helped to bolster the results.

**Table 7.1: Some strengths and weaknesses of evaluation tools**

	<b>Advantages</b>	<b>Disadvantages</b>
<b>Stakeholder interviews</b>	Give a good overview of what has happened since the risk assessment	Involves few staff and might give a distorted picture
	Little disruption for the majority of staff	Most staff feel less involved in the project
<b>Staff interviews</b>	Have the potential to provide a great deal of rich information	Take staff away from their work for 20-30 minutes
	Questioning can be flexible	Information takes a lot of 'sifting through'
<b>Questionnaire measures</b>	Give 'hard figures' that can be compared to the risk assessment results	May not capture 'rich' data
	Can be completed during unexpected, or unplanned 'lulls' in workload	Inflexible, set, rigid question structures
<b>Organisational data</b>	Give 'hard figures' that can be compared to the risk assessment results	The behaviour of these measures is unpredictable: they may be influenced by many factors, not just the intervention
	Obtaining the data causes little (if any) disruption to staff	Problems may have occurred during data collection that affect the reliability of the data

Some methods may be more practicable than others. For example, we used interviews heavily in the ENT & Eye OPD and with senior nursing staff in East Central NHS Trust. In the ENT & Eye OPD, most staff were in the department between 9am and 5pm, and there was adequate cover for staff involved in interviews. The East Central NHS Trust Children's Services was large and could absorb the loss of one member of staff (the interviewee) for a short period of time. In contrast, North NHS Trust Children's Services and the Accident & Emergency department employed staff on shift work basis and there were only small numbers of staff present at any given time – making it difficult to manage the 'absence' of even one member of staff. Here fewer interviews were carried out and questionnaires (which could be completed during lulls in workload) provided the majority of the data.

The evaluation tools (staff interviews, stakeholder interviews and questionnaires) contained three elements, each of which provided important information:

- Measures of employees' awareness of, and reactions to, the interventions. These measures gave us information about whether or not the interventions had been noticed, and whether staff felt the interventions had made things better. These measures also provided information on how effectively the interventions had been implemented and managed
- Measures of working conditions. These measures gave us information about whether the interventions had an impact on working conditions (see Section 4.5.1)
- The measures that made up the health profile (see Section 4.5.2), or in the case of interviews, questions about employee well-being. These measures gave us information about whether the interventions have had an impact on the health profile

Generally these three pieces of information were gathered by asking specific questions about specific changes. Stakeholder interviews were usually carried out first to 'catalogue' the changes. Throughout the project we asked managers and staff about the interventions and other changes, and collated a list of all changes. Prior to the evaluation, staff were also asked (usually during interviews) which changes had occurred in order to ensure that no important changes were missed.

As highlighted in Chapter 6 these changes encompass a wide range of events and interventions that had happened over the intervention period. The evaluation looked at the impact of all the changes – both planned and unplanned change - including the direct response to the risk assessment - and 'background' changes within the case groups.

### **7.2.1 Evaluation interviews**

Both the stakeholder and staff interviews were structured and executed in a very similar way. Box 7.1 illustrates some of the questions asked. These interviews proved a powerful source of information about interventions. They allowed for the outcome and process of intervention to be evaluated, and provided rich and useful data on both. For example, questions were asked not only about whether the intervention was implemented or not, but also about how it was implemented and whether it was managed effectively and properly maintained. For instance, team meetings might have been regular and well-attended, but they might not work well if they are not effectively chaired and managed. Evaluating the process allowed us to understand why interventions worked or failed. This was important information for the organisation involved – using the results of the evaluation they were able to re-visit the implementation of interventions if necessary. It also allowed them to construct and better implement new interventions.



### **Box 7.1**

#### ***The evaluation interview***

Question: *Are you aware of [the intervention?] What impact has this had on you and your job?*

*For example in the ENT & Eye OPD in North NHS Trust*

*'Are you aware that clinic sizes have been reduced in the ENT Side of the department? What impact has the reduction in clinic sizes had on the work that you and your colleagues do?'*

For more 'active' interventions, the questions were phrased a little differently.....

*'Have you been involved in teambuilding meetings with admin and technical staff? What impact has being involved in these had on you and your job?'*

We also asked about how changes had been managed and implemented. These questions covered a range of issues, the nature of which was determined by the type of intervention implemented.

*For example in A&E Department in West Central NHS Trust*

Question: *'What was done to make staff aware of the communication book and its contents?'*

*'How have the departmental meetings been publicised? Is the agenda of the meetings generally relevant and useful.'*

These questions covered a range of issues. For example, did the intervention happen as often as it should have? Were staff adequately informed? Was it implemented as effectively as it could have been? Were adequate arrangements made to enable the maximum number of staff to experience the intervention and benefit from it? (etc.)

To gather information about work and well-being it was sometimes necessary to ask further questions e.g. about the impact of these interventions on staff. Usually this information was obtained from the questions above, but other questions can elicit this information such as:

Question: *'In what ways has the [intervention] affected your work?'*

More specific questions can be asked. For an intervention designed to improve team-working: *'how have the meetings impacted on communications between different groups in the department?'*

To make sure nothing was missed other questions were asked about change:

- What other changes have there been?
- Has anything been done to tackle [the problem identified in the risk assessment] ?
- What else about the job has improved / got worse?

### **7.2.2 Evaluation questionnaires**

To evaluate the interventions fully the work and well-being of staff was also re-assessed using questionnaire surveys. These were very similar to those used in the risk assessment, but with one extra ingredient: they asked staff to comment on their experiences of the interventions. In practice, this required inserting an extra page of questions into the evaluation questionnaire.

The interviews yielded rich data – some examples of which are presented in Chapter 8. The set of questions included in the questionnaires was very similar to that used in the interviews. For active interventions staff were asked:

- whether they were aware of the intervention
- whether they were actively involved in it,

*and if they were involved in the intervention.....*

- the size of the impact the on them and their job
- the valence of the impact of them and their job (a positive, or a negative, change)

An example from the questionnaire given in the ENT & Eye OPD is given in Figure 7.1

Change / event	(1) Do you know about the change?	(2) Have you been involved in this?	(3) How much of an impact has this had on you and your job?	(4) As a result of this change are things better, worse, or the same?
Team building meetings (meetings between patient admin., nursing, audiology and orthoptic dept. staff)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> A big impact <input type="checkbox"/> A small impact <input type="checkbox"/> No impact	<input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse  Briefly say why:

**Figure 7.1: A measure of an active intervention**

For ‘passive’ interventions – interventions that staff need to know about, but do not necessarily need to be involved in – the second question was omitted. An example from the Catering Department is given in Figure 7.2.

Change	(1) Are you aware of the change?	(2) How much of an impact has the change had on you and your job?	(3) As a result of this change are things better, worse, or the same?
Purchase of more trolleys / increased availability of trolleys	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> A big impact <input type="checkbox"/> A small impact <input type="checkbox"/> No impact	<input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse

**Figure 7.2: A measure of a passive intervention**

### 7.3 Evaluating change

The central aim of the evaluation work was to assess the impact of the interventions. This revealed whether the problems identified in the risk assessment had been successfully tackled or managed. We looked at three indicators of the impact of the interventions. Together they gave an indication of the success of the intervention. These are described in Sections 7.3.1 to 7.3.3.

#### 7.3.1 Exposure and reactions to interventions

We presented staff a set of questions that asked them to comment directly on the interventions themselves. The tools described in section 7.2 provided a good broad measure of the impact of the intervention. A measure of exposure to an intervention provided us with a measure of a necessary condition for its success. People needed to be aware of, and sometimes involved in

interventions for them to be successful. This measure told us whether the people targeted actually experienced the intervention. The more of the target group who experienced the intervention, the better chance the intervention had of being a success for the group as whole.

Staff reactions to the interventions also gave an indication of their success. Figures 7.1 and 7.2 give examples of the questions we asked staff. The number of people indicating the intervention had an impact on them and / or their jobs is another indicator of success. The proportion of those people who reported that the intervention had made things better was yet another indicator of success. Of course, the proportion of the group the intervention was intended to reach was also considered when interpreting this data.

This information was gathered by looking at percentages in questionnaire surveys (e.g. 50% of staff were aware of the intervention and 100% of those thought it had an impact, with 100% of those reporting that the impact was positive). Where interviews were used awareness and impact of the intervention was judged by looking at the consensus view of those interviewed e.g. if six out ten people interviewed indicated involvement in an intervention that was intended to reach everyone then that aspect of its implementation was judged to have been relatively successful.

As discussed in Chapter 1, it is the appraisal of working conditions that underpins the experience of work stress. Therefore it is sensible to gather information about employees' appraisal of interventions in order to understand whether they are effective and why they are effective. This aspect of measurement has been neglected in much previous work on work stress.

In summary this section of the evaluation answered three questions:

- Did the intervention reach those it was intended to reach?
- Did those it reached think the intervention actually made a difference?
- Did those people who the intervention reached, and thought it made a difference think that the change made things better and in what way?

### **7.3.2 Changes to the design and management of work**

The aim of the interventions described in Chapter 6 was to tackle the sources of work stress. In doing so they should lead to improvements in the design and management of work. Therefore measures of work design may show improvements.

An assessment of whether or not things had improved was made by comparing information on working conditions gathered during the risk assessment to information on working conditions gathered during the evaluation. Both questionnaire data and information from interviews was used.

The success of an intervention was evaluated by looking for improvements in work design. We looked at whether fewer people reported the problem at the evaluation stage when compared to the results of the risk assessment. For example if 70% of staff reported inadequate communications with senior management during the risk assessment, but only 30% of staff reported to be a problem in the evaluation survey then something positive had happened.

It is worth noting that the evaluation of these changes is complex. An intervention may well tackle a particular problem, but events unrelated to the intervention may make that problem worse. For example, patient numbers in some clinics in the ENT & Eye OPD were reduced – easing the pressures in those clinics. But in other clinics the situation worsened. As a result most staff continued to report that overbooked clinics remained a problem. To get around this problem, the evaluation tools described in Section 7.2 included questions that asked directly

about the impact of an intervention on working conditions and well-being. Section 7.4 discusses this issue in more detail.

### **7.3.3 Changes in the health profile**

Improvements in the health profile are another possible indicator of success. As with changes in working conditions, changes were evaluated by comparing the health profile obtained during the evaluation to that obtained during the risk assessment. For example, if a group reported high worn out scores during the risk assessment, was there any evidence that these had reduced?

However, as an indicator of success, changes in well-being should be used with caution. A host of factors might influence well-being, not just working conditions – in this sense changes in well-being are rather ‘distant’ from the intervention. Measures of working conditions are much ‘closer’ to interventions and would be more likely to show the impact of the intervention in the short-term.

This reasoning is best explained by using an example from the field of health promotion. A ‘stop-smoking’ campaign might be instigated in an effort to reduce the incidence of lung cancer. After a year or so it would be sensible to evaluate the success of the campaign by looking for a reduction in the number of people who smoked. It would not be realistic to look for a reduction in the incidence of lung cancer. In the same way, reactions to interventions and changes to working conditions are more realistic measures of the success of interventions in the short-term. That said, we still looked to see if there were any particularly powerful interventions that had an influence on well-being.

Employee ratings of the impact and benefits of the intervention (see Section 7.3.1) are more sensitive to the impact of interventions. If these changes are accompanied by improvements in well-being, then that means they are even more successful, and have had an immediate impact. We were particularly keen to see if improvements in health profiles came about when risk factors were tackled by interventions.

## **7.4 Evaluation in context**

The interventions reported in Chapter 6 did not occur in isolation. The background information we included in Chapter 6 describes some of the important issues and events that surrounded the interventions.

Some of these ‘contextual’ factors can also impact on the indicators of success: the working conditions and the health profile of the group. In some cases they also had an impact on the way interventions were delivered and subsequently perceived by staff. During the evaluation work we asked staff about the context and examined its impact on the results (see Box 7.2).

### **Box 7.2**

#### ***The importance of context***

In the East Central NHS Trust, despite management’s efforts to increase access to office hours for ward sisters, a number of wards were staffed below establishment during the winter months. This meant that some ward sisters got less office hours as a result. We looked at whether wards were fully staffed in order to get a more reliable picture of whether intervention was having an effect.

Contextual issues such as staffing, fluctuations in patient workload, whole scale re-location etc. were all things could have had an impact while the intervention was taking place. For instance, a cluster of risk factors for North NHS Trust Children's Services were linked to problems with the physical working environment –some of these were tackled when two of the wards re-located to a new site. When a lot of good things are happening alongside the intervention, the situation might make the intervention *seem* more effective than it really is. However, if stressful events occur alongside an intervention, they might make the intervention *seem* less effective than it is. For example, no matter how powerful an intervention might be, the well-being of staff might not be improved if the intervention takes place against a backdrop such as the threat of large-scale redundancies.

We can draw another parallel with our smoking prevention analogy (see Section 7.3.3). Factors other than smoking might be linked to lung cancer. It might not only be the anti-smoking campaign that influenced people's choice of whether to smoke or not. In our case studies it was not just the interventions that had an influence on employee well-being. Factors other than the intervention may have impacted on the working conditions targeted by the intervention. In our case studies we catalogued as many of these 'contextual' factors as we could and evaluated their impact, and their impact on the interventions.

We considered one other factor in our evaluation work. We checked to see whether the interventions had been implemented as planned. For a host of reasons interventions might not be implemented as planned. In such situations the intervention is not necessarily a bad idea, it might just not have been implemented correctly. Interviews with staff and spaces for comments on questionnaires (see Figures 7.1 and 7.2) provided us with this information.

#### **7.4.1 The difference between an 'Experiment' and an 'Evaluation'**

In an ideal world interventions are evaluated as if they are planned 'experiments'. Traditional experiments are tightly controlled. They look at changes over time. For example, if we take a pill does our health improve? To gauge the impact of the pill we might compare those taking the pill to those that did not, or to those that took a placebo. As far as possible the experimenter would control for the conditions in the time between their measures e.g. use of other drugs, height, diet, age etc. As far as possible, all conditions are tightly controlled.

When evaluating organisational interventions the situation is very different. Real-life functioning organisations are not particularly suitable settings for experiments, and as a consequence the experimental approach may not be entirely suited to the evaluation of job re-design intervention in their organisational context. It is very difficult to control intervening conditions. People go on doing their work, being managed on a day-to-day basis, interacting with and shaping their work setting and the job they do. Employees are subject to a host of influences outside of their control e.g. changes to budgets, difficulties in recruiting staff, unusually high patient workload etc. Another problem arises when trying to establish control groups: sometimes it is not possible, or even desirable, to restrict or control the delivery of an intervention e.g. it would be impossible to control how much the extra mid-day (meal time) staff appointed by the Catering Department helped various members of staff. Even if it is possible to divide the group in some way (such as into control wards and experimental groups) it is not always possible to ensure that external influences do not affect them differently. For example, staff recruitment and retention may be more difficult in some wards than in others. That is why we used evaluation by comparisons based on the 'penetration' of the intervention.

#### **7.4.2 Evaluation by comparisons**

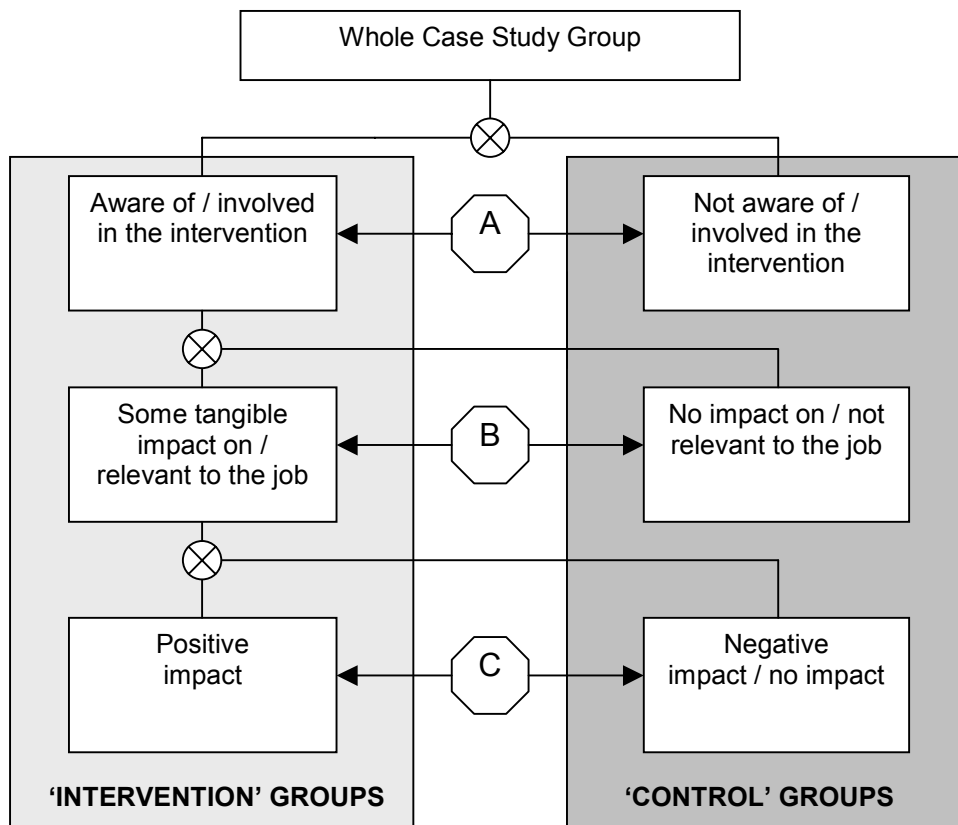
Evaluation by comparisons allowed us to, wherever possible, isolate the impact of the interventions. In some groups there were distinct variations in involvement in, or exposure to, interventions. For example, not all staff had been involved in team-building sessions in the ENT

department. Nor were all sections of the Catering Department were able to benefit from the use of better trained cover staff (bank staff could not be used to cover the cook's role). Sometimes this variation is intentional. However, because of problems with the way an intervention is implemented it may be that some groups feel it more than others.

Both types of situations can be used to provide information about the impact of the interventions. For example, the group of staff thoroughly and properly 'exposed' to the intervention may report improved working conditions, where as the group not exposed to the intervention does not. This provides us with information about the impact of the intervention. These comparisons can be made at a number of 'levels' (see figure 7.3) that reflect the 'penetration' of the intervention. First we measured the levels of awareness of, or involvement in, the interventions (comparison 'A' in figure 7.3). Awareness is important for passive interventions (such as the appointment of new staff). Involvement is more important for the active interventions (such as training courses, meetings etc.). This allowed comparisons to be made between those aware of / involved in the intervention and those who were not.

However, there may still be significant variations within the groups aware of, or involved in, the interventions. We asked staff to judge the impact of the intervention on them and their job (comparison B, figure 7.3). For some staff a given intervention might be more important than it is for others (e.g. because of the exact nature of the job they do). This enabled us to compare those who reported that the intervention had a significant impact to those who believed it had not. However, asking about the size of the impact did not allow us to judge its direction e.g. a good or a bad change. To this end we asked staff to judge whether the intervention had made things better or worse. There were no cases in which a response to the risk assessment was widely reported to have made things worse. However, this comparison enabled us to assess the impact of events that had occurred over the intervention period (e.g. high turnover of staff in patient administration in the ENT / Eye OPD) that might have affected the impact of other interventions or the work and well-being of staff. This allowed us to make 'fairer' evaluations of the actual impact of interventions.

These comparisons were used to provide the data that is reported throughout Chapter 8. In Chapter 8 we focus on reporting this analysis and its results *in detail* for the evaluation work carried out in East Central NHS Trust Children's Services. To save space in that chapter we summarise the analysis strategy and its results for the other case studies.



**Figure 7.3: The comparison model of evaluation**

As Figure 7.3 shows we used all three measures of intervention ‘penetration’ to shape the evaluation i.e. we made comparisons at all three levels (A, B and C in Figure 7.3). These three measures are also measures of the success of the intervention process and its outcomes:

- The proportion of staff aware of, or involved in, the intervention answers the question: did it reach those it was intended to reach?
- The proportion of staff indicating that the intervention had a significant impact on their job give clues as to the answers to a number of questions: was the intervention implemented as effectively as it could have been? Was it relevant to all of those affected by the problem? Does the intervention need to be refined or re-designed?
- The proportion of staff indicating that the intervention had made their work and/or well-being better also answers a number of questions: overall did staff think the intervention was beneficial?

Before attempting to evaluate the interventions we looked at these three ratings for each intervention. We used this information to identify ‘where’ the variability was in the group. There were a number of possibilities. Some of the most common are illustrated in Table 7.2.

**Table 7.2: Identifying comparisons used in the evaluations**

Consensus ratings of interventions	Comparison
Most people who were aware of or involved in the intervention gave it a high impact rating and a similar success rating	Aware / involved in group vs. Not aware / not involved in group
People who were involved in / aware of the intervention have varying views about the size of its impact	Group reporting the intervention to have a sizeable impact vs. Group not reporting the intervention to have a sizeable impact
People who rated the intervention as having and impact varied in terms of whether they thought it had a good or a bad impact	Group reporting the intervention to have a positive impact vs. Group reporting the intervention to have a negative impact

### 7.4.3 Headline figures

In all the evaluation work we compared the results from the risk assessment to those gathered during the evaluation work. This was provided some ‘headline figures’ as comparisons. These are interesting in that they identify any large changes affecting the group as a whole. We have summarised some of these figures in Chapter 8 for each of the case studies.

However, headline figures may also be misleading. They can mask improvements that are occurring within part, but not all of the group. For example, the group that is aware of the intervention may show an improvement not found in the rest of the group. For this reason, evaluation by both comparison and the examination of headline figures was used to give a balanced picture.

Comparisons were not always based on quantitative data. These comparisons were also made using data drawn from interviews. What was said by people *affected by* an intervention was compared to what was said by those *not affected by* the intervention. For example, we tested whether the group involved in the interventions had noticed improvements in areas that were *still* reported as problems by those that had not been involved in the interventions.

It should be clear that there is not a measure of work stress per se. What were measured were the likely precursors and ramifications of work stress. Some ‘outcome’ measures exhibit ‘context specificity’ i.e. they behave differently in different situations. For example, it might be that absence would not be a suitable measure to use for hospital based doctors, who tend to be reluctant to take absence even in the face of severe difficulties. Such measures must be interpreted with reference to the context in which the data was obtained. Other markers of the ramifications of work stress may be useful in various contexts: reliable and valid questionnaire measures of well-being should not be affected by context to such a high degree. The sensitivity of the various ‘markers’ of the impact of work stress is also discussed in Section 9.1.2.

## 7.5 Chapter summary

We have covered considerable ground in this chapter. The evaluation of work stress interventions is an emerging discipline. In this chapter we have described an alternative



approach that has been workable in the case studies reported here. This approach used natural variations in the 'intervention experience' (what things are like for those on the receiving end of the interventions) to provide a sensible basis for comparison and evaluation. It also asked staff to directly appraise an intervention and its impact – this proved to be extremely useful for interpreting and understanding the progress made.

This approach had a number of benefits. First, it was workable. Second, it helped organisations to understand why interventions were working (or failing). Third, it allowed for the isolation of the impact of the intervention. Fourth, it provided information that organisations could use to modify or improve existing interventions. Fifth, it gave initial data on what employees thought about the interventions – whether they were important or beneficial – changes which may take a while to translate to improvements in working conditions and / or well-being. Sixth, it allowed us to examine the impact of context (e.g. staff turnover) on the effectiveness of the interventions, working conditions and on employee well-being.

## **8. EVALUATING THE INTERVENTIONS II: THE RESULTS OF THE EVALUATIONS**

This chapter gives a commentary on the success of the interventions described in Chapter 6. A key question we asked in this project was: do the interventions work? This chapter describes the evidence that allowed us to answer this question for each of the case studies.

### **8.1 The aims of this chapter**

In this chapter we describe the impact of the interventions. Interventions were evaluated using the methods described in Chapter 7. We do not re-iterate those methods here. This chapter focuses on describing the results. Here we do this for each intervention in each case study group. Each is presented differently and each focuses on different aspects of the data analysis, and presentation. For each, we describe the situation at the time of the evaluation and provide an overall commentary on the intervention process and its results.

### **8.2 North NHS Trust ENT & EYE OPD**

#### **8.2.1 *Participation levels***

A large number of staff were involved in the interview phase of the evaluation – approximately 60% of those employed in the department. 48 staff returned questionnaires adequately completed for analysis – with the return rates being high across all sections of the department.

#### **8.2.2 *Headline figures***

##### ***Staff well-being***

Overall, the nursing, orthoptic and audiology staff reported few problems in terms of their well-being and satisfaction with the organisation (see Tables 8.1 and 8.2). There was little change since the risk assessment. This should be seen as a positive finding: the strong well-being of the group had been maintained. Indeed, given the initial scores it was unlikely that a great deal of change would occur: many of the scores had reached a ‘ceiling’ or a ‘floor’ whereby little change could be expected. Worn out scores remained close to normative scores. Job satisfaction was high, and intention to leave low, with absence around ‘average’ levels.

The one area of concern was the increase in worn-out scores found for the audiology group. Although some problems with working conditions had been tackled, staff in the evaluation survey reported some new areas of concern. These, and possible reasons for them, are described in the following sections of this report.

For patient administration staff there were some signs of improvement in the well being of the group, although there were still areas of concern. Job satisfaction had increased, intention to leave had decreased and absence was remarkably low. However, the group reported being worn-out and there was a relatively high incidence of musculoskeletal pain. Actual turnover within the group had been a problem during the intervention period, but the situation had stabilised by the time of the evaluation, and there were few vacant posts.

**Table 8.1: ENT & Eye OPD worn out scores at assessment and evaluation**

		Whole Group	Nursing / HCA	Audiology Staff	Orthoptic Staff
<b>WORN-OUT</b> Average (normative) range 16-17	<b>Assessment</b>	17.4	17.3	16.5	18.9
	<b>Evaluation</b>	18.6	17.6	20.1	18.1

**Table 8.2: ENT & Eye OPD other markers of well being at assessment and evaluation**

		Whole Group	Nursing / HCA	Audiology Staff	Orthoptic Staff
<b>MUSCULOSKELETAL PAIN</b> % Reporting work-related pain: Average (normative) range 40-50%	<b>Assessment</b>	22%	21%	31%	11%
	<b>Evaluation</b>	32%	31%	43%	13%
<b>ABSENCE</b> Self-report of absence (days/year) Average (normative) range 6-8 days/year	<b>Assessment</b>	8	7	13*	8
	<b>Evaluation</b>	7	5	8	10*
<b>INTENTION TO LEAVE</b> % Wanting to leave the department Average (normative) range: 30-35% wanting to leave	<b>Assessment</b>	17%	16%	23%	0%
	<b>Evaluation</b>	11%	6%	14%	13%
<b>JOB SATISFACTION</b> % Satisfied, or very satisfied overall Average (normative) range: 50-55% satisfied	<b>Assessment</b>	71%	74%	69%	67%
	<b>Evaluation</b>	79%	88%	72%	75%

\* data was affected by one very high score

## **Working conditions**

Direct care staff (nursing audiology and orthoptic department staff) generally reported that the positive working conditions reported in the risk assessment (see Section 4.5.1, Box 4.12) had been maintained. There were also signs of improvement – a significant drop in the number of staff reporting problems - in the following areas:

- Help from patient administration staff
- Communications with patient administration staff
- Appreciation and recognition from consultants
- Having more time to finish jobs (with the exception of audiology staff - see below)

Separately, orthoptic staff reported two other improvements:

- Flexibility in appointment times
- Less working under pressure to do things quickly

The picture was mixed for audiology staff. This group reported improvements in three of the problem areas identified in the risk assessment:

- Personal development opportunities (with only 35% reporting this to be a problem)
- Interruptions by telephone calls (with only 36% reporting this to be a problem)
- Covering the work of absent staff (with only 43% reporting this to be a problem)

However, some ‘new’ problems emerged in the audiology department. The problems appeared to relate to the physical working environment (lack of space to hold discussions with patients, poor ventilation and uncomfortable temperatures) and increased time pressures (lack of control over the pace of work during clinics, working under time pressure, interruptions and lack of time to plan ahead). Several of these time-related issues may have appeared to have been related to changes in the delivery of the service (the modernisation of the hearing aid service) that occurred over the intervention period. Lack of appreciation and recognition from consultants also appeared to have worsened.

Encouragingly, a number of improvements in working conditions were reported by patient administration staff. These related to three clusters of working conditions: communication and consultation, equipment and the working relationship with management.

In terms of communication and consultation there were a number of specific changes:

- Fewer staff reported problems with communication and co-operation between administration and other staff in the department (73% reporting the problem in the risk assessment, going down to 22% in the evaluation survey)
- Fewer staff reporting that there was a lack of information about changes to the job (60% down to 22%)
- Fewer staff reporting a lack of discussion and consultation about change (60% down to 11%)
- Fewer staff reporting that important information was not being made available when it was needed (60% down to 33%)
- Fewer staff saying that team meetings were too infrequent (54% down to 33%)
- Fewer staff indicating that communication from Trust senior management was inadequate (60% down to 11%)

Improvements in work equipment appeared to be more modest, but included:

- More comfortable workstations and desks
- Fewer staff indicating that they did not have enough computer equipment
- No-one now saying that they were not given enough training on PAS (the computerised system for managing appointments and patient records - it was 53% in the risk assessment)

Working relationships with management appeared to have undergone a sea-change:

- Fewer staff reporting inadequate appreciation and recognition from senior managers in the department (87% in the risk assessment down to 44% in evaluation survey)
- Fewer staff indicating that there was a problem with inadequate appreciation and recognition from line management (67% down to 33%)
- Most staff reporting that support from line management was adequate (60% reporting a problem with line management support in the risk assessment, down to 22% in the evaluation survey)

Apart from these three ‘clusters’ of improvements, there also appeared to be much less of a problem with accessing patient notes for this group of staff – although it was still perceived to be a problem by care delivery staff.

### **8.2.3 The success of the interventions**

In small samples such as this the interviews were crucial in teasing out the impact of the interventions on working conditions. We relied on a detailed analysis of interview data that drew out the links between the intervention and changes to working conditions and well-being. Where possible, links are drawn to the questionnaire data already described in Section 8.2.2.

We also looked at background changes that might have impacted on staff – such as the high turnover within the patient administration group. These were evaluated in the same way as the interventions.

The interventions addressed underlying issues as presented in Section 6.3.1.

#### ***Interventions to address poor communication and co-operation***

Team building meetings between the various groups in the department

At the time of the evaluation, just over half of the nursing staff reported being involved in these team building meetings. Most agreed that they had made things better, but that their impact had been modest.

Many of those who had been involved indicated that the meetings were having the desired effect. Several said that there were better working relationships between staff in different sections and that communication had improved as a result:

“.....there is a better rapport between staff and communication between different parts of the department is better”

In addition several staff indicated that a number of practical problems had been resolved through the meetings. For example, misunderstandings about the differences between the way paediatric and adult orthoptic appointments were booked appeared to have been resolved. The impact of these meetings also seemed to be reflected in improvements in communication

between nursing and patient administration staff observed in the questionnaire data. Many said it gave them a new insight into how other groups in the department worked.

“...these meetings enable us to work out problems at the shop floor level”  
“...we have time to talk about things that can improve the situation for patients, like reducing the waiting times”

Administration staff had been strongly involved in the meetings: two-thirds of the reported being directly involved. Those involved generally reported that they were a positive step. Some staff reserved judgment, indicating that they would like to see more firm actions come out of the meetings and then for them to be implemented. In terms of specific comments about the interventions, many staff echoed the feelings of nursing staff (reported above).

While the picture was generally very positive, staff that had not yet been involved in the meetings did not appear to have been made aware of what had been discussed, and were uncertain as to whether any action would be taken as a result of the meetings. Some indicated that steps should be taken to make staff aware of the content of the meetings and to ensure that the discussions led to actions.

Around a third of the audiology staff indicated that they had been involved in this intervention. It was reported to have had a small impact, but nevertheless a positive one. Only two orthoptic department staff indicated that they had been involved in the meetings. The team building meetings were described as something that had the potential to increase understanding between different groups of staff. However, there were some comments that they had not been regular enough, and had not involved enough staff: issues that were being addressed by the department as a result of the findings of the evaluation.

### ***Interventions to reduce time spent on ‘peripheral’ tasks***

Appointment of a departmental clerk to work with nursing staff

This appeared to be one of the most positively received interventions. All nursing staff were aware of the change, and most agreed that it had a large impact and had made things better.

Most of those who commented on the intervention agreed that it had reduced the amount of paperwork faced by nursing staff. Although paperwork completed in clinics still appeared to be an issue – staff still reported that they had to complete paperwork under time pressure – most reported a significant reduction in the overall amount of paperwork. This appeared to be directly attributable to the appointment of the administration clerk:

“.....less work to do with things like ordering, answering phones, and other general admin”  
“... it takes the pressure off nursing staff and allows us to get on with our job”  
“.....she is well organised, very helpful and cheerful”

This intervention has clearly had a very positive impact on staff. Although clinics were still reported to be very busy and the time of nursing staff was still pressured, the administration clerk was clearly playing an important role in easing the pressure on nursing staff. Some types of interruptions (e.g. those caused by having to locate test results) had eased considerably. However, the clerk did not deal with telephone calls coming into the treatment room and this remained a problem.

Introduction of a 'one week' rota in audiology with specific time for administration work

The vast majority of audiology staff (72%) reported being affected by the implementation of the rota. Most indicated that its impact had been modest. However, more staff (36%) indicated that their working conditions were worse as a result, than indicated their working conditions were better as a result (21%). There was a clear split among the group: some staff welcomed it because it made their work more predictable. Others felt that it made their work too repetitive and lacking in variety. Importantly, however, the survey results indicated that most audiology staff were satisfied with the level of variety in their work. Some typical comments illustrate the situation:

“...it's good to know what I am doing on a regular basis”  
“...there's a lack of variety in the job – jobs are not shared as fairly”  
“...the repetition of work means that there is less job satisfaction”

On the positive side, the administration session and time for personal development training that were part of the rota were well-received. The vast majority of audiology staff reported having an administration session in their rota. Most of those (58%) indicated that it had made things better for them, but that its impact had been modest. Those who commented on the intervention indicated that it had helped them to cope with their paperwork, meaning it was less rushed and could be better organised and managed:

“...having more time for paperwork makes the job less stressful”  
“...I can manage my time better – less urgent tasks can be left until the admin session”  
“...it's useful having sessions to do admin – I'm not having to rush letters, results etc.”  
“...we at least get some time set aside for training now”

Appointment of an Assistant Technical Officer (ATO) in audiology

Audiology staff extremely enthusiastically endorsed this intervention. Most reported that it had been of direct relevance to their work and that the ATO's presence had enhanced their working conditions. Staff generally agreed that the ATO's contribution to carrying out repairs and completing paperwork had eased their workload, and freed them up to get on with their 'core' job. This was important for a number of staff:

“.....she oversees routine admin and repairs and that frees up my time”  
“...there is less clerical work to do now”  
“....I do less workshop sessions now and that has released me to get on with my job”

***Interventions to manage demands to work late to cover clinics***

Scheduled rotas of late working for nursing staff

All nursing staff reported being involved in this intervention and the vast majority indicated that it had a significant impact on their jobs. Although some disagreed, the vast majority (7 out of 10) indicated that their working conditions were better as a result.

Staff commented that the intervention had meant that there was more equality when it came to working late. On the negative side, there were some comments that staff were still working late – even if not scheduled to – when more than one clinic over-ran. Many staff felt that the intervention should be modified to tackle this problem. However, many indicated that it had helped to make their working hours more predictable, while others reported that it had decreased the number of lates they were working:

“...now I work fewer lates”

“...it seems more equal, there are less complaints that ‘only certain people stay late’”

“...although we don’t know exactly what time we will finish, at least we are able to plan ahead, and know which day we are working late”

### ***Interventions to tackle large clinics sizes***

‘Capping’ the size of new clinics in ENT

Most nursing staff reported that they had been involved in clinics on the ENT side that were noticeably smaller. Around half of those indicated that this had a big impact on their job, with a similar proportion indicating that the impact was more modest. Unsurprisingly, most indicated that their working conditions were better as a result of this change.

This intervention appeared to have a range of effects. Although the general view (reflected in the questionnaire data) was that clinics were still over-booked, the smaller clinics that were implemented were extremely well-received. Staff reported that they allowed for the better delivery of patient care, that they relived the time pressure on staff and that there was a better working relationship with patients as a result.

“...clinics run more to time....there is less aggravation from patients”

“...it helps with less pressure on staff in the treatment room...less complaints from patients about waiting times”

“...we have more time to spend with patients”

However, when asked about this change, many audiology staff questioned whether clinic sizes had reduced. They reported their workload to be similar, or increasing.

Of those administration staff involved in this change, there were mixed feelings as to its impact. Most staff indicated that it had made a big difference to their working conditions. On the positive side, comments indicated that the clinics themselves ran more smoothly, and there were less problems caused by patients having to wait to be seen:

“...it’s a better level of treatment for patients, less waiting, resulting in less stress for patients and for us”

However, the change did seem to have created problems when it came to organising the clinics, especially in the booking of follow-up appointments. Some staff reported that there was “nowhere to put patients” as a result.

Orthoptic staff reported that the appointment of more consultants had a substantial impact on their job, but opinion was divided as to whether the change was a positive one: it was felt that staffing in other areas of the department would need to be increased in order to deal with the increased workload.



Similarly, nursing staff felt that the appointment of more consultants would have a large impact on their job. However, opinion was divided as to whether it would be a positive or a negative change. One comment was typical of the reaction:

“...better in that there will be shorter waiting times for patients, but worse in that extra staff have not been taken on to absorb the extra work”

Audiology staff were more unequivocal- nearly all believed the addition of extra clinics had made their working conditions worse. Administration staff were also concerned about the impact of the appointment of more consultants. Most agreed it was having (and would have) a big impact on their job, and around half indicated that it would make their working conditions worse. Staff cited increased workload and lack of space as their two major concerns. Many indicated that they did not believe that additional staff would be made available to deal with any additional workload.

### ***Interventions to improve communication with patients and manage patient appointments effectively***

#### The use of a clinic liaison nurse

Almost all nursing staff reported that they had been involved in clinics that had a clinic liaison nurse. The majority view was that this had a big impact on their working conditions. Just fewer than 70% of staff reported that this change had improved their working conditions – it should be noted that the question asked staff to comment on the impact of the clinic liaison nurse in clinics where they themselves were not working as the clinic liaison nurse.

It was felt that the nurse made clinics run much more smoothly and efficiently, and that patients were much better informed – and subsequently more relaxed – as a result. There were also ‘knock-on’ effects in terms of a reduction in interruptions, and allowing staff more time with patients.

“...they can do the checking of notes and keep patients informed of delays”

“...it takes a lot of queries away from clinic nurses and patients are less anxious”

“...you get to spend more time with your patients, actually doing your job looking after patients rather than answering queries from those in the waiting room”

However, several staff indicated that it was not always possible to allocate a nurse to the clinic liaison role because of staffing problems. As a result, many clinics were still running without a clinic liaison nurse (and were running less smoothly).

A ‘down side’ to the intervention was reported by some of the nurses who worked as the clinic liaison nurse. They said it was a demanding role and that it was very tiring. However, they could all see its benefits.

#### The movement of ENT notes into the waiting area

The vast majority of nursing staff indicated that they had been involved in some way in the movement of ENT notes into the waiting area (where they were managed by the Clinic Liaison Nurse). A significant number reported that it had a big impact on their work, with nearly all staff indicating that it had some impact on them. However, the reaction to the intervention was

mixed. While around a quarter said that it had made things better, just under half indicated that the change had made things worse for them.

Comments from the interviews and questionnaires illustrated several key issues that underpinned these findings. Staff believed that the intervention had the potential to lead to better organised and more efficient clinics that would, in turn lead to better patient satisfaction:

“....notes can be put together properly and completed, and audios [audiograms – hearing tests] carried out if there are enough staff”

“.....patients are often prepared before the clinic actually starts”

“.....I can keep patients better informed of how things are going”

However, the additional workload placed on staff was cited as a problem by a number of staff. Several also mentioned problems with getting notes prepared on time because of missing notes, or incomplete sets of notes.

“.....when notes are missing we end up spending time looking for them, which is less time you can give to your patients”

“...there is not enough time to pull together notes”

Two-thirds of administration staff indicated that they were directly affected by this intervention. They were unanimous in saying that it had a big impact on their working conditions and almost all reported that it had made things better for them. Staff indicated that it had freed-up space in the administration area, and had eased their workload, since nursing staff now dealt directly with questions related to the notes.

### ***Interventions to tackle the problem of aggression from patients***

A number of the interventions mentioned above were designed to improve the running of clinics and thus to help alleviate problems caused by long-waiting times or uninformed patients. However, one specific intervention was also evaluated:

Encouragement of staff to attend ‘in-house’ training on the management of violence and aggression

The remit of this research did not permit us to carry out an in-depth evaluation of the effectiveness of this training. However, attempts to increase the uptake of the training appeared to have been successful. Eight nursing staff had attended the violence and aggression study day – seven said it had been useful in helping them to deal with problems they had faced at work. Eight audiology staff indicated that they had attended the training. The reaction to it was similarly positive: six indicated that it had been useful in their work.

### ***Interventions to tackle problems in obtaining information from administration***

Patient administration clerks being allocated to work with a ‘named’ consultant

Nursing staff generally reported that this intervention had a modest, but positive impact. It was generally felt that it was much easier to locate the appropriate clerk to answer their queries as a result of the change, and that there appeared to be a better quality of help available, since clerks were more familiar with the intricacies of the clinics:

“...before they did this you just used to wander in to the administration area looking for someone to help you, and no-one would, and then you'd approach someone and they didn't know anything about that clinic. So you'd ask someone else until you found out. Now you just go straight to the person dealing with that clinic - and they know the answer...”

Most orthoptic staff were aware of this intervention and generally reported that it had a modest impact, but that it had made things better for them. Most commented that it was good to be able to identify a particular person to go to (it saved time and reduced uncertainty) and that people with a solid knowledge of a clinic were in a position to provide more help.

Most administration staff agreed that that this change had a big impact and all reported that their working conditions were better as a result. The intervention had many effects. It reduced uncertainty among staff, improved relationships between clerks and consultants, and gave staff more control and ownership over their work:

“...you get to know the names and work closer with the consultant”  
“...we know what we are responsible for – we now have much more control over our workload”  
“...you know exactly what you are meant to be doing and when”

Several comments indicated this intervention may have been one of the key factors in improving communication between patient administration staff and their colleagues. A typical reaction was:

“...It's better because only one person deals with the clinic so you can get it organised yourself and get know where things are and how the clinic works. You can build up a relationship with a consultant and know everything about that clinic and how it runs. That's got to be better than knowing a little bit about a lot of clinics.....”.

However, this intervention appeared to have been undermined by the high turnover within the department with staff building a good working relationship with particular clerks, only for them to leave the department. Both nursing and orthoptic staff frequently mentioned this in interviews and on questionnaires.

### ***Interventions in the administration section to tackle problems with training***

Appointment of 'in house' trainer and scheduling of PAS (the computer system for dealing with patient appointments and records) training

Results from the questionnaire survey indicated that administration staff were much more satisfied with the provision of PAS training. This was confirmed during the evaluation of the intervention – most staff indicated that they had benefited from this improved access to training and that there had been a significant, positive impact on their working conditions as a result. PAS training was a major problem issue raised during the risk assessment.

Comments from the interviews indicated that staff felt much more confident with the PAS system. Although many had substantial experience of PAS before receiving formal training, staff reported that the training had allowed them to learn about useful features of the software they might otherwise never have known about. As one person put it:

“...you get to know about the applications you would not normally have used”

### ***Interventions in the administration section to improve communication and consultation***

Appointment of a patient administration manager to work 'on-site'

This was another intervention that was enthusiastically endorsed by administration staff. Nearly all said it had a big impact on their work and that it had made things significantly better. The main effect of the intervention was to increase the availability of management to staff (to provide advice, feedback, help and support) – both in terms of the addition of another manager and by freeing up other supervisory staff. This was reflected in questionnaire responses that showed relationships with management had improved significantly. It was also strongly reflected in comments made during interviews:

“...I think that having a manager as well helps us – you have more than one person to ask about any problem”

“...the supervisor is more available to help staff now”

This intervention appeared also to be particularly relevant for staff in the orthoptic department, who tended to work closely with administration staff. All orthoptic staff were aware of this change and most reported that it had a small, but positive impact on their working conditions. Staff commented that it had given them an “identified member of staff who to approach with queries”.

Introduction of regular staff meetings

Nearly all administration staff indicated that they had been involved in regular staff meetings: this was another intervention that was enthusiastically endorsed, with almost all staff indicating that these had made working conditions better.

The evaluation survey revealed that communication, support and consultation had improved within the group – comments from the interviews suggested that the meetings had contributed strongly to these improvements:

“...it keeps us up to date with recent issues”

“...there is much better communication between staff now”

“...it gives staff a chance to air any grievances which can stop bad feeling”

### ***Interventions designed to tackle the problems with missing notes***

Staff on temporary contracts to organise notes and use of tracer cards

Although viewed as having a more modest impact than some other interventions the use of temporary staff on certain projects was seen as a positive step by the majority of administration staff. Several staff reported seeing real improvements in the organisation of notes and the state of the patient notes library – they indicated that this made their life much easier. Some staff indicated that the work done by temporary staff was work that they would otherwise have to: therefore it eased their workload and some of the pressure they were facing.

“...it takes pressure off staff so that they can get on with the job they are doing”  
“...notes are usually where they should be...  
the library is cleaner and the notes are easier to find”

When asked specifically about missing notes, nearly all administration staff reported that there had been a reduction in the number of missing notes, and that this had been an improvement. The tracer card system was reported to be useful, and administration staff indicated that by having fewer missing notes there were fewer demands on their time from other staff (who were looking for notes). Although recognising that the situation was improving, nursing staff indicated that even a small number of missing notes caused significant problems for them.

Most orthoptic staff had been directly involved in the use of tracer cards and tracer lists. Several indicated that this intervention had helped to track down some notes, but that missing notes remained a problem.

### **Impact of background changes**

#### Implementation of Clinical Governance

Most orthoptic staff reported being involved in clinical governance in some way. They reported its impact to be modest, but positive. Most indicated that it facilitated an open exchange of ideas that could then be used to deliver better care to patients:

“...it allows open discussion of the issues”  
“...it makes people more aware of the overall picture and that enables us to give better care”

Those audiology staff involved indicated that Clinical Governance had opened up training opportunities and enhanced the interaction between different groups of staff in the ENT side of the department. However several staff indicated that they had received little feedback from Clinical Governance meetings.

Around half of the nursing staff returning questionnaires indicated that Clinical Governance had a big, positive impact. Sharing of ideas, and improvements to the quality of care were the two most frequently mentioned benefits.

#### The high turnover of staff in patient administration

Staff in the orthoptic department appeared to be particularly affected by the high turnover in patient administration. Almost all reported that it had a big impact on their work and the majority indicated that their working conditions were significantly worse as a result. As with other groups of staff, problems appeared to be created when new staff were unfamiliar with the intricacies of the clinic booking systems. Particular problems concerned the intricacies of booking of adult and paediatric appointments. The high turnover also stopped staff from building up strong working relationships with administration staff.

“...there is never anyone around who knows the system well enough”  
“...new staff do not know how the clinics run and book inappropriately”

Nursing staff reported similar problems – the high turnover resulting in a lack of continuity and problems in obtaining help when it was needed.

Naturally this problem was felt most in patient administration itself. The majority of staff reported to have had a big impact and that had made things worse for them. Many adverse effects of the high turnover were cited. However, increased workload appeared to be the main problem:

“...its added stress for the remaining staff, trying to do more than one person’s job, there are fewer opportunities for teambuilding”

Modernisation of the hearing aid service:  
use of digital hearing aids in audiology

Almost all audiology staff reported being directly involved in this change. Almost all agreed that it had a big impact on them. However, opinion appeared to be divided as to whether the change had resulted in an improvement in working conditions: as many people said the change had made things worse as said it had made things better.

Many staff reported that there was more workload and pressure as a result of the change. However, most recognised the benefits that it was having for patients. Several staff cited some problems with training and equipment that had made the situation more difficult.

“.....its better for patients, but worse for us – there’s more pressure – the job is more stressful”

“.....everything seems to take longer, creating more pressure”

“...there have been problems getting the equipment working and training has been limited”

However, there were numerous positive comments about the impact of modernisation:

“...its good, we are learning new things”

“...it’s a better quality service, patients get better hearing aids”

In terms of the training provided the majority of staff indicated that they had received some training. Most indicated that the training had a big impact on their working conditions and were positive about its impact. Some staff indicated that there had been time constraints on training, but many reported that progress was being made. Most reported that the training they had received had been very useful. However, around half indicated that they felt they needed more training. Some staff indicated that they needed more time to practice and get ‘up to speed’. However, staff made a number of comments on the type of training they felt they still needed:

“...I feel I need additional training on setting things up (programming hearing aids)”

“...more on the management of audit base (the digital hearing aids programming system)....and on how to query the database”

Audiology staff being asked to leave patients’ notes in boxes  
outside of consulting rooms

This was a change that almost all staff reported being affected by. Just under half of those indicated that the change had a small impact, but a fifth reported that it had a big impact on them. The most telling finding, however, was that the majority of staff affected by it indicated

that their working conditions were worse as a result. Although staff generally recognised that it did save time, the key problem appeared to be isolation from medical staff, a problem that was strongly endorsed in the questionnaire survey.

“.....probably better for patient confidentiality,  
but not as easy to discuss things with medical staff”  
“.... I no longer see the doctors – only when there is a problem”  
“....there is an isolation of audiology staff”

#### Nursing staff's involvement in the Nurse Development Unit accreditation work

Just over half of those returning questionnaires indicated that they had been involved in the Nurse Development Unit accreditation work. Of those, half indicated it had a big impact, with the other half indicating that its impact had been more modest. However, most agreed that working conditions had improved as a result. Involvement in the work seemed to have several benefits. Staff reported feeling “proud” of what they had achieved, and that it was good to get recognition. Several also indicated that it had been good for morale:

“...feeling valued, and sharing knowledge – its good for morale”  
“....it gives the department prestige and direction”

### **8.2.4 A commentary on the intervention process**

There were a number of positive changes brought about by the interventions, even though the group was relatively satisfied and healthy at the time of the risk assessment. This case study showed that risk management could be beneficial, even to healthy groups.

To move forward further, the department is looking to tackle the problems that still exist in patient administration, and with the over-booking of clinics and the physical working environment. The results of the evaluation are being used to identify the priorities for action in this group. Some problems identified by nursing staff in the evaluation (e.g. staffing levels) are also being addressed. The turbulence experienced within audiology as a result of the modernisation of the hearing aid service was easing at the time of the evaluation. The problem of turnover within patient administration was also easing. The Steering Group decided to revisit the implementation of some interventions e.g. by looking at how the workload of the clinic liaison nurse could be made more manageable.

That said, the nursing, audiology, and orthoptic staff remain relatively healthy and satisfied – with many of the interventions being well-received.

## **8.3 North NHS Trust Children's Services**

### **8.3.1 Participation rates**

The information required for the evaluation in the neonatal unit was gathered from both questionnaires and interviews. Questionnaire return rates were moderate (15 questionnaires returned) due to problems with staffing levels that occurred unexpectedly around the time of the evaluation survey. However, it was possible to interview 10 staff from the group to bolster the information gathered from the questionnaire survey. Data from questionnaires formed the cornerstone of the evaluation data from Wards A and B where 30 questionnaires (65%) were returned. Here it was only possible to carry out a small number of interviews due to the small number of staff who worked on each shift.

Data is presented in two ways for this case study. First, overall changes observed across at least two, or all three of the wards are discussed. The results from the neonatal unit were rather different from those reported by Wards A and B. Second, we report more local changes that affected particular wards.

### 8.3.2 Headline figures

#### Staff well-being

Across the three wards, staff well-being was relatively stable, with worn and tense scores slightly, though not seriously, higher than normative (UK population norm / average) levels (see Table 8.3). However, as Table 8.4 shows absence had dropped from around 8 days per year to 3 days per year. Intention to leave remained low and job satisfaction extremely high. The incidence of work-related musculoskeletal pain was stable and moderate-to-low. These results were similar across the three wards.

**Table 8.3: Children’s Services worn out and tense scores at assessment and evaluation**

	Average (normative) Range	Whole Group	Ward A	Ward B	NNU
<b>WORN OUT</b>					
Risk assessment	16-17	20.0	21.4	19.4	19.3
Evaluation		19.8	20.7	20.7	17.8
<b>TENSE</b>					
Risk assessment	6-8	8.3	8.7	7.7	8.3
Evaluation		8.1	7.5	8.1	8.8



**Table 8.4: Other markers of organisational and individual health in Children's Services**

	Average (normative) Range	Whole Group	Ward A	Ward B	NNU
<b>MUSCULOSKELETAL PAIN</b>					
% Reporting work-related pain					
Risk assessment	40-50%	32%	16%	42%	36%
Evaluation		36%	20%	53%	39%
<b>ABSENCE</b>					
Self-report of absence (days/year)					
Risk assessment	6-8	8	5	9	10
Evaluation		3	4	3	4
<b>INTENTION TO LEAVE</b>					
% Wanting to leave the Service					
Risk assessment	30%	33%	37%	26%	36%
Evaluation		32%	33%	33%	31%
<b>JOB SATISFACTION</b>					
% Satisfied, or very satisfied overall					
Risk assessment	40-50%	70%	63%	73%	72%
Evaluation		71%	53%	87%	77%

### ***Working conditions***

A strong pattern emerged in this data – few changes were observed for staff in the neonatal unit, while a number of important changes were reported by staff in Wards A and B.

In the neonatal unit staff reported having to spend less time supervising the work of temporary staff, and that there were fewer problems for them in terms of dealing with work that should have been completed by their colleagues. Fewer staff reported problems with a lack of support staff. However, the group as a whole reported few other overall changes in working conditions. These findings are discussed more fully in section 8.3.3 – the evaluation of the interventions indicated that their impact was off-set by the effects of the loss of a number of experienced staff from the unit. Indeed, given the severe staffing problems faced by the unit, the interventions may have helped to at least maintain positive working conditions and staff well-being. A number of the problems identified in the risk assessment persisted e.g. lack of recognition and feedback, time and dependency issues, high demands, lack of support and staffing problems (see boxes 4.14 and 4.25).

In contrast a substantial number of improvements were reported by staff in Wards A and B with the situation in Ward A improving markedly. Pressures on time seemed to have eased and staff

reported that they felt able to deliver better care to patients, with fewer interruptions. There were fewer problems monitoring the work of temporary staff, and strong improvements in housekeeping support and some aspects of communication. The results are detailed in Table 8.5. There was evidence that these improvements were linked to the interventions implemented (see Section 8.3.3).

Some problems identified in the risk assessment (see Boxes 4.14 and 4.25) did persist in these two wards. These included inadequate recognition and feedback, irrelevant and repetitive paperwork, difficulties when working with medical staff, lack of support and support resources, problems with the physical working environment, and training and development issues.

**Table 8.5: Improvements to working conditions reported in Children's Services Wards A and B**

	% of staff reporting the problem in ward 'A'		% of staff reporting the problem in ward 'B'	
	Risk assessment	Evaluation	Risk assessment	Evaluation
<b>Time and dependency issues</b>				
Lack of time to deliver additional patient care once priority care tasks had been completed	79	33	100	47
Lack of uninterrupted time to get on with the job	74	33	84	47
Lack of time to plan ahead and complete tasks ahead of time	53	40	74	33
Not having enough time to strike a balance between patient centred care and task driven nursing	58	33	74	47
Lack of control over the pace at which work is carried out	63	20	79	67
<b>Monitoring the work of temporary staff</b>				
Quality of work done by other staff on the ward making the job more difficult	42	27	48	33
Having to spend significant amounts of time giving advice to, or monitoring the work of, temporary staff	47	27	84	60
<b>Housekeeping support</b>				
The need to carry out housekeeping tasks or support work frequently interrupting and taking time away from patient care	95	40	95	67
Lack of support staff	63	20	90	60
Support staff not knowing enough about stock storage and equipment use	68	13	74	7
<b>Communications</b>				
Senior managers not knowing enough about the job done by nursing staff	53	27	58	33
Inadequate communication with Children's Services senior management	58	27	58	40
Irregular team meetings	47	7	58	27
<b>Work equipment</b>				
Lack of storage space for equipment not in use	100	0	100	13
Unreliable systems for delivering specimens and tests results	90	27	79	47

In addition to these general improvements, there were also some changes that were reported by staff in particular wards. In Ward A, fewer staff reported problems with obtaining stock from pharmacy, which appeared to be an important benefit of the move to the main hospital site.

The list of specific improvements for Ward B was more extensive and is listed below:

- More time to supervise students
- Staff indicating they had more time to document their work
- Few staff reporting problems with lighting levels and excessive noise
- Nearly all staff indicating that there was now enough time for staff training
- Medical staff being more reasonable in their requests for nursing staff to carry out 'extended role tasks' (e.g. set up intravenous drips).

### **8.3.3 The success of the interventions**

In this section we describe the likely impact of the wide variety of interventions implemented in the three wards. Different wards implemented different interventions to tackle underlying problems (see Section 6.3.2). In the shaded boxes that highlight each intervention we have identified, in brackets, the ward(s) in which the interventions were implemented. This enabled us to evaluate the impact of some interventions by comparing the work and well-being of:

- different wards that had implemented different interventions, or
- different wards that had implemented the same intervention but in a different way, or
- different wards that had implemented the same intervention but to a different degree

It was challenging to evaluate the impact of the interventions implemented in the neonatal unit. The *implementation* of some of the interventions had been adversely affected by the loss of experienced staff from the department – which most staff believed to have had a serious deleterious affect on the department. Further the *impact* of some interventions was diluted by the loss of experienced staff and the problems that it caused. Consequently, the direct evaluation of interventions by staff provided most of the data used to evaluate the interventions in the neonatal unit. At the time of the evaluation new staff had been recruited to address staffing problems, but were not yet in post.

#### ***Interventions to tackle problems brought about by the high-dependency of patients and a high peripheral workload***

Recruitment of additional support staff / changes to the hours worked  
by support staff (all wards)

The increases in support staff were particularly strong in Ward A with 80% of staff being aware that support staff were more available. There were less fundamental changes in ward B – both in terms of the increase in numbers of staff and in the hours they worked. Only 40% of staff in ward B indicated they were aware of a change. Most staff who were aware of the changes agreed that they made an appreciable and positive difference. Efforts to provide training and guidance to support staff about stock storage and equipment use also appeared to have been successful (see section 8.3.2).

By comparing the results from Ward A and ward B it was possible to isolate the impact of the introduction the changes to support staff arrangements. There was a direct impact on some time and dependency problems (see Table 8.5), in particular it appeared to enhance the control that staff in Ward A had over the pace at which they worked (their work was less rushed). There was

also some obvious impact on judgements about the adequacy of housekeeping support (that improved more dramatically in Ward A than they did in Ward B).

The impact of having housekeeping staff working during the evenings in the neonatal unit was felt by a number of staff (around two-thirds indicated it had a large positive impact). The majority had also been affected by the recruitment of extra housekeeping staff into the ward. The comments made by staff indicated that both interventions allowed more time to deliver nursing care (“...nurses have more time to nurse instead of clean and wash...”) and that equipment was more readily available because of the work done by housekeeping staff (“...equipment is usually clean and the shelves are pretty much always stocked...”). The “bottom line” benefits of this intervention (in terms of freeing up of time) were, however, diluted by the loss of experienced staff from the area and the extra workload that had created.

Appointment of an extra clerk (Ward B) / ward clerk to work during the evenings (neonatal unit)

This intervention appeared to be, in part, responsible for driving reductions in time pressured working in Ward B. Staff reported fewer interruptions, having to do less paperwork, and having more time to deliver care. Several staff indicated that the intervention meant they spent less time filing and dealing with notes:

“...less time was spent on paperwork and filing...”  
“...we don’t have to file notes any more...”

The impact of having clerking cover during the evening was rather different in the neonatal unit. In the main it appeared to have tackled the problems caused by having to interrupt patient care in order to grant visitors access to the ward, answer phone calls or complete paperwork. Almost all staff indicated that the intervention had a significant and positive impact:

“...it may seem like a small thing but we get more time to spend with the babies and parents as a result – clerks help with the answering of the phone, the doorbell and dealing with admissions paperwork...”

Rotation of staff between areas (in the neonatal unit)

Most staff in the neonatal unit agreed that this would be a positive intervention. Unfortunately it was not working effectively due to the significant staffing problems the ward were experiencing. Staff were often required to ‘cover’ for shortages and work in the areas they were most needed, often the intensive care section of the department. The group hoped to re-establish this intervention once staffing problems had been addressed.

***Interventions to tackle problems with gaps in the staff establishment and the use of temporary cover staff***

Filling gaps in the establishment with trained student nurses (wards A and B)

This change appeared to be most important in Ward B where the complement of permanent qualified staff had been strengthened by the recruitment of qualified students into permanent

posts. Staffing issues were still being addressed in Ward A, and the problems experienced in the neonatal unit have already been mentioned. Around 4 out of 5 staff in Ward B indicated they had noticed an increase in the number of permanent staff in the unit and that there were more permanent staff on each shift. This intervention increased the amount of time available for staff to deal with patient care, and reduced the number of patients each was assigned to work with. Those staff who reported being affected by the intervention reported that they were more able to deliver additional care to patients (“...I feel more able to deliver the total care package and that includes talking to children and parents...”) after delivering priority care, and that they had more time to plan the care they delivered:

“...there is more time to focus on planning and delivering care...”  
“...there is more time for the children which is so important...”

Problems with not having enough time to spend with the parents of very sick patients had also eased, and staff reported fewer problems with finding time to document work. It was also reported that there was more time available for staff training. Similar, but smaller, changes were evident in Ward A, where some, but not all, vacant posts had been filled at the time of the evaluation work.

Reduction in the use of temporary (bank) staff &  
the use of only experienced bank staff (all wards)

A reduction in the use of temporary staff was reported in both Wards A and B, where problems with permanent staffing were being addressed. This was seen as a major positive change in both Ward A and Ward B. It appeared to drive a reduction in the number of staff who reported not having adequate control over the pace at which they worked, and, naturally a significant reduction in the number of staff who reported that problems were created by having to monitor the work of temporary staff.

“...bank staff don’t know the ward routine...we spend less time supervising them now...”  
“...we rarely use bank staff any more and we only draw on those that are experienced...they don’t need to be so heavily supervised...”  
“...now we are not spending time worrying about the capabilities of staff that we don’t really know...”

Bank staff were still heavily used in the neonatal unit. There was a drive to only use the most experienced bank staff and this was noticed by some staff:

“...the bank staff who know the area allow us to maintain continuity of care...”  
“...they know what they are doing so we don’t have to keep an eye on them all of the time...”

### ***Interventions to tackle lack of recognition from and communication with senior management***

A more visible service management presence on the wards (all wards)

In the evaluation staff from both Wards A and B indicated communications with senior management within the service had improved, and that senior management appeared to be more aware of the problems being faced by staff. Staff indicated that this change was directly attributable to the relocation of senior management offices to within the wards as part of the

move. Unfortunately, staff did not report that service management had attended ward meetings. A lack of communication with service management persisted as a problem for staff in the neonatal unit, with very few staff noticing an increase in the number of visits service management made to the unit.

### ***Interventions to tackle problems with the lack of support for staff involved in distressing or upsetting situations***

Bereavement care training (on the neonatal unit)

Just over a third of those interviewed or returning questionnaires, indicated that they had been involved in the bereavement care training. Several saw it as a positive change. It was reported that the guidelines for dealing with the death of patients had helped staff to understand and carry out the procedures that needed to be followed in such circumstances. However, some staff also commented that the training needed to focus more on the impact of a bereavement on staff and how they should deal with their reactions to it.

### ***The impact of background changes***

The impact of the move to the main hospital site (wards A and B)

The move to the hospital's main site had mixed results for staff in Wards A and B. Most staff reported that test results were available more quickly and that the system was slightly more reliable (since there was no need to transport samples between sites). The significant problems with the re-stocking of medical supplies on the wards by pharmacy had also eased considerably. The wards were dealt with by pharmacy in the same way as the other wards on the main site; when based at the 'satellite' site the wards were 'special cases' with special deliveries being made to them. After the move, the speed of response to requests was quicker and replenishment more efficient. Staff also reported that surgeons were available more quickly when their help was required. The wards were also brighter and less noisy: a change which many staff were extremely enthusiastic about.

One of the most significant changes was that the wards were given significant space in which to store equipment that was not in use. Problems with equipment storage during quiet times (equipment getting in the way and cluttering up wards) had presented as a risk factor in the risk assessment. This problem was all but eliminated by the move. In addition the wards were also allocated a large staff room that was away from patient care areas. Many staff indicated that this had strengthened team spirit since staff were likely to want to use the room during their breaks: on the previous site, staff had used various canteens around the hospital during their breaks.

On the negative side, however, staff indicated that access to porters had worsened – the portering service was more stretched than it was at the satellite site. Many staff also indicated that the wards were hot. Staff were also having to become accustomed to the different 'shape' of the new wards: patients were accommodated in beds and cots that were placed in rooms or small bays along corridors and these were not always observable from the central nursing station. Before the move all beds could be seen from the nursing station, and many staff indicated that they had changed their nursing routine to ensure they could adequately observe all patients. Staff did not indicate that access to interpreters had improved as much as was hoped as a result of the move.

### Practice development groups (in the neonatal unit)

Most (70%) of those questioned during the evaluation were aware of these groups. Although only around a third of staff had actually been involved in them, most staff indicated that their recommendations and the changes that had resulted had been positive. Two of the groups had looked at research and practice on pain relief and ‘parent craft’ (guidance for parents looking after babies) and many staff commented that these had been extremely useful (“...we are much more innovative now in terms of delivering pain relief for babies, and we feel better knowing that we are doing our best for them...”). One other group had looked at reducing noise levels in the department (e.g. by staff answering the alarms on monitoring equipment more quickly), but many staff indicated the recommendations had been difficult to implement because of the increase in dependency levels on the ward (more babies requiring very intensive levels of care).

### Appointment of a practice development nurse (in the neonatal unit)

This intervention was seen as an extremely positive change by staff on the unit. Around half perceived to have a big and positive effect on them. This intervention seemed to have several effects. It was reported that staff development was better organised, more relevant and more useful as a result of interventions implemented by the practice development nurse.

“...we are able to discuss our educational needs...and she is able to organise training for us on an individual basis...”

“...I think it has made a big difference in lessening the gap between theory and practice...”

### Interventions to improve working relationships with medical staff (all wards)

Unfortunately little progress appeared to have been made in improving working relationships with medical staff. Significant problems were still reported across the wards. However, some staff working in the neonatal unit had noticed positive comments from consultants being entered in the ward communications books. These comments appeared to have a disproportionate impact: a few comments were seen as extremely important by staff.

“...it really boost staff morale...it makes me feel part of a good team...”

### Re-scheduling and repetition of team meetings (all wards)

Renewed efforts at organising regular and inclusive team meetings on Wards A and B were successful. Before the intervention the content of meetings had been seen as useful and informative, so their actual content and structure changed little. However, the situation was yet to improve in the neonatal unit. Efforts were being made to organise team meetings on essential training days, but staff shortages had meant that some had been cancelled. With the recruitment of staff into vacancies, team meetings were being re-scheduled to occur on essential training days taking place just after the evaluation work.



### **8.3.4 A commentary on the intervention process**

The most influential interventions in this case study involved dealing with staffing problems and increasing the help available to staff to help them deal with the ‘peripheral’ parts of the job that impacted on their ability to deliver patient care.

It was a difficult time to evaluate interventions in the neonatal unit: some interventions did not take place because of problems with staffing and an increase in the number of high dependency patients admitted to the ward. However, it was encouraging that in spite of these difficulties the well-being of staff had been maintained. The direct evaluation of interventions indicated that positive changes had been made and these may have off-set the impact of staffing problems and increases in patient dependency levels.

The three wards still have number of issues to deal with. At the time of preparing this report other interventions were being considered. These focused on improving management communication, consolidating staffing across the wards, further improving the physical working environment and enhancing the support available to staff. Although problems remained, the list of problems faced by the group *after the evaluation* was considerably shorter than that faced by the group *after the risk assessment*.

## **8.4 West Central NHS Trust Accident and Emergency Department**

### **8.4.1 Participation rates**

Given the demands placed on staff we carried out only 14 interviews with care delivery staff and 3 interviews with administration staff. 21 care delivery staff and 8 patient administration staff returned completed questionnaires. This represented a response rate of approximately 70%.

### **8.4.2 Headline figures**

#### ***Staff well-being***

On some indicators (worn out scores) there was some sign of improvement for both administration and nursing staff. These changes were small for nursing staff, but more marked for administration staff. Tense scores were stable for nursing staff, but as with worn out scores, there was a drop for administration staff. Setting aside data from a small number of staff who had just returned from long-term sick leave, absence was relatively low (at around 6 days per year). Intention to leave had risen slightly among the nursing staff (up to 43%), but had dropped among the administration staff (see Table 8.6).

There had also been a slight drop in job satisfaction among nursing staff: a number of staff had shifted their rating from being very satisfied with their job, to more moderate (though not low) ratings of satisfaction. For administration staff job satisfaction remained high and stable. The incidence of work-related musculoskeletal pain had also risen to around 50% in both groups. This was a complex pattern of results: it reflected the fact that interventions had been implemented in a turbulent and difficult working environment created by high workload, some persistent problems with work design and problems with moving stabilised patients out of the department.

**Table 8.6: Accident and Emergency well-being measured at risk assessment and evaluation**

	Average (normative) Range	Care delivery staff		Administration staff	
		Risk assessment	Evaluation	Risk assessment	Evaluation
<b>Worn-out</b>	<b>16-17</b>	<b>22.3</b>	<b>20.5</b>	<b>20.2</b>	<b>12.9</b>
<b>Tense</b>	<b>6-8</b>	<b>10.5</b>	<b>10.6</b>	<b>13.0</b>	<b>6.0</b>
<b>Absence</b> Self-report of absence (days/year)	<b>6 days</b>	<b>11</b>	<b>7</b>	<b>4</b>	<b>3</b>
<b>Musculoskeletal Pain</b> % Reporting work-related pain	<b>40-50%</b>	<b>29%</b>	<b>52%</b>	<b>40%</b>	<b>50%</b>
<b>Intention To Leave</b> % Wanting to leave the department	<b>30%</b>	<b>21%</b>	<b>43%</b>	<b>30%</b>	<b>13%</b>
<b>Job Satisfaction</b> % Satisfied, or very satisfied overall	<b>40-50%</b>	<b>67%</b>	<b>34%*</b>	<b>80%</b>	<b>75%</b>

\*57% neither satisfied nor dissatisfied

## ***Working conditions***

It was encouraging that the vast majority of positive working conditions reported by both administration and nursing staff during the risk assessment (see Box 4.15) had been maintained or strengthened.

A number of improvements were reported by nursing staff. Most notably there were improvements in aspects of communication, training and staffing that were reflected in the judgements that staff made about their working conditions:

- Fewer staff reporting inequalities with the availability of information within the department
- Far fewer staff reporting problems with the staffing levels during both day and night shifts
- A modest reduction in the number of staff reporting problems with a lack of training on new developments in medical research and patient care techniques
- Far fewer staff reporting problems with inadequate notice of shift work hours, and an excessive impact of shift work on home life
- A modest reduction in the percentage of staff indicating that meetings with their peers were too infrequent
- More staff reporting that appreciation and recognition from patients was adequate

However, it should be noted that for nursing staff there were also a number of problems that persisted. The most significant of these were:

- Stabilised patients not being moved quickly enough to wards coupled with poor co-operation from wards
- Working under time pressures with little control over the management of workload
- Lack of training for dealing with violent or aggressive members of the public
- Lack of opportunities to discuss experiences after dealing with bereaved relatives and a lack of support for staff involved in upsetting or distressing situations
- A lack of consultation with, and feedback from, management

A similar picture of change emerged for the administration staff: some marked improvements against a backdrop of some important and persistent problems. Within such a small group it was challenging to identify significant change and only the most important of these are presented (i.e. those problems that were reported by 3-4 fewer people in the evaluation survey than in the risk assessment). These included:

- Important information being made more readily available when it was needed
- More frequent appraisals, and fairer grading
- Fewer staff reporting problems with the frequency of departmental meetings
- More staff indicating that communication with team leaders was good enough
- More staff reporting that tasks were allocated efficiently enough amongst the administration team
- A cluster of improvements around training and guidance: improved guidance from other staff about priorities, better training when taking on new tasks, improved support for staff involved in distressing situations, and better training from other staff, and in particular training on how to use computer equipment.

### ***8.4.3 The success of the interventions***

The interventions reported here were designed to tackle the underlying problems described in Section 6.3.3.

## ***Interventions to tackle the demands on nursing staff's time***

### Introduction of the administrative co-ordinator

The vast majority of staff (62%) said that this change had a significant impact on their job – and almost all of those said things had changed for the better as a result. Most staff had cause to work with the administrator on a frequent basis. The impact of the intervention appeared to be that it eliminated some of the more frustrating tasks faced by staff trying to deliver patient care.

“.....It's been great. The amount of time I used to spend on the phone chasing beds for patients...it was unbelievable. He does that now so I can get on with doing the job I'm paid for, and that I enjoy.....”

Most staff indicated that the intervention had freed up their time to deliver care. Some staff said that their colleagues were now more accessible since they spent less time on the telephone organising tests, or beds, patients (“...it has released the nurse co-ordinator so that she can actually manage the clinical area”). A number of staff also indicated that the co-ordinator also intercepted telephone calls coming into the department, easing the number of interruptions faced by staff. The only problem with the intervention was that the co-ordinator was only available between 9am and 5pm. Staff reported noticing a huge difference when he was not there.

### Locating ECG staff on the wards

Although a fairly modest change, just over half of the nursing staff indicated that this had a significant, and positive impact on their jobs. Many staff reported that although they enjoyed doing ECGs, at busy times it was a tremendous help to have someone in the department that they could call on for help, without raising the workload of other nursing staff.

“...it allows nurses to be freed-up for other duties.....ECGs get done quicker and there is more time to do other jobs...”

Staff also indicated that having help with ECGs meant that they were faced with fewer interruptions caused by requests to carry out ECGs themselves.

### Presence of community psychiatric and community liaison nurses on the ward

The locating of these specialist nurses in the department was reported to have had a large, positive impact. These nurses were able to complete jobs that were extremely time consuming and disruptive for staff trying to deliver emergency patient care. Most staff indicated that they had been faced with the long, complex job of organising care for patients leaving the department. Most said that this problem had eased tremendously since these nurses had been located in the department. Staff reported that this had many important benefits.

First, it eased the pressure on their time by allowing them to get on with delivering care to other patients (“...it lessens the time us nurses spend doing referrals...”). Second, it meant they were not exposed to an extremely difficult and frustrating aspect of the job that they had received little specific training for (“...psychiatric patients get dealt with more effectively...”). Third, it

enabled them to concentrate better on other tasks (without having to think about the management of movement of patients into the community, sometimes for the whole length of a shift).

***Interventions designed to improve communications and to deal with unequal distribution of information in the department***

Fortnightly departmental meetings

Attendance at these meetings was generally good. Those who attended reported that the meetings had relatively large and positive impact. These staff said that the intervention had allowed them more opportunities to discuss problems with colleagues and that the meetings were a good source of information about important changes occurring in the department:

“...if nothing else, at least you are able to air your views...”  
“...I get to know what’s going on and if I can’t go at least I get to see the minutes...”

However, not all staff could attend, and several staff pointed out that because of shift patterns some staff attended them frequently, while others were rarely in the department when they were taking place (although many commented that useful minutes of the meetings were available). Some staff who attended the meetings reported that although problems were discussed, little action was taken as a result. It did seem that the meetings were useful for communication but that their potential for enhancing consultation and involvement in decision-making had not yet been fully exploited.

Communications folder and the Staff Information Book

Most staff were aware of the communications folder. It was reported that it was well-publicised and regularly updated, with useful information. Many staff reported that they found it useful for keeping up to date with minor changes that were not immediately noticeable or heavily publicised, but that nonetheless had a large impact on their job:

“...It’s very handy for the silly little things you might not get to hear about - like a change in the door access codes, or new telephone numbers for [the] X-ray [department]. Things that cause problems if you don’t know about them – the bits of information you can easily miss or forget...”

However, many said that the impact of the change on their job was only modest. Some staff commented that they did not use folder very often. Others said that it was not prominently enough displayed. However, those that did use it commented that the information in it was useful.

***Interventions to tackle problems with training***

Nurse practitioner run training sessions

By no means all staff had attended these. However, those that did indicated that they were extremely useful. The sessions had run for a number of months, but at the time of the

intervention had not been organised for a few weeks (for a variety of reasons). However, sessions had been run on a number of important topics such as pain management and resuscitation methods. The intervention appeared to greatly improve the availability of research-based training for many staff – this was reflected in their questionnaire ratings during the evaluation survey. More junior staff seemed to find these sessions the most helpful, with several mentioning they had built up their confidence and competence through the sessions. Senior staff tended to regard the sessions as a source ‘refresher’ training. Many also remarked that it was useful to have the training ‘in-house’ since it was difficult and disruptive to organise time to go for training outside of the department:

“...before we had these, there was very little in the way of research based training provided in-house. We rarely get the time to go outside the department for training. I know a lot of it, but it doesn't hurt to go over it again - it makes you more confident that you are doing the right thing...”

### ***Interventions to address problems with staffing levels***

Recruitment of extra staff (and qualification of staff as nurse practitioners)

Around half the nursing staff indicated that the appointment of extra nursing staff had made significant, and positive difference. Several did indicate that the impact had been tempered by some long-term sickness absence within the department. Some reported that there were problems with the skill mix since many new recruits were relatively inexperienced. However, for most staff the impact of this change was very noticeable. Several indicated that “...stress has lessened considerably...”. Others also believed that “...with increased staffing we can give better care...”. During the interviews several staff also mentioned that they felt staff were more able to support each other – both emotionally and in terms of workload – since staffing levels had increased.

### ***Interventions to address problems with lack of notice about the off-duty***

Clarifying responsibility for the management of the off-duty rota, with the goal of it running 6 weeks in advance

Although several staff reported that there was more advance notice of working hours, there had been some problems with this intervention. Several commented that when it had first been implemented the situation had improved markedly. However, the member of staff responsible for organising the rota took a period of extended leave from the department, and since that time the off-duty rota was not organised as far in advance. That said around 60% of staff indicated that the rota was better organised than it had been, with many of those saying that the change had a large, and positive impact on them. The main benefit they felt was the relative ease with which they were able to organise their family, leisure and social activities.

“...it makes it much easier to have a life – if you know the hours you are working at least you can organise things....and its so important to have a good social life when you work in such a pressurised and difficult job...”

## ***Interventions to address lack of communication within the administration section***

Introduction of monthly team meetings and attendance at departmental meetings

The involvement of administration staff in these interventions was modest. The impact of the intervention was similar as that reported by nursing staff. Those interviewed commented that they could "...learn more about what was going on in the department..." and that it increased their feeling of 'belonging' in the department ("...we get to see more people in an environment where you can just talk about things...").

## ***Perceived inappropriate grading of jobs***

Re-grading the jobs of several staff

Although only a handful of staff had been re-graded, these staff were extremely positive about the change reporting that the responsibility they had taken on was finally being recognised. Those involved felt that they were "...being paid for the work we are doing, instead of just doing it out of the goodness of our hearts...". Some staff also indicated that re-grading had increased flexibility within the department with a more organised management structure emerging with tasks being allocated more efficiently. This was one of the major improvements reported by staff in the evaluation survey.

## ***Impact of background changes***

The introduction of remotely monitored beds in the resus area was reported to have had a large impact and was seen as a positive by almost all staff, with many of them commenting that it helped them to 'keep an eye on' patients without having to take the time to go to their cubicles. Nursing staff indicated that this was less disruptive for them and that it meant patients could be monitored much more effectively. The introduction of the relatives' room was also regarded as having a large, positive impact: it enabled staff to talk to relatives in privacy and its position meant that bereaved relatives did not have to walk the length of the department to reach a viewing room.

The new specialist paediatric cubicles were reported to have had a modest, but positive, impact: staff commented that these enabled children to be treated in a more relaxed atmosphere with the appropriate equipment always being on-hand. Staff also felt that the increased privacy that was achieved through having cubicles in resus was beneficial for patients (many commented that when curtains were used to divide the space it was noisy and there was little privacy) and led to fewer interruptions during care.

The introduction of the new computer system in patient administration had a large impact. Most staff indicated that training on the new system had been better than that which had been available for the system it replaced, and that the system itself represented an improvement. In particular, the speed with which data could be accessed and interrogated was said to be greatly improved:

"...it is far easier to locate patient records and to track what they have attended the hospital for in the past"

Several staff in the area also reported that the enhanced security measures had been noticed, but that there were still problems with members of the public being aggressive and abusive. One other major change within the area was linked to the allocation and management of workload, associated with re-grading.

#### **8.4.2 Commentary on the intervention process**

As described above, a number of the changes made in the department were well-received by staff. Most notably, changes that eased the demands on nursing staff's time were seen as important. These changes did not require any extra money that had not already been budgeted for. For example, the introduction of ECG staff and community liaison nurses into the department simply meant moving those staff into the department and not employing extra staff. Although modest, changes in the administration section appeared to have had positive impact on the work and well-being of its staff.

The impact of change on the well-being of nursing staff was modest. Indeed, there was a slight drop in job satisfaction and an increase in work-related musculoskeletal pain over the intervention period. There were two possible reasons for this.

First, the slow movement of stabilised patients out of the department to wards was cited as a huge problem. Many staff indicated that this was the most significant problem they faced: it appeared to adversely affect many aspects of their work and worsened the problems caused by an already high workload and lack of staff at busy times. The Steering Group also felt that this was a problem that was outside of their control. Delays in releasing beds tended to occur at the ward level, and at times when there was insufficient medical staff to discharge patients. At the time of writing, this problem was being investigated and tackled by senior management within the hospital.

Second, systems for supporting staff (who had been involved in distressing situations) did not improve during the intervention period. Many staff reported this to be a significant problem. Lack of support is often related to the experience of work stress. During intervention design, a number of ideas for enhancing support were discussed, but the Steering Group felt unable to progress them: the development and implementation of the ideas required time that few staff felt able to spare in such a pressurised environment. After the feedback of the evaluation report, a renewed effort has been made to improve the situation.

### **8.5 West Central NHS Trust catering department**

#### **8.5.1 Participation rates**

22 staff returned questionnaires and 11 staff were involved in interviews (including some of those who also completed a questionnaire). This translated into a participation rate of approximately 60%.

#### **8.5.2 Headline figures**

The relatively strong well-being of this group was maintained, job satisfaction remained high, few staff reported wanting to leave, and absence was low. Worn out scores were, however, still a little higher than is desirable (see Table 8.7). The incidence of musculoskeletal pain was steady and moderate.



**Table 8.7: Catering department well-being measured at risk assessment and evaluation**

	Average (normative) range	Catering Staff Assessment	Catering Staff Evaluation
<b>Worn-out</b>	<b>16-17</b>	<b>19.3</b>	<b>19.9</b>
<b>Absence</b> Self-report of absence (days/year)	<b>6 days</b>	<b>7 days</b>	<b>6 days</b>
<b>Musculoskeletal Pain</b> % Reporting work-related pain	<b>40-50%</b>	<b>40%</b>	<b>47%</b>
<b>Intention To Leave</b> % Wanting to leave the department	<b>30%</b>	<b>30%</b>	<b>29%</b>
<b>Job Satisfaction</b> % Satisfied, or very satisfied overall	<b>40-50%</b>	<b>80%</b>	<b>81%</b>

However, improvements in working conditions were noticeable. Significantly fewer staff reported problems with several aspects of their job, namely:

- Issues around staffing cover (e.g. the competence of cover staff)
- Consultation about change
- The availability of equipment and equipment maintenance

In addition, staff in particular areas of the department reported some specific improvements that were associated with specific interventions. These are discussed below.

### **8.5.3 The success of the interventions**

Different interventions were implemented in different parts of the department (e.g. staff in food preparation received different interventions to those in the dining room, for instance). Therefore, the impact of specific interventions varied from group to group within the department. This section details the impact of these interventions and reconciles them with them with the headline changes (reported by the group as a whole) already described.

The interventions reported in this section were designed to tackle the underlying problems identified in Section 6.3.4.

#### **Interventions to improve consultation and communication**

Team leader meetings & changes in management structures

These meetings had occurred on a monthly basis, as intended, throughout the intervention period. Team leaders had found them very useful when it came to solving problems that affected a number of different sections of the department. For example, updating the menus in the dining

room had implications for both dining room and kitchen staff. Through the team leader meetings staff were able to work together to come up with a solution. From the viewpoint of the majority of staff, there had been some modest changes in communication and co-operation between different sections of the department as a result.

Staff in the central washing up area were pleased to have a team leader, and felt that it gave them more of a voice when decisions were being made. Similarly, dining room staff saw the appointment of a restaurant supervisor as an improvement - they felt that it led to more consistency in the way the area was managed. They also reported that they felt more confident that something would be done if they approached the one person in charge with a problem (rather than one of three team leaders that shared responsibility before the appointment).

### ***Interventions designed to tackle problems with equipment***

Re-location of maintenance staff to a base near the department

Most staff reported that having maintenance staff based near the Catering department had improved the speed of equipment repair. The impact was felt more in the washing up areas where large machines were maintained and repaired by hospital maintenance staff. The impact of this intervention was reflected in the drop in the number of staff reporting problems with slow equipment repair and maintenance. The impact was more modest from the perspective of the food preparation staff: much of their machinery was repaired by engineers sent by equipment manufacturers. This change was reported to have had a small, but positive, impact by dining room staff.

Purchase of new trolleys

The purchase of new trolleys was well-received throughout the department. Most staff indicated that this intervention had a large impact. Staff indicated that there was “less arguing over trolleys”. One remark was typical: “we don’t have the added stress of finding a trolley when we are already busy”. Many of those interviewed also indicated that having the trolleys had eased some of the physical demands of the job: staff needed to carry heavy objects less often.

Use of plastic plates

This change was seen as a dramatic improvement by staff in the washing up areas of the department. It was reported to have reduced the physical load placed on them – and that this was particularly helpful in a job that involved lots of repetitive movements.

### ***Interventions to improve the quality of work done by cover staff***

Recruitment and training of more bank staff

The recruitment of more bank staff affected some areas of the department more than others. The cooking areas did not use bank staff, but staff in both the dining room and the washing up areas

reported noticing this change. Both those in the dining room and those in washing up areas indicated that it had a moderate impact on their work - but that things were better as a result.

It was also reported by the vast majority of staff that they had noticed that cover staff were better trained and more knowledgeable. This was reported to have had a big, positive impact by staff in the dining room, but appeared to have less of an impact in some of the washing up areas.

Information obtained from the questionnaires reflected these improvements. Staff reported fewer demands to cover the work of others, or to supervise and help inexperienced staff.

### ***Adjustments to staffing levels***

Additional staff, and extra hours for existing staff at key times

Extra staff – and additional hours for some staff – were relevant to several sections of the department. The response to the extra member of staff in the dining room was extremely positive. Almost all dining room staff agreed that it had a large positive impact on their working conditions – relieving the pressure on them at busy times. The new members of staff generally cleared tables and re-stocked food in the cafeteria – established staff reported that this enabled them to serve food and deal with customers with fewer interruptions, and under less pressure.

The addition of extra time for vegetable preparation was well received by food preparation staff – this intervention in particular was reported to have had a big impact. Cooks reported that ingredients were “ready to go” at the right time for them: instead of waiting around for ingredients to arrive they were able to get on with preparing dishes, easing the intensity of their workload around mealtimes.

The addition of three new trained chefs to the team also appeared to have helped tremendously – staff indicated that it was much easier to find cover for staff who were on holiday or on sick leave and that there were enough cooks in the department more often – thus easing workload a little.

### ***Background to changes***

The removal of the smoke room had a big impact for staff in the dining room area – most reported that it made things better for them because they no longer had to clean the room, leading to a reduction in workload – some staff felt this to be an unpleasant task. Staff in other areas of the department who used the smoke room were less positive about the change.

The diverting the of the telephone was noticed as a significant improvement by staff in the dining room in particular, and that it had a big impact – making things better particularly around mealtimes when it reduced interruptions.

Staff appraisals had also been re-visited – the vast majority of staff had found these useful as a route to training and development and as a way of discussing problems and concerns.

There was also a change in management within the department, with a deputy manager being promoted to take on overall responsibility for the running of the department. Staff reported that the manager had a very ‘hands-on’ approach which many staff appreciated.

### 8.5.4 A commentary on the intervention process

The Catering Steering Group managed its own response to the risk assessment. As can be seen, the interventions were good management practices that were easy to implement. The creative use of existing resources characterised the intervention package implemented by this group.

There were still some problems at the time of the evaluation. The work was physically tiring for many staff, and this appeared to underpin the worn out scores reported by the group. Managers and team leaders were increasing their efforts to monitor manual handling procedures and training in their efforts to manage this problem. Difficulties with equipment were also being tackled, but the Steering Group felt that improvements to this aspect of work were only likely to be achieved in the long-term.

## 8.6 East Central NHS Trust Children's Services

### 8.6.1 Participation rates

Participation in the evaluation work was high. We received 55 completed evaluation questionnaires and interviewed 24 staff. Participation rates were high among all the different grades of staff involved in the evaluation work. We drew on both the data from questionnaires and interviews equally to evaluate the interventions.

### 8.6.2 Headline findings

Evaluation data for this group was collected only six months after the risk assessment: some of the interventions implemented had been in place for much less than six months. This was dictated by the timescale of this research project. However, it meant that some interventions may not have exerted their full impact by the time of the evaluation.

#### **Staff well-being**

Overall, there were some encouraging findings in terms of employee well-being (see Table 8.8). Average worn out scores had dropped from 20 to around 18 for G and H grade staff. The improvement was less pronounced for F grade staff. Job satisfaction remained high and intention to leave relatively low, while low average absence was maintained. One unexpected finding was a slight increase in the incidence of work-related musculoskeletal pain among G and H grade staff: a particular problem with the types of cots used in the department (requiring staff to bend and lift awkwardly) had contributed to this and was being addressed at the time of the evaluation (see Table 8.9).

**Table 8.8: Children's Services F, G and H grade worn out scores at risk assessment and evaluation**

	Average (normative) Range	F Grades		G/H Grades	
		Assessment	Evaluation	Assessment	Evaluation
<b>Worn out Score</b>	16-17	19.5	18.7	20.0	18.4

**Table 8.9: Children’s Services F, G and H grade  
individual and organisational well-being at risk assessment and evaluation**

	Average (normative) Range	F Grades		G/H Grades	
		Assessment	Evaluation	Assessment	Evaluation
<b>Job Satisfaction</b> (% satisfied)	40-50%	64%	68%	58%	60%
<b>Intention to leave</b> (% wanting to leave)	30%	27%	36%	42%	36%
<b>Absence</b> (days / year)	6-8	7	6	2	2
<b>Musculo-skeletal pain</b> % reporting pain	40-50%	27%	32%	29%	46%

### ***Working conditions***

In terms of working conditions, however, there were some significant ‘headline’ improvements. These are shown in Table 8.10. Working relationships with management appeared to have improved significantly. There had also been improvements in the quality and availability of support available to staff on a number of issues. Several markers of training adequacy and the communication of ideas also showed improvements.

**Table 8.10: East Central NHS Trust Children's Services:  
Large reductions in the proportion of staff reporting problems**

	% of staff reporting the problem	
	Risk assessment	Evaluation
Lack of praise and recognition from immediate management	60	31
Inadequate availability of study time / time for training	66	41
Inadequate availability of information on a continuous basis, about how the ward is performing e.g. against its budget	79	56
Poor quality of advice and support on long-term planning issues	59	37
Lack of sharing of good ideas and good practice between wards and across the service	80	49
Inadequate support from line management	57	21
<b>F Grade problems</b>		
The ease with which important information could be identified within large amounts of written communications/ memos	67	40
Poor quality of support and advice from more senior staff on day-to-day issues	61	36
<b>G/H Grade Problems</b>		
Amount of time spent with consultants discussing the way the ward was running and any plans / ideas for the future	67	37
Availability of support for staff who have been involved in distressing or upsetting situations	54	32
The extent to which other staff understand your workload and your priorities	79	50

There were also further, more modest improvements the amount of time available to tackle some managerial tasks, and administrative support. There were also improvements in the balance between the clinical and managerial workload, and amount of control that staff had over the way they went about achieving that balance. Staff also reported that new ideas were allowed to develop, gain approval and be put into practice more quickly.

### **8.6.3 The success of the interventions**

These interventions were designed to address the underlying issues identified in Section 6.3.5.

***Interventions designed to free-up time for administrative work and to make it easier to manage the balance between administrative and clinical work.***

Review of office days and subsequent changes to office hours

Most G and H grade staff were aware of the ‘Office Hours Review’ and the changes that had occurred as a result of it. As expected, awareness among F grades was less pronounced. However, those who were aware of the change generally reported that it had an appreciable, positive impact for them.

The impact of this intervention proved challenging to interpret. First there seemed to be a number of positive effects. Those involved in the intervention were less likely to report the following problems (see Table 8.11):

- Infrequent office days
- Ideas not being allowed to develop and progress quickly enough
- Lack of information about the performance of the ward
- Lack of time to tackle short, or quick managerial tasks
- Lack of time to deal with clinical workload

These were clearly directly related to the intervention. Many staff reported that “office days were now recognised as vital”, or that there was “time to do office work at work, not at home”. However, the intervention also appeared to be associated with improved working relationships with management. Praise, recognition and support from management were all less likely to be problems for those aware of the review. For example, several F grade staff indicated that their manager (G grade staff) was more available and could do more to support and advise them since they had regular office days.

However, there did appear to be some problems associated with having extra office time. Those with office time tended to report more problems with interruptions, and tensions between their managerial and clinical workload. Not all the extra time appeared to be “quality time”.

While the intervention was regarded as positive some wards were clearly not feeling its full benefits. Staffing appeared to be a problem that limited access to office days. Several staff commented that there was “insufficient staff to manage office days”, or that “office days were always cancelled for ward work”.

**Table 8.11: Likely impact of office hours review and resultant actions**

	Risk assessment	Evaluation Survey	
		Group aware of the review's impact % reporting the problem	Group not aware of the review's impact % reporting the problem
<b>Working conditions</b>			
Infrequent office days / slots of time in which to work on managerial tasks	71%	43% (reporting problem)	71% (reporting problem)
Lack of uninterrupted time during the time set aside for managerial and admin work	76%	71%	48%
Lack of information on a continuous basis about how the ward was performing	79%	39%	62%
New ideas not being allowed to develop, gain approval and then be put into practice quickly enough	66%	46%	67%
Lack of praise and recognition from immediate management	60%	25%	42%
Conflicts between managerial workload and clinical workload	57%	71%	43%
Lack of advice and support for more senior staff on day-to-day issues	52%	18%	48%
Lack of time available to tackle short, quick managerial tasks	38%	18%	52%
Lack of available time to deal with clinical workload	38%	29%	52%

Placing of computer facilities on every ward

At the time of the evaluation, around half of the wards had received new computer equipment. Staff in those wards that had received the equipment believed it had made a positive difference to their work. However, staff indicated that there were a number of issues that were limiting the impact of the new technology.

Many indicated that computers had not yet been fully installed or connected to networks. Some of those that had did not have email software installed and working. Many staff reported that they had not been trained on how to use the computer facilities. These issues were recognised by management and were being addressed at the time of the evaluation.

However, computers in several wards were fully operational and staff were reporting the benefits (see Table 8.12). Many said it was important that they were able to do “ward work at work – and not on the PC at home” and that access to email was a very useful means of



communicating within a large service..... “access to memos, news and information is much better”.

Information from the questionnaire survey provided evidence that access to computers was easing some communication problems and helping senior staff to manage their time. Those whose wards had new computers were less likely to report that they had problems in finding slots of time to undertake administrative work, or that they had insufficient time to deal with their clinical workload – problems that had been linked to poor well-being in the risk assessment. Before the purchase of computers for each ward staff had to spend time finding computers on other wards that they could use. For those wards with email facilities the introduction of computers had also eased the flow of information.

**Table 8.12: Likely impact of the introduction of new computer facilities**

	Risk assessment	Evaluation Survey	
		Wards with new computer facilities	Wards without new computer facilities
<b>Well-Being</b>			
Worn out score	19.6	17.2	20.4
<b>Working conditions</b>	<b>% reporting the problem</b>	<b>% reporting the problem</b>	<b>% reporting the problem</b>
Infrequent slots of time in which administrative tasks can be undertaken	71%	42% (reporting the problem)	68% (reporting the problem)
Lack of feedback from staff who have been on training courses	67%	63%	44%
Lack of time available to deal with the clinical workload	38%	29%	48%
Clarity of who to contact about various issues	26%	17%	40%

The appointment of staff in a housekeeping / support role

Just over a third of staff worked in wards that had a housekeeper, with almost all of those housekeeping staff working on a part-time basis. There was almost total agreement that having a housekeeper had resulted in an improvement. While it was noted that the housekeeping role was more relevant to the work carried out by more junior staff, F, G and H grade staff reported numerous benefits (see Table 8.13).

Most agreed that they helped to keep the ward tidier and that this helped to maintain a visibly high standard of hygiene in the ward. But the most significant impact reported by staff was the impact that the housekeeper had on the ‘peripheral’ workload faced by staff e.g. making beds, fetching drinks for patients and their relatives, maintaining stock levels etc. These benefits were evident in the information collected from both interviews and questionnaires. Questionnaire data indicated that morale was higher in wards with a housekeeper. An additional benefit was that because senior staff had been involved in the recruitment of housekeeping staff they reported being more satisfied with their level of input into staff recruitment.

This proved to be a challenging intervention to evaluate. The benefits felt by staff were clear. However, the wards who had made a strong case for having a housekeeper appeared to be the busiest (see Table 8.13). Staff from these wards tended to report having less time to deal with

their clinical workload. However, the benefits of the intervention were well-recognised by management and at the time of the evaluation, many wards were in the process of appointing a housekeeper.

**Table 8.13: Likely impact of the appointment of housekeeping staff**

	Risk Assessment	Evaluation Survey	
		Wards with a housekeeper	Wards without a housekeeper
Working conditions	% reporting the problem	% reporting the problem	% reporting the problem
Problems with the arrangements in place for covering sickness absence	64%	80%	48%
Inadequate advice and support on long-term planning issues	59%	20%	52%
Lack of support staff in the wards	52%	35%	57%
Lack of say over which staff worked on the ward	45%	26%	65%
Lack of control over the way staff decided to manage and use their own time at work	42%	45%	22%
Low staff morale within the ward	40%	40%	61%
Lack of time to deal with clinical workload	38%	60%	18%
Lack of control over the way staff managed the time of other staff on the ward	38%	45%	13%

***Interventions designed to tackle problems with training provision***

Updates to the study leave policy and publicising of training involvement

The majority of staff reported being directly affected by easier access to, and approval of, study leave. A slightly higher proportion of F Grade staff were aware of the intervention. The view of most of those involved was that the intervention had a modest impact on them, but that things were better as a result.

In terms of the impact of the intervention, there was higher job satisfaction among the group who had been directly affected by the changes to the policy. Table 8.14 shows the likely direct impact of the change. Those affected by the change reported that study time was more readily available and that the short notice cancellation training courses was less of a problem. Overall there was already signs that more staff felt that the feedback was adequate that staff were given after being on training course.

There also appeared to be some indirect effects of the change. For example, staff affected by the change were more likely to report being adequately supported by management, and felt that

their efforts were more adequately recognised. Provision of training was reported by some staff to be seen a sign of the recognition of their efforts.

Table 8.14 also highlights an important ‘moderating’ factor in the success of the intervention. It appears that those staff who were aware of the changes to study leave policy were those who reported having adequate time to tackle short, simple managerial tasks. In the interviews, organising and approving training were often described as short and simple managerial tasks – those staff with more time to spend on them appeared to be more likely to have time to notice and act on the changes to the study leave policy.

**Table 8.14: Likely impact of changes to the study leave policy**

	Risk assessment	Evaluation survey	
		Group involved	Group not involved
<b>Well-being</b>			
Job satisfaction	60%	65% Satisfied	50% Satisfied
<b>Working conditions</b>	<b>% reporting the problem</b>	<b>% reporting the problem</b>	<b>% reporting the problem</b>
<b>Direct effects</b>			
Lack of study time / time for training	66%	38%	58%
Short notice cancellation of training courses	38%	30%	50%
<b>Knock-on effects</b>			
Amount of praise and recognition from your manager	60%	27%	50%
Quality of advice and support from more senior staff on day-to-day issues	52%	21%	58%
<b>Moderating factors</b>			
Amount of time available to tackle short, or simple managerial tasks	38%	30%	92%

***Interventions designed to improve the sharing of good practice, and communication and co-operation between wards***

OPEN forums

G and H grade staff were more likely to report being involved in the OPEN forums. Among F grade staff involvement was relatively low. In terms of the impact on their jobs, those involved reported that the intervention only had a small impact on them. However, of those that said the intervention had made a difference, the majority were positive about the forums indicating that they had made things better.

In terms of the impact of the forums on work and well-being, there were a number of differences between those involved in the forums and those not involved (see Table 8.15). Those involved in the forums tended to report higher levels of job satisfaction. This may mean that only those already satisfied with their job attended the forums. However, those involved were less likely to report the following problems:

- Ideas not being allowed to develop and be implemented quickly enough
- Lack of support for staff involved in distressing or upsetting situations
- Infrequent meetings with peers
- Lack of knowledge about who to contact within the hospital when dealing with a problem

Information from the interview and questionnaires suggested supported these findings. Many staff indicated that the forums had “opened up communication channels” and had given them the “opportunity to meet other staff” and be “more informed”.

The impact was regarded by staff as relatively modest. A number of staff commented that they had yet to see any actions taken as a result of discussions at the forum. The difficulty with the forums was that not all staff were able to attend them. Several staff commented that they would like to attend, but that the forum tended to take place at a busy time, or (especially for part-time staff) on a day that they were not working.

**Table 8.15: Likely impact of OPEN Forums**

	Risk Assessment	Evaluation Survey	
		Group involved	Group not involved
<b>Well-being</b>			
Job satisfaction	60% Satisfied	75% Satisfied	50% Satisfied
<b>Working conditions</b>	<b>% reporting the problem</b>	<b>% reporting the problem</b>	<b>% reporting the problem</b>
Ideas not being allowed to develop and, gain approval and then be put into practice quickly enough	66%	45%	64%
Lack of support for staff who have been involved in distressing or upsetting situations	50%	25%	50%
Infrequent meetings with others at a similar grade / peers	37%	15%	45%

Regular problem-solving and development workshops for staff working at similar grades

Although not new, the evaluation included an assessment of the impact of the workshops. Involvement in the workshops was very high among the G and H grades. However, only just over half the F grades reported being regularly involved in them. There also appeared to be some difference between the two groups of staff in terms of how they rated the importance of the intervention. G and H grade staff generally reported that the interventions made a big difference, while F grade staff tended to indicate they only had a modest effect. Generally, both groups indicated that the workshops were a good, positive intervention that had made things better for them.

In terms of the questionnaire data there was one strong and important difference between those who had been involved in the workshops and those who had not (see Table 8.16). Among those that were involved in the workshops a slight majority felt that ideas were allowed to develop,

gain approval and be put into practice with sufficient speed. Those who had not been involved in the workshops were more likely to report problems with this aspect of their work.

The interviews suggested that the workshops had a broader impact, which perhaps was not reflected by the questionnaire results. Different people appeared to take different things from the workshops, and perhaps this was why strong messages did not emerge from the questionnaire data. Some staff reported that the workshops were “good for networking and gaining knowledge”, others that they were “a good forum for sharing information”, or for “sharing support”.

This was an intervention that was affected by staff shortages and scheduling. Some staff reported that they could not attend on certain days - and that these were when the workshops tended to be held. Others reported that they were unable to attend due to staffing problems on the ward.

**Table 8.16: Likely impact of staff workshops**

	Risk assessment	2001 Survey	
		Group involved	Group not involved
<b>Working conditions</b>	<b>% reporting the problem</b>	<b>% reporting the problem</b>	<b>% reporting the problem</b>
New ideas not being allowed to develop, gain approval and then put into practice quickly enough	66%	48%	67%

Introduction of a staff newsletter

Awareness of the newsletter was high: most staff reported reading it on a regular basis. Unsurprisingly the vast majority of staff indicated that it had only had a modest impact, but their views on the newsletter were almost universally positive. Since awareness of this intervention was so high a slightly different approach to its evaluation was adopted. Those staff who said the intervention had made things better were compared to those who said it had made no difference. This allowed for a more detailed examination of the likely impact of the newsletter.

The results of the analysis indicated that the content of the newsletter had made more difference to some staff than it had to others (see Table 8.17). It had started to carrying information from staff who had been on training courses and usually contained information about changes affecting some of the wards. Innovations implemented by some wards were often publicised in the newsletter. These features all came through strongly in the evaluation.

**Table 8.17: The benefits of the staff newsletter**

	Risk assessment	Evaluation survey	
		Group saying it had made things better	Group not saying it had made things better
Working conditions	% reporting the problem	% reporting the problem	% reporting the problem
Lack of information on a continuous basis about how the ward was performing	80%	30%	76%
Lack of feedback from staff who had been on training courses	67%	44%	62%
Inadequate information about changes / developments in the service that affect one's ward / area	50%	19%	48%
Inadequate sharing of good ideas and practices between wards	79%	37%	67%

The results of the evaluation of the impact of the newsletter are interesting. They demonstrate the variability that can be found within a group experiencing essentially the same intervention. The interviews we carried out with staff from this group helped us to understand why. Many of those who saw the newsletter as a positive change recounted incidents where they had been able to draw out information from it that had been useful to the running of their particular ward. Those who were less positive tended to indicate that they found little in it that was of use in their ward. The differences between the wards in the service clearly underpinned the 'usefulness' of the newsletter. It was anticipated however, that the coverage of the newsletter would even out with time, with more and more staff finding useful content in its pages.

***Interventions to improve problem-solving systems and participation***



As it was in its early stages it was expected that the impact of this intervention would be modest. However, it had been heavily publicised and this was apparent in the responses given by staff. The vast majority were aware of Shared Governance, with the interviews confirming that most had an accurate idea of what it would involve. Many G and H grade staff had been actively involved in early planning meetings and this was reflected in their responses to the questionnaire. However, the vast majority of staff reported that it had yet to make a real difference to their working conditions.

Although in its early stages, those staff involved in Shared Governance were less likely to report problems with the available of information about changes or developments in the service (see Table 8.18). These staff appeared to be better informed, a finding that was supported by some comments made on questionnaires or in interviews:

"it is already helping with better communication, colleagues are interested and ready to change, it will move the service on....."

"there is lots of information about it, and it is talked about a lot. It's a positive thing"

Most were aware of its goals and potential. As was expected, most commented it was yet to make a difference. This was consistent with the fact that it was still in its early stages.

**Table 8.18: Likely early impact of Shared Governance**

	Risk assessment survey	Evaluation Survey	
		Group involved	Group not involved
Working conditions	% reporting the problem	% reporting the problem	% reporting the problem
Lack of information about changes / developments in the service that affect your ward or area	50%	11%	45%

***Interventions to improve control over ward management decisions***

Most staff appeared to be aware that there was a gradual shift of responsibility for decision-making down to the ward level. The impact of this was perceived to be relatively small, but generally positive. Some tangible changes had been noticed – some staff had attended budget management training; some had driven the recruitment of housekeeping staff; and many had been given control over spending money for ward refurbishment.

Staff who were aware of the change reported being more in control of various aspects of their own work and the way in which they managed the time of staff on the ward. For example, they felt better able to achieve a balance between their clinical and managerial workload. They also reported more 'freedom' over how they managed the time of the staff they worked with. There also appeared to be some benefits for staff morale. Staff reported “feeling more involved in changes and decisions” and that there were “less channels to plough through to get things done”. A number of staff said attributed this change – at least in part – to a change of management culture bought about by the background change of the appointment of an acting senior nurse manager.

Those staff reporting an awareness of increased responsibility tended to report strong working relationships with management. This may have contributed to an awareness of the intervention. However, it was also reported that a more open management style had strengthened working relationships. Increased responsibility for decision-making was linked to good praise and recognition from management, and good quality advice and support.

By no means all wards were aware of increased decision-making responsibility. Many staff were aware that it was likely to happen, but had yet to see any tangible changes. With the development of G grade roles and responsibilities (the ‘modern matron’) the hospital was planning at the time of the evaluation it was likely that this intervention would be expanded in the future.

***Interventions designed to improve working relationships between different levels of management***

Staff workshops (as evaluated above)
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### Staff 'acting-up' to cover the senior nurse role

Just under half of those returning questionnaires indicated that they had acted up to cover the senior nurse role. Most agreed that it had some appreciable impact on them and their jobs, with just under half of those involved reporting that it had a big impact. Among G and H grade staff, views on the intervention were generally positive. However, among F grade staff views were mixed: as many staff indicated it had made their job worse as indicated it had made their job better.

In terms of the impact of acting-up on work and well-being, there were a number of differences between those who had acted up and those who had not. Those who had acted-up tended to report higher levels of job satisfaction than those who had not.

Those who had acted up appeared to have significantly better working relationships with management: they were less likely to report problems with the quality of advice and support from management on day-to day issues and more likely to report that they received adequate praise and recognition from management. Compared to those who had not acted up, they were also less likely to report three other problems

- Problems with staff morale in their work area
- Problems with work equipment
- Problems with the work environment

There was little information on these three findings in the interviews. It could have been that staff who act-up are more aware of problems elsewhere in the unit and this leads them to view the situation in their own ward more favourably.

Information from the interviews confirmed that there were mixed views about acting-up. Some staff indicated that it was a good "learning experience" that gave them "more involvement in the unit" and "more access to information at source". However, several staff indicated that it created extra demands when the was "enough workload on the ward already". This may reflect differences in the demands faced by different wards: staff in more pressurised wards may be faced with more disruption to their core job when acting-up. The evaluation suggested that the impact that acting-up has on existing workload needed to be carefully managed.



**Table 8.19: Impact of acting-up**

	Risk assessment	Evaluation survey	
		Group acting-up	Group not acting-up
<b>Well-being</b>			
Job satisfaction	60%	70% Satisfied	55% Satisfied
Musculoskeletal pain	28%	55% (reporting problem)	31% (reporting problem)
<b>Working conditions</b>			
	<b>% reporting the problem</b>	<b>% reporting the problem</b>	<b>% reporting the problem</b>
Lack of praise and recognition from your manger	61%	20% (reporting problem)	41% (reporting problem)
Problems with work equipment	55%	30%	55%
Poor quality of advice and support from more senior staff on day-to-day issues	52%	20%	38%
Low staff morale within one's ward / area	40%	35%	56%
Problems with the working environment	52%	45%	69%

Most staff (69%) had acted-up, and this was a significant part of most of their jobs. The vast majority had used the guidance and reported finding it very useful.

The production of guidance for staff who were 'acting-up'

Staff indicated that the acting up guidance had proved useful for a number of reasons. Some of the most commonly cited ones were:

- It was useful having all the information together in one place, that was easy to access
- It was useful for checking what to do when faced with unfamiliar or unusual situations
- As a way of ensuring that staff acted consistently when faced with similar problems
- It provided a clear step-by-step guide for dealing with some of the more difficult and unusual tasks faced by staff

***Interventions to improve equipment levels and the work environment***

Purchase of patient care equipment

Problems with work equipment were raised by many staff during the risk assessment. This evaluation work focused on changes in the interface between clinical and managerial aspects of the job. However, the majority of staff reported significant changes in equipment during interviews and in the evaluation questionnaire. 70% of staff indicated that this had a big impact and that things were better as a result. The service had made a substantial investment in new syringe pumps: staff indicated that the new equipment was better, and that there was more of it,

making it much more easily available. Training on how to use the new pumps had taken time, and created some problems, but many staff indicated that this was being addressed.

The purchase of new equipment was seen as a clear improvement by the vast majority of staff. However, overall as many staff reported problems with work equipment in the evaluation as during the risk assessment. The interviews and questionnaires revealed that there were significant problems with the cots and beds used in many wards. Although these were being addressed these were driving reports of inadequate work equipment despite the improvements in syringe pumps. Many staff reported that problems with cots and beds were causing them musculoskeletal problems. Many staff attributed their problems to bending over cots, and moving equipment or patients.

#### Making available funds for ward decoration

Most staff (76%) reported working in wards that had been re-furbished or re-decorated. Just under half of these said that the change had a big impact.

The wards varied enormously, as did the efforts at re-decoration and this was reflected in the comments made by staff. However, many indicated that wards were “brighter and more cheerful” and that this was a much needed and long-awaited change. Several wards were awaiting significant re-decoration at the time of the evaluation.

#### ***Impact of background changes***

#### Fluctuations in staffing levels

34% of staff indicated that wards never or rarely were staffed at establishment – this reduced the potential of some interventions e.g. office days – very few G grade staff indicated that they did not have a clinical caseload on office days.

#### **8.6.4 A commentary on the intervention process**

Many of the interventions we evaluated in this hospital will demonstrate the benefits over a long period of time. We were only able to evaluate their short-term effects. Nonetheless, the overall picture was encouraging.

Efforts at allowing senior staff control over their workload and their managerial responsibilities were already showing benefits, as were those aimed at improving communication and training. The interventions designed to ‘ring-fence’ time for administrative work have been enthusiastically received, their impact was noticeable but somewhat limited by staffing problems.

The organisation has decided to continue with the interventions. At the time of writing this evaluation report, the results of the evaluation are being examined. The challenge for the organisation is to manage the interventions in a way that maximises their benefits for the maximum number of staff.

## **8.7 Chapter summary**

This chapter has described and discussed the outcome of a large number of interventions. Most represent sensible management practices – many have been well-received.

The chapter has also highlighted the complexity of the evaluation situation. Each intervention took place in a constantly changing workplace, in the presence of other interventions. Questioning staff directly about the interventions helped to isolate their impact. The background to the changes made it difficult for some of the interventions to be properly implemented and evaluated. However, a number were clearly successful.

In Chapter 9 we summarise the main conclusions from the evaluation work: we feel that these represent some of the most important findings from this research.

## 9. CONCLUSIONS

This chapter identifies the key messages from the research and discusses those that warrant further comment. In this section we draw our findings together.

In presenting the main findings from this Report, a number of conclusions have been drawn from the different stages of the risk management procedure: these are discussed here along with the over-arching conclusions reached when reviewing the project as a whole.

### 9.1 Tackling problems faced by hospital staff

#### 9.1.1 Common sources of problems

Before commenting on the major issues facing the staff involved in this project, two things should be noted. First, a variety of groups and workplaces were involved in this research project. This was one of the requirements of the project funding. Second, the remit of this project was not to provide a representative survey of working conditions in British hospitals but to illustrate the application of the risk management approach to work stress in hospital staff. Nevertheless, there are a number of strong themes that emerged *across* the groups involved. These are highlighted here since they may have wider implications for the management of work and well-being within hospital settings.

Many staff reported experiencing difficulties brought about by a heavy workload. The reasons for this were varied, but some common themes emerged.

First, staffing was an issue for several groups. The problem was particularly acute for specialist staff, where recruitment and retention were difficult. It was evident that problems were not caused simply by a lack of numbers, but rather by teams working short of just one or two members of staff. Such *small* shortages of staff appeared to have a disproportionate impact. Many of the groups involved in the project were working to solve the problem through local interventions – such as the retention of student staff once they had qualified. However, it is clear that wider national initiatives aimed at large scale recruitment and retention have a crucial role to play in alleviating this problem. In the groups we examined, perceived problems with grading and pay not adequately reflecting the level of responsibility attached to a job, were often cited sources of dissatisfaction. This may also be an issue that lends itself to action at the national as well as local level.

The second factor contributing to problems of high workload was related to the ‘peripheral’ workload that was placed on many staff. This was particular issue for more specialist and highly qualified staff. In several departments administrative workload was a major problem. At the same time, it was accepted by most staff that some administrative workload was part of the job, and could only be done by staff with clinical training. However, some administrative tasks were being done not for this reason but because of a lack of administrative support (e.g. the chasing up of X-ray results or the filing of test results, answering the security doors on wards etc). Several groups were tackling these problems and with some success. Of course, interventions here usually required extra resources to employ more administrative staff. However, the impact of such changes was tangible, significant and far-reaching. Among other things, staff reported that they were able to provide better quality care, that patient satisfaction improved and that workload was perceived to be more manageable, less rushed and wearing. Employing administrative staff on a part-time basis was sufficient to have a significant impact in some areas.

A third factor contributing to problems of high workload was the high level of patient demand within the hospitals involved in this project. Patients have been encouraged to expect much from the service and to voice their needs and demands. This is likely to remain the case. Given the present situation within the NHS, high levels of demand from patients present real challenges to staff well-being.

Adequate staffing and other resources are needed to effectively manage high workloads and patient demands. At the same time, more creative and effective management strategies will be needed to deal with the problems that the high levels of workload will continue to create. The risk management process can be an effective means of identifying appropriate interventions and monitoring their success. Moreover, the case studies in this Report provide several examples of where imaginative management interventions were successfully implemented despite on-going problems with staffing and other resources. Whatever the circumstances, reasonably practicable action can usually be taken to more effectively manage the demands placed on staff.

One important finding from our research concerned non-direct care staff – specifically administrative and catering staff. Traditionally, the focus of research in hospitals has been on direct care staff: doctors and nurses. A requirement of the project was that our work included non-direct care staff. Interestingly, many cases the problems reported by direct care staff also affected non-direct care staff (e.g. busy clinics, poor communication structures etc.). As a fortunate consequence, in these instances interventions tended to benefit both groups. However, as the case studies show, non-direct care staff also reported their own unique problems – some of which impacted on the work of direct care staff and the delivery of care to patients. It is important that non-direct are *not* seen as peripheral to the delivery of the service. Risk management is of equal importance for both direct and non-direct care staff. Indeed, it may be a way of achieving a more balanced approach to problem-solving among work groups that contain both direct and non-direct care staff.

We found that verbal abuse and aggression towards staff was relatively common. Violence less so, but it occurred worryingly often. Several groups implemented training courses for staff to help them manage difficult situations, and implemented interventions to tackle the sources of frustration for patients. Some enhanced security measures. Some achieved a balanced approach that included a consideration of:

- What could be done to prevent incidents occurring by examining the precursors of such incidents (e.g. by looking at changes to the design and management of work)
- What could be done to prepare and plan for incidents before they occur
- What could be done by way of de-escalation and satisfactory conflict resolution
- What could be done to help staff and encourage learning following incidents

However, we feel that an in-depth treatment of these issue lies outside of the remit of this Report. These are important problems within the healthcare sector. They are also complex and require detailed examination. Chapter 11 contains some references (e.g. Beale et al., 1998; Leather et al., 1998) that will prove useful for those wishing to tackle this problem in their hospital.

### **9.1.2 The well-being of hospital staff**

Work-related well-being and satisfaction with work varied across the groups involved in the project. Generally, job satisfaction was high and few of those involved indicated that they wanted to leave their job to work elsewhere. Absence was also generally low – although in

some workplaces even these low levels of absence had a disproportionate impact on the functioning of the workplace<sup>3</sup>.

Some patterns did emerge across the groups involved in the project. In many groups, staff reported being worn out despite being satisfied with their job and being content to continue working within the organisation. Their work was satisfying but wearing. In our experience, this 'health profile' is found less frequently in non-healthcare settings. Such an occurrence makes the careful assessment and monitoring of working conditions and well-being especially important.

*Staff turnover* is one of the more visible markers of dissatisfaction. It can be assessed and evaluated with little effort. However, our results suggest that actual turnover may not always be a good indicator of the impact of poor work design on staff. By-and-large highly skilled working people do not 'vote with their feet' except in the most exceptional circumstances. Despite this, for reasons discussed below, even low levels of turnover can create problems in healthcare settings. Monitoring the working conditions and well-being of staff using other measures, such as sickness absence or exhaustion, or through other means, such as the risk management process, may be necessary to obtain a balanced picture of working conditions and well-being.

The measure of exhaustion (the worn-out scale) used in this project measures the frequency and variety of symptoms of tiredness, changeable emotions, and cognitive confusion. Together these symptoms offer an indicator of work-related well-being that is sensitive to work design and management problems. This is so even for staff who find their work satisfying, and who are likely to remain in the job. It can function as an indicator of the need for action in a workplace where turnover is low, and the work is inherently satisfying. We have found it to be a particularly sensitive and informative measure in hospital settings. Using it, problems with work design and management can be recognised and tackled before they translate themselves into more visible problems such as high turnover.

Several other findings are also worth highlighting.

First, there were several common clusters of 'risk factors' that tended to be reported by staff that also reported poor well-being. In summary, these included:

- Time pressures and workload
- Communications and consultation
- The physical working environment
- Training and development

Time pressures and workload issues frequently presented as risk factors – their link to high levels of exhaustion being obvious. However, levels of exhaustion were also often linked to problems of poor communication both with management and between different groups of staff. Interestingly, the most 'healthy' groups tended to be those with the strongest communication and problem-solving structures. Problems with the physical work environment presented as risk factors in a number of settings – staff found these problems to be particularly wearing in terms of their interaction with the physical demands of their work and the impact of the physical environment on their work with patients and their relatives. Finally, problems with training and development were often linked to intention to leave the organisation. These were the common problem clusters that affected the groups involved in this project. Fortunately, these proved to

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<sup>3</sup> The fact that relatively small challenges to the system have disproportionate effects indicates that it is functioning at the limits of its tolerance. This phenomenon has been observed before by the authors in an earlier study of hospital-based doctors funded by the British Medical Association (Cox, Griffiths, Macafee and Rial-Gonzalez, 1997). Contact the authors of this report for details.

be problems that could often be tackled by reasonably practicable intervention. Real employee consultation and creative management thinking underpinned the design of appropriate interventions in many of these areas.

Second, the incidence of musculoskeletal pain among staff was relatively low in many of the groups. This is in contrast with many large scale surveys that show professions such as nursing to have a particularly high incidence of this problem.

Third, it is worth recognising that work of the various groups was inherently satisfying. We were always careful to point out that care should be taken to maintain and strengthen those aspects of work that contribute to staff satisfaction. Risk management for work stress is not just about solving problems: its goal should be the development and maintenance of healthy work.

### **9.1.3 Existing good practices**

In this section it is important to acknowledge the good practices already in place in a number of the groups involved in the project. Several groups of staff reported strong well-being. Where this was the case, strong well-being was often associated with conspicuously good management practices.

Examples of good management practice existed within all the groups studied. Having a regular forum for communicating information and discussing and solving problems was a central feature of many such workplaces. Regular team meetings, or problem-solving workshops appeared to be features of healthy workplaces.

The healthcare setting clearly provides a host of opportunities for designing work that is varied interesting and stimulating. This was a strong aspect of work for many of those involved in this project. In several settings, once staff were appropriately trained and qualified they were given a high degree of control over how they did their job. This autonomy was a strong source of staff satisfaction. In situations where work was not so inherently interesting or satisfying, management attempts to ensure job rotation and variety proved beneficial.

For direct care staff, job satisfaction clearly came from seeing their work make a difference to people. Most management systems ensured that, wherever possible, there was continuity of care. Taking responsibility for the care of patients and being able to see improvements in their conditions was a strong source of satisfaction for many staff.

Continuity of staffing was important in securing the well-being of staff in many of the groups we studied. Managers had often ‘come up through the ranks’ and had first hand experience of the work and its problems – making them more effective managers in the eyes of many staff. This situation also had its downside however: career stagnation was an issue for several groups of staff who reported that promotional opportunities were infrequent. This is a broader issues for hospitals to tackle: ways of eliminating stagnation from career progression *within hospitals* (many staff saw a move to another hospital as the only way of maintaining career momentum) should be investigated.

The use of ‘in-house’ training and systems to consolidate and spread expertise was a feature of many of the healthy workplaces involved in this research. Healthy workplaces used the knowledge and expertise of their staff as a resource for the training of others. The effective sharing of knowledge was achieved in a number of ways e.g. through regular training sessions, or through the appointment of staff whose role had a specific training component e.g. nurse practitioners. Strong and effective performance appraisal systems also helped to support staff development in healthy workplaces.

Flexibility in working hours was important for many staff involved in the project. Most of the groups involved in this research had established systems that allowed staff to make reasonable requests (e.g. through request books) for specific shifts or working hours. This helped to manage the impact of work on the home and social life of staff. Of course, limits are placed on flexibility by the needs of the service – but many groups achieved a great deal of flexibility within these limits. Open dialogue between those organising working hours and staff was crucial to making these systems work.

Staff in healthy workplaces tended to work in strong, cohesive, well-managed teams. Working relationships with colleagues were important to staff. Management practices that actively discouraged isolated working enhanced this team-working environment. In several groups, time was put aside specifically to allow teams to meet and discuss work-related issues.

Finally, the more tangible aspects of the work environment were well-managed in healthy workplaces. Equipment was kept up-to-date and well maintained, and systems were in place to ensure its condition and availability was monitored.

## **9.2 The success of risk management**

### **9.2.1 *Important successes***

The majority of groups involved in the risk management work improved their working conditions, even in the face of disruptive changes co-occurring with the interventions. Taking all the case studies together, employees' reactions to the risk management interventions was generally favourable. Also, there was little evidence of problems worsening while risk management was implemented.

Some problematical working conditions may be 'facts of life' for some staff. However, there is nearly always a way in which problems can be effectively managed. The creative strategies adopted in the various case studies show this to be the case.

The aim of risk management is to manage working conditions so that a healthy working environment is established and maintained. As such the impact of interventions on working conditions was a key marker of success (see Section 7.3.2). In this respect many of the groups involved in this research made considerable progress. For those groups reporting problems with well-being, the subsequent impact on well-being may take a little longer to become apparent (see Section 7.3.3) although there were some encouraging signs.

### **9.2.2 *The challenges of measuring impact***

In many of the case studies the impact of interventions on employee well-being was modest. This does not mean that certain interventions have failed. There may be a number of reasons for such results.

There are numerous and varied factors that impact on employee well-being. Changes may only be apparent over a period of time, once there have been sustained improvements in working conditions. The relationship between work and well-being is complex, and even more so when trying to estimate the impact of an intervention. For example, genuine improvements in *some* working conditions might not be accompanied by improvements in well-being if *other* working conditions worsen.

Another consideration is the relatively 'healthy' state of many of the case study groups involved in this research. If, for example, worn out scores are low to begin with it may be that interventions are unlikely to lower them further – this is known as a 'floor' effect. As similar



effect was observed for job satisfaction – these scores were often high to begin with (a ‘ceiling’ effect) e.g. staff in the Catering Group were extremely satisfied with their jobs both before and after the interventions. In this sense a ‘no change’ finding is positive - it means that the strong health profile of the group has been maintained.

What makes the situation even more complex is that interventions take place in a complex environment. For a host of reasons they may not be implemented as effectively as they could be: in this situation the intervention is not necessarily ineffective, it is just that it is not implemented correctly. This is discussed in Section 7.4. Interventions also take place in the presence of other interventions - or background changes - that can have an impact on work and well-being.

For these reasons the focus of evaluation was on working conditions and employee judgements on the interventions. Ultimately, risk management tackles problematical working conditions. If poor working conditions are a precursor to poor well-being, it makes sense to look for improvements in working conditions as markers of intervention success. If those working conditions improve then these ‘risk factors’ and ‘hazards’ are being successfully managed. These give early and important indications of success. Working conditions provide measures of success that are ‘closer’ to the intervention – the intervention is targeted at specific problems with the job itself. In time, improvements in well-being may well follow if working conditions improve.

### **9.2.3 Interpreting change**

Care should be taken even when looking at working conditions as markers of success. A problem – say, for instance, time pressures – may be addressed by an intervention, such as a reduction in one aspect of workload. Staff may well report that the intervention did help to alleviate the problem some, but not all, of the time. An example is the introduction of smaller clinic sizes in the ENT / Eye OPD. Some clinics reduced in size and the response to this change was positive. However, other clinics remained large. Consequently, overall ratings of time pressures and clinics sizes showed little change. The use of interviews, and direct questions about interventions in questionnaires, helped us to get around this problem. Staff were questioned directly about the impact of each intervention. We also used direct questions in the evaluation questionnaire about the impact of each intervention. Measures that directly asked staff about the impact of change are sensitive enough to highlight change. The questionnaire-based measures of working conditions are good enough to identify problem areas and will register overall changes in working conditions. For example, if the majority of clinics were reduced in size in the ENT department we would have expected changes in the questionnaire-based measures of working conditions (such as reduced time pressures).

Because it needs to be realistic and useful, evaluation is not simple. However, we found that by asking staff directly about interventions and other background changes (including questions about how changes were implemented and their impact) a wealth of important information was obtained. This can then be used to give meaning the data obtained from quantitative questionnaire-based surveys.

### **9.2.4 Compliance**

There is another obvious, but often overlooked, marker of intervention success. That is compliance with the risk management process. If the process is followed correctly problems will have been correctly identified and appropriately managed where it is reasonably practicable to do so. Of course, however, risk management is a cycle of continuous improvement and monitoring should continue. Risk management involves extensive employee consultation and empowerment: for these reasons the risk management process itself brings with it its own benefits.

Adhering to the process and executing it well enough is a success in itself: it indicates that focused attempts are being made to tackle problems, and that the success of these interventions is being evaluated. In some instances action may not be possible. Following the risk management process requires the organisation to consider the implications of, and the justification for, not taking action. It is for these (and other) reasons that documenting the risk management process is important.

### **9.2.5 Other benefits**

The risk management process also demonstrated a number of other important benefits. First, it was often a useful tool for stimulating new ideas and new ways of thinking about problems. Second, it quantified problems so that they could be prioritised (for examples, in terms of the number of people reporting a particular problem) and resources organised appropriately. The first risk assessment may also raise awareness of problems. Third, it focused efforts and actions, promoting a coherent and targeted approach to tackling problems. Finally, it provided a framework for evaluating progress and monitoring change – a framework that could be used to assess the impact on employees of planned and unplanned change.

### **9.2.6 Some stumbling blocks**

In Section 9.5 we identify some management strategies that can be used to ensure the risk management process runs smoothly. However, some parts of the process can prove challenging. Here we describe some of the problems encountered. Most can be tackled through the effective monitoring and management of the process. They are highlighted here in order to identify some of the potential pitfalls.

Risk assessments generally ran smoothly. Some problems arose when the communication of its aims and objectives was carried out using ineffective communication mechanisms. This was a problem for those groups whose existing communication structures were weak. To remedy this we took a more active role in communication and encouraged the groups to set up ‘one off events’ to publicise the project.

Risk reduction presented several challenges. Some groups responded enthusiastically to the risk assessment, others less so. We adjusted the level of facilitation offered to each group in order to address this problem. We also checked on progress frequently when intervention design was handed over to the groups. Some groups began planning interventions without involving key stakeholders – in these instances the composition of the Steering Group was adjusted to include those stakeholders. Some groups found it difficult to set aside time for staff consultation, or even for intervention design meetings – we worked with them and their managers to help them find some time within their work hours.

As facilitators of the process, the implementation of interventions was the stage of the process we had the least control over. However, as we have described, good ideas can come to nothing if they are not implemented correctly. Not being able to obtain resources (time, people, money) for an intervention was sometimes a problem. Obtaining the appropriate permissions for an intervention sometimes proved difficult. Sometimes the people tasked with implementing an intervention left the organisation, or were absent from work. These problems were usually avoided through thorough planning, but some could not be foreseen. Monitoring implementation was used to detect these problems – once detected efforts were made to resolve them.

Obtaining the information needed to evaluate the interventions caused few difficulties. We interviewed many staff in order to test the utility of interviews: this caused some logistical challenges that are less likely to be an issue in subsequent risk management projects.

Few of the interventions failed to have an impact. Some suffered problems during the implementation. Those changes that had a negative impact tended to be 'background changes' rather than those interventions planned as a response to the risk assessment. Generally, interventions that were 'imposed' without the input or involvement of staff were the least successful. For some interventions there were 'winners and losers' – some who felt the change was an improvement while others felt it was detrimental. This information was used to help the hospital identify whether they should persist with the intervention – and if they did, how they could modify the intervention to maximise its benefits.

### **9.3 Effective interventions**

This Report illustrates the variety of interventions that can be implemented as part of a risk management approach to work stress. Few of them are costly or disruptive. Many are creative and imaginative responses to difficult aspects of work design and management. A selection of the successful ones are summarised below.

Several groups implemented interventions designed to reduce the peripheral workload placed on skilled staff. For example by increasing the administrative support available to staff in the ENT / Eye OPD and Accident and Emergency Department, or by enhancing clerical and 'housekeeping' support as in North NHS Trust Children's Services. These interventions seemed to have many benefits. They increased the amount of time available for staff to concentrate on their 'core job'. This had 'knock-on' effects on team-working and the availability of extra help and assistance. These staff also commented that they felt they were more able to deliver the quality of care and service that they wanted to.

Several groups acted to remedy the staffing problems they were experiencing. Often this did not involve actually increasing staffing levels, but rather filling vacancies. Often this required concerted effort and careful planning to source and recruit appropriately trained staff. Many groups took it upon themselves to drive recruitment, rather than passing the task on to staff in human resources. The impact of enhanced staffing levels was felt strongly by a number of groups. Even small shortfalls in staffing can have a major and far-reaching impact and this was apparent in several case study groups. However, although staffing problems may be tackled locally with some success, most groups experienced difficulty in finding appropriately qualified and experienced staff. As we have already mentioned, national initiatives designed to increase the 'pool' of appropriately qualified staff are needed to underpin long-term solutions.

It was notable that staff within the case study groups generally reported that team spirit was strong, and that staff supported each other. Most working environments were friendly, with colleagues often also being friends. In such an environment it may be expected that communication would take care of itself. However, this was not always the case. The case studies demonstrated that work needs to be done to ensure that communication systems work well. The groups that spent time developing, implementing and maintaining effective forms of communication felt the benefit in many ways. Staff were able to work more effectively, and in many cases felt more able to contribute to the development and improvement of the area they worked in. Problems were dealt with more effectively and efficiently as a result of having strong, managed communication systems. For example, staff meetings with clear agendas were seen as useful even in areas where there was a friendly and co-operative working atmosphere. Multidisciplinary groups were beneficial where there was a danger that departments would split into factions. Regular, structured contact with management was associated with a workforce that felt adequately appreciated and recognised.

Workload is likely to remain high for hospital staff. We have already discussed the importance of proper staffing. But management action is often needed to keep workload manageable. In the case studies, staff simply got on with the work they were given. Sometimes they raised

concerns, but they always dealt with their workload, sometimes placing their well-being at risk. For this reason, difficult management decisions about workload sometimes need to be made. For instance, staff were extremely positive about the capping of clinic sizes in the ENT & Eye OPD (a decision made jointly by consultants and management).

Interventions that ‘manage’ the workload of staff are important. These may involve limiting total workload, or providing dedicated slots of time for dealing with certain tasks (e.g. office days). Creatively marshalling staff resources around peaks in workload was another effective strategy employed by some groups. Of course, tackling workload problems may require intervention outside of a department, or perhaps on a hospital-wide basis (e.g. to free up beds in other wards more quickly to enable the movement of patients out of the accident and emergency department). Staff also felt the benefits when working hours were organised in a way that minimised the impact on their home, family and social life (e.g. by being given adequate notice of working hours and having some control over the hours they worked).

Training and development was relatively strong across the case studies. The most effective interventions did not require expensive training to be bought-in to departments. Most often it meant spreading expertise that already existed in the workplace through in-house training. Departments that identified and utilised staff expertise in this way (e.g. through nurse practitioner training sessions) felt the benefits.

A number of broader conclusions were supported by this work. These may seem obvious, but within busy departments may be easily overlooked. Interventions that gave staff the equipment they needed to do the job well were effective. As jobs change equipment needs change (e.g. the need for computers among senior nursing staff) and these needs should be assessed and addressed. Tackling problems with environmental conditions is important (e.g. through re-decoration or refurbishment, changes to lighting, heating systems) – these were often the among most serious problems reported by staff.

## **9.4 Who can manage the risk?**

### **9.4.1 *The expertise needed***

Using risk management to tackle work stress requires the collaborative efforts of several key stakeholders. The employees themselves were always central to the process. Their involvement needs to be appropriately supported and managed. Various levels of management and those in expert roles such as Health and Safety, Occupational Health or Human Resources and Trades Unions, may have a particularly important part to play. Of course, there are also more technical aspects of the risk management process that may require ‘expert’ input.

We have tried to illustrate the technical aspects of the risk management process throughout this Report. We hope that the practical application of the methods and tools is relatively transparent. We have also stressed that the method must be applied appropriately. For example, the uninformed use of tools such as the general well-being questionnaire could cause significant problems. The Report illustrates that specific expertise might be needed at various points in the process. Readers should bear in mind that this project was not commissioned to provide and test a ‘do-it-yourself’ manual for risk management.

Hospitals may believe they have this expertise within the organisation (for example in terms of questionnaire design and data analysis). Different hospitals will have different resources available to them. Each will need to make its own judgement as to which parts of the process (if any) can be adequately carried out ‘in house’ and which parts will be delivered by external experts. Some of the case study groups found it helpful to have an ‘outsider’ conducting the risk management project: they felt it added ‘objectivity and importance’ to the process. If carried out

‘in house’ staff from Occupational Health, Health and Safety, Human Resources and Union representatives (etc.) may be able to offer expertise that would support the risk management activities.

#### **9.4.2 Judging the need for risk assessments**

Some organisations have opted for ‘two pass’ system of risk assessment. As a ‘first pass’, a less formalised assessment of working conditions and well-being is carried out. A sample of staff may be interviewed and organisational data inspected. If this ‘first pass’ indicates that there may be a problem, a more formal analysis is carried out i.e. the risk assessment as has been described in this Report.

In order to assess the need for a ‘second pass’ the findings from the ‘first pass’ need to be evaluated. This can be accomplished by bringing in a ‘critical friend’ to examine the data. This should be someone who does not work within the area / department, but who has a reasonable working knowledge of the work that it does. This system has been successfully employed in other public sector organisations. The ‘first pass’ is similar to the Audit of Management Systems and Employee Support described in Section 4.5.4.

There is guidance in UK and European legislation about the need for the assessment of work stress. There are also legal cases that have implications for the management of work stress. These also need to be taken into account when judging whether to undertake risk management for work stress.

### **9.5 Practical lessons from the case studies**

#### **9.5.1 Making risk management work**

To be useful and effective, it is crucial that risk management is workable within busy hospital settings. Risk management should fit in closely with everyday management practices. The case studies provide clear evidence that this is achievable.

However, those embarking on risk management projects may benefit from some help in order to maintain the momentum of the work. Where good systems are already in place for dealing with problems less support will be needed. However, in some instances these systems will need to be established and problem solving will have to be more actively facilitated.

Most of the case study groups were actively facilitated in some way: this approach was chosen in order to secure progress and data collection during this short research project. In practice such a high degree of facilitation will not always be necessary.

#### **9.5.2 Establishing the risk management process**

Risk management involves assessing and managing the complex social and technical systems that together make up the workplace. For it to be effective the process has to be managed professionally and sensitively. Work needs to be done at the start of the process to tackle misconceptions and to establish the momentum of the project. This proved to be especially important in this research.

#### **9.5.3 Successful completion of the risk assessment**

Risk assessment requires some expertise (see Section 9.4). But it also requires a high degree of involvement from management and staff. This involvement was crucial in the risk assessment described in this Report. The involvement helped the logistics of the projects to run smoothly.

Furthermore, risk assessment centres on gathering and interpreting information from employees. Ensuring a high degree of employee involvement in the process is absolutely crucial if the risk assessment is to be successfully completed.

#### **9.5.4 Planning the response to the risk assessment**

Most of the groups involved in this research needed help when they were planning their response to the risk assessment. This is described in detail in Chapter 5. This is a pivotal phase of the risk management process and needs to be managed carefully. The most successful risk management projects were those in which this part of the process completed effectively. Groups that took a realistic view of what could be achieved and were focused in their discussions produced the most effective intervention packages.

#### **9.5.5 Implementing interventions**

This part of the risk management process rests with management and staff. In the risk management case studies, few interventions relied on providers, or resources, external to the group involved in the assessment. We found a 'hands off' approach to this part of the project to be effective. We monitored the implementation of interventions (through regular contact with the Steering Group) to help them identify and deal with any problems that arose. This process allowed effective and practicable interventions to 'survive' in the organisation.

#### **9.5.6 Evaluating interventions**

As an applied science the evaluation of stress management interventions is relatively new. We found that it was important to evaluate both the intervention process (how interventions were designed and implemented), and its outcomes (the impact of interventions on work and well-being).

To achieve this we employed qualitative methods (such as interviews) as an adjunct to questionnaire data and organisational records. We asked employees to directly appraise interventions. Carrying out the evaluation in this way produced rich, revealing and useful data that may have been missed by attempting to rely only on interpreting changes in quantitative measures (e.g. scores on questionnaires).

### **9.6 Risk management: The users view**

Responses to the risk management process were generally positive. For most of the groups involved it provided an aid for making everyday management decisions and for planning management actions. The ease with which the process was integrated in this way was extremely encouraging. With the pressures on everyone's time, this was an extremely important feature of the process.

Several of the groups drew up a list of existing plans for change when they were in the possession of the risk assessment report: this proved extremely useful in action planning. Some groups drew a matrix to examine future plans against the problems identified in the assessment. The 'gaps' where problems could not be matched to interventions formed the focal points of efforts at interventions design. This allowed the groups to focus - and not duplicate - their efforts.

Most managers and staff involved in the work found few problems with the process itself. Intervention design was the most challenging and intensive phase for them. Publicity helped to involve staff and to ease their concerns. Apart from any role in the design of the interventions themselves, staff involved in some of the projects readily commented that they felt the process

had provided them with more input into decision-making and that this in itself was a very positive step. This is a common finding in studies of participative decision-making: the process of problem-solving itself can be beneficial.

We asked those involved in running and supporting the risk management work (e.g. Health and Safety representatives, staff from Occupational Health, Trades Unionists, and line managers) for their overall reactions to the work. Positive reactions covered a number of features of the work. Many indicated that the process had enabled them to get a handle on the size of the problem and its nature. It was also felt that following the process through had enabled staff to see that something was being done to tackle problems – and that it enabled staff to get involved in the problem-solving process.

Several commented that the process had enabled them to ‘think outside of the box’ in terms of interventions. The evaluation work also appeared to be well-received: it provided information on the impact of management change that would otherwise not have been collected. There were concerns as to whether hospitals could implement and manage the risk management process by themselves. We hope that reports such as this will give them the information and confidence they need.

There were also some concerns about the amount of work required on our part to see the risk management process through: several ‘in-house’ staff indicated that they would not be able to find the time to work ‘full-time’ on such a project. We assured them that our approach to the work reflected the fact that we were collecting data to support a research project. In practice the methods used could be employed flexibly and economically.

## **9.7 Some practical considerations**

### **9.7.1 Timescales**

The time taken to complete one cycle of the risk management project – from assessment to evaluation – varied across the case studies.

Risk assessment can be carried out quickly. With good co-operation from the organisation it can be carried out in four to five weeks, with one to two weeks being taken up by the distribution and return of questionnaires. Of course, setting-up activities precede this period, and are important to the success of the risk assessment.

Once the risk assessment is completed, timescales become more difficult to predict. The time taken to plan the response to the risk assessment depends on a number of factors. First, the results of the risk assessment: if it uncovers a large number of problems then planning will take longer than if it uncovers a small number of problems. Second, the nature of the problems detected by the risk assessment: some require a more complex and considered response than others. Third, the amount of consultation and employee input required to tackle the problem: this presents logistical challenges. And fourth, the situation within the organisation: there are ‘good’ and ‘bad’ times during which an intervention can be implemented. In practice, the planning of interventions was rarely a discrete phase of the project. It began after the risk assessment, but was often still underway at the time of the evaluation. Risk assessment results were often used by management when making medium to long term management decisions: in practice there is no definite ‘end’ to the action planning phase.

For the reasons given above, it is difficult to make firm recommendations about when evaluation should be carried out. Interventions need to be given a reasonable amount of time to have an impact. Some may take longer than others. When they were planning the interventions we asked the Steering Groups to make some recommendations about a suitable timescale for

evaluation. The shortest evaluation period employed in this project was six months (i.e. the evaluation data was collected 6 months after the end of the risk assessment).

In terms of collecting the evaluation data itself, the activities were similar to those carried out for the risk assessment and the timescale is similar. Four to five weeks was usually sufficient with adequate co-operation from the organisation involved.

### **9.7.2 Disruption**

The risk management process can be a source of disruption in two ways. First, the activities that make up the process require staff to invest some time and effort. Second, the interventions implemented as part of the risk management process are likely to have an impact. However, this disruption can be managed through careful planning. In order for the process to flourish, disruption needs to be minimised.

By involving management and staff as much as possible in the planning of project, this disruption can be minimised. We found that staff could readily anticipate problems and see ways in which the project could be executed in order to avoid disruption. Regular Steering Group meetings helped us to manage this aspect of the project. We also took a very flexible approach to managing our own time, and planned key activities around lulls in workload within the groups we working with.

### **9.7.3 Costs and benefits**

It was not within the remit of this project to make an actuarial assessment of the costs and benefits of specific interventions. However, the evaluation work did provide some evidence as to their benefits. This aspect of the risk management project should be explored further.

In terms of costs, it is clear that the vast majority of interventions were carried out at very little cost and with minimum disruption. The most resource intensive interventions were those that involved employing extra staff – usually administrative or support staff – or those that required work to be carried out to improve the physical working environment. Much of the expenditure that was involved was, for most of the hospitals, already in budgets and was simply re-directed or refocused.

In many of the groups, turnover and absence were low and as a result significant improvement in these ‘markers’ was unlikely. Despite this, and because of the disproportionate effects observed with small changes in turn-over and absence, it may still be worth exploring the impact of interventions in these areas. Furthermore, questions about their utility as markers of success have been raised elsewhere (see Section 9.1.2). Benefits were clear in terms of improved working conditions reported by staff, and in some cases improved well-being. There was also anecdotal evidence of improved patient satisfaction in some areas where the interventions had a direct impact on the delivery of care to staff.

## **9.8 Concluding remarks**

There is clear evidence in this Report of the usefulness of the risk management approach as a strategy for tackling work-related stress.

The Report has described the nature of this approach and discussed, quite frankly, how it was applied to a variety of staff groups in three hospitals. The assessment of risk to health associated with work design and management was translated into action plans for risk reduction. Those plans were implemented and their impact evaluated. The changing nature of work and work organisations, particularly in the healthcare sector, challenged our thinking about how



interventions could be evaluated and forced new and innovative evaluation strategies. This was a spin-off benefit of the project and we hope it will add appreciably to our ability to evaluate interventions in real life work situations.

In all the groups involved, the project and its methodology were well received, and in most of the groups the investment in the risk management process will continue beyond the formal completion of the funded project: one risk management cycle rarely solved all the problems. Beyond this general level of satisfaction, there was evidence both from the quantitative and the qualitative data collected that improvements in staff well-being and satisfaction, and in the quality of the service offered were achieved. Nothing is ever perfect, but reasonable gains were made, sufficient to persuade those working in the hospitals studied that the methodology worked and benefited them.

In the course of the project, a number of problem clusters were identified that spanned the different groups involved. This information is important because it is a snapshot of a number of groups within the British NHS as an organisation and points up some of its key problem areas. While these could be addressed locally, group by group, hospital by hospital, perhaps for some of the problems, national level action represents a more effective way forward.

Finally, the authors hope that this Report has been both accessible and informative: a good read for those involved in managing and working in hospitals. The aim of the project was to demonstrate to the reader that the risk management approach to work-related stress offers a practical way forward. We hope that we have achieved that.

## 10. CASE STUDY SUMMARIES

In this Chapter we present very brief summaries of the five case studies included in this report. These brief overviews do not represent detailed accounts and contain no technical data. What they contain do contain are the important points of each case study. They are included here for two reasons: first to give an easily accessible account of each case study, and second to provide a point of reference to help readers identify the key issues covered in each case study.

### 10.1 North NHS Trust; Ear, Nose and Throat (ENT) and Eye Outpatients Department

We worked with approximately 65 staff made up of four groups: nursing staff and health care assistants; audiologists; orthoptists; and administration staff. These groups of staff worked closely with each other to deliver out-patient care.

Risk assessment revealed that direct care staff were satisfied with many aspects of their working conditions, reflecting strong management practices in the department. Staff indicated that their work was varied. They reported being properly trained and felt that the department was well-enough equipped to deliver a high standard of care. Working relationships with management were sound, with solid communication structures and effective consultation. The well-being of direct care staff was strong.

However, the group identified some problems. Communication with administration staff was reported as poor. Clinic time was pressured with staff reporting that clinics were over-booked and that there was often insufficient time allocated to see each patient. Nursing staff also reported that treatments were often interrupted by telephone calls or requests to access patients' notes, test results or to complete paperwork. There were problems with aggression from patients (staff also felt that patients were not given enough information when clinics were running behind schedule) and many reported that there was inadequate appreciation and recognition from consultants. Difficulties caused by covering the work of absent colleagues and problems with the physical working environment were reported by most direct care staff. There also appeared to be a specific problem with the inequitable distribution of late working hours.

The picture that emerged was rather different for administration staff. Although they reported that their work was varied and interesting, and that teamwork was strong, they identified a significant number of problems that suggested they were a group of staff under real pressure. Staff turnover was high and this was having a significant impact on the ability of the section to deliver an effective service. Staff reported severe problems with a lack of training and heavy workload that were exacerbated by the high turnover. Their job was complex and was being made more difficult by the pressures placed on their time. Working relationships between administration staff and direct care staff were strained. The group's well-being was not strong, job satisfaction was low and intention to leave high.

In response to the risk assessment a number of telling interventions were implemented in the administration. Reflecting the strong well-being of the group, a more modest package of interventions was implemented for direct care staff.

A series of teambuilding sessions were introduced to allow direct care staff to meet and discuss issues with administration staff. A departmental clerk was appointed to work part-time to ease the administration load placed on nursing staff. To ease clinic sizes, some new clinics were run with a smaller number of patients. To improve the management of clinics and the information given to patients, one member of nursing staff was assigned to work as a clinic liaison nurse (to

keep patients informed of delays and organise their passage through the clinic). Specific training courses were offered to staff to help staff deal with aggression from patients. A 'late working rota' was introduced to help distribute late working more evenly.

In the audiology department a new rota was implemented that included time set aside for administrative work to be completed, and a new junior member of staff was appointed to take on some of the administrative workload. Interventions in the audiology department took place against a backdrop of significant change in the way the service was delivered.

In the administration department several interventions led to a fundamental change in the way work was organised. First, staff were allocated to work with named consultants on the booking and management of their clinics – this was designed to increase the ownership of information about clinics and raise the level of expertise each member of staff had about a particular consultant's clinic. A programme of training was set up to teach staff about the full capabilities of the patient administration computer system. A new management structure was implemented to give the section a more 'hands-on' and influential management team. Regular staff meetings were also instigated. Special projects were also run to help track down missing notes and files (the source of significant problems for all staff in the department).

The evaluation showed that the majority of staff saw the interventions as positive changes. Problems with communication between administration and direct care staff had been all but eliminated. Time pressures had eased. Staff well-being remained strong. The introduction of the administration clerk had eased workload, teambuilding sessions had worked well, and the extra time for administrative work given to Audiology staff was well received. Clinic liaison nurses were also seen as an improvement that had helped clinics to run more smoothly. Staff indicated that the distribution of late working was more equitable since the introduction of the late working rota. Although the department remained busy, with time pressures during clinics remaining a problem, staff reported that the clinics that were kept smaller represented a major improvement. It did appear, however, that audiology staff had been through a difficult time dealing with the fundamental changes that had occurred with the delivery of the service during the intervention period.

Staff in administration reported large improvements in communications with management, consultation about change and communication within the department in general. While it was recognised that there was still work to be done to tackle worn out scores (these had not reduced as much as was desired), staff reported higher job satisfaction, lower absence and fewer staff indicated that they wanted to leave the department.

## **10.2 North NHS Trust Children's Services**

This case study focused on a group of just under 100 qualified nursing staff working in three wards in a medium-sized hospital. They delivered all aspects of in-patient care, dealing with both acute and chronic conditions. Patients ranged from small babies in the neonatal unit to young adults in the two other wards.

The risk assessment indicated that staff were adequately appreciated for the work they did, and that their jobs were varied, interesting and rewarding. Staff indicated that they had a good input into patient care decisions, that working relationships between colleagues were strong, performance appraisals were frequent and useful. Communication systems also worked well, with information being freely available through a programme of ward and team meetings. However, a number of 'clusters' of problems were identified by the group. Staff were faced with a heavy workload and many felt unable to deliver a total care package as a result. Many temporary staff were being used to cover for sickness absence or unfilled posts and this was placing permanent staff under extra pressure. There was also a perceived shortage of

housekeeping and other support staff. There were a number of problems with the physical working environment and the adequacy of hospital services (e.g. portering, pharmacy) in two of the wards. There were problems with the level of support offered to staff who had dealt with distressing situations. Many staff reported that appreciation and recognition from senior management was not good. Some other, more 'local' problems also affected the wards.

The Steering Group identified that several problems were being driven by difficulties with staffing levels, a shortfall in the number of highly trained support staff, and a lack of clerical assistance in the ward. Two of the wards made a concerted effort to address staffing issues by recruiting their trained students into full-time posts on the ward. All wards recruited support staff and instigated additional training for them, with one ward changing the hours that support staff worked so that they were able to provide cover during the evenings. Two of the wards also moved to the main hospital site during the intervention period: this was a major operation for staff, with many being involved in planning the move.

The evaluation revealed that problems with workload had eased in the two wards that had tackled problems with staffing and support. Staff felt better able to deliver a total care package to patients and problems caused by lack of housekeeping support and the supervision of temporary staff had eased considerably. The move to the new ward had eased a number of problems: management was more 'visible' (they were now based on the wards) and the service delivered by pharmacy had improved. There remained some problems with the support offered to staff, working relationships with medical staff, and appreciation and recognition. These may be the focus of future interventions.

However, little had changed in the third ward: several senior members of staff had left during the intervention period and staffing was a major problem for the group. As a result, many of the problems identified in the risk assessment persisted. Despite these problems a number of interventions aimed at improving the support available to staff (housekeeping, clerical support etc.) were well received.

### **10.3 West Central NHS Trust; Accident and Emergency Department**

This case study focused on a group of 35 nursing staff (25 qualified nursing staff, 10 health care assistants) and 12 administration staff working an Accident and Emergency Department. The department dealt with both minor and major injuries and disease conditions.

In the risk assessment, nursing staff indicated their satisfaction with a number of aspects of their work. Their jobs were varied and team spirit was strong – with colleagues and managers providing good quality advice and support about patient care issues. Most said their job was rewarding and that they were very involved in making decisions. Roles and responsibilities were clearly defined and working hours were acceptable. Although infrequent, staff meetings were viewed as useful and informative. Equipment levels were good within the department.

However, care delivery staff in the department were facing a number of problems. Once stabilised, patients were not being moved into the wards quickly, and this resulted in extra work for the department's staff – when workload was already heavy. Many nursing staff indicated that their 'peripheral' workload (e.g. organising community-based care, dealing with paperwork etc.) was a problem. Although communication was strong, staff indicated that consultation about change was weak. The availability of support for staff involved in distressing situations was not rated highly. There were some vacant posts in the department, and many staff reported that they were not notified of their working hours far enough in advance. Some problems with training were also cited by the majority of staff. There was frequent abuse from patients and some staff had been physically assaulted. Together, these problems appeared to impact on the

well-being of staff: most found their job satisfying but, on average, they were worn out and tense.

Although the problems expressed themselves differently, administration staff were faced with a similar set of issues. There were difficulties with several aspects of communication. A number of staff expressed dissatisfaction with their grading. Their time was pressured, and there were problems with the physical working environment. Several indicated that training on computer systems had been poor. Many staff reported that they had been faced with verbal abuse and aggression from the public. They did, however, report strong satisfaction with a number of aspects of their work: they indicated that it was varied and interesting and that teamwork was strong.

Interventions aimed at the nursing staff focused on addressing problems with staffing, reducing the peripheral workload placed on staff, and improving communications, training and the organisation of shifts. These included: the recruitment of staff to fill gaps in the establishment; the introduction of an administration co-ordinator and the re-location of specialist and support staff into the unit; the introduction of a communication book to relay important information; the introduction of in-house training sessions; the instigation of more regular and inclusive departmental meetings; and the re-organisation of the management of the off-duty rota.

The interventions designed to reduce the peripheral workload placed on nursing staff were seen as particularly effective, as was the recruitment of staff. The impact of the other interventions was more modest, but nonetheless important for a number of staff. It did appear, however, that persistent problems with the movement of stabilised patients to wards and its impact on workload, as well as problems in providing support for staff tempered the impact of these interventions.

A modest package of interventions did appear to make a difference for administration staff. The introduction of a communication book and increased involvement in departmental meetings were well-received. Some staff had been re-graded and they indicated that there was more recognition of their efforts as a consequence. As a result of the re-grading, staff indicated that work was allocated more efficiently within the team. A new computer system was also introduced into the department, with a good package of training support - something that had not been available with the previous system. At evaluation the situation appeared to have improved for administration staff.

#### **10.4 West Central Trust: Catering Department**

This case study was based in a Catering department that provided meals for in-patients as well as a canteen service for staff and visitors. It employed around 40 staff working mainly in food preparation areas (cooking or serving food, and cleaning utensils and working areas).

On the whole the group reported that many aspects of their job were well designed and managed. Many indicated that they had a good deal of control over the way they went about completing their work. The use of work schedules in several areas of the department had succeeded in introducing and maintaining variety into their work. Working relationships were strong within the teams in the department. Although the work done by staff was monitored, they were encouraged to take on responsibility for completing tasks and developing their own ways of getting the job done effectively. The working atmosphere was friendly, and it was reported that management within the department had a good knowledge of working methods and procedures – this helped the group to deal with problems as they arose. The group reported high levels of job satisfaction, low absence, and very few staff indicated that they wished to leave the department.

Some aspects of work design were identified as problematic. Peaks in workload around mealtimes caused problems for several groups of staff. Many staff also indicated that staff who covered the work of absent colleagues were often poorly trained and needed to be heavily supervised – causing problems in small teams. There were some tensions between different parts of the department when co-operation was required. Many staff also felt that there was a lack of consultation about change. There was also a cluster of problems regarding work equipment: repairs to machinery were slow, and there was a lack of trolleys for moving heavy equipment. These were issues that appeared to contribute to feelings of being worn out that were reported by some staff.

The results of the risk assessment indicated that a modest response was needed to tackle the problems identified. The group was able to easily integrate interventions into everyday management practices. Introducing monthly team leader meetings strengthened the links between different sections of the department. Team management structures were strengthened in several sections of the department. A training programme for cover staff was instigated, and a shortage of cooks was addressed by training people from within the department. The allocation of staff around meal times was also adjusted (more staff made available at busier times) to ease the pressure on staff. A number of new trolleys were also purchased as a direct response to the risk assessment. Maintenance technicians also moved nearer the Catering department.

At the time of the evaluation staff reported that they had noticed clear improvements in the competence of cover staff, indicating that the training had made a real difference. The cooks were extremely positive about the recruitment of new staff into their section. Consultation about change had also improved and there were far fewer problems with work equipment as a result of the interventions implemented. Although many staff still indicated that workload was high around mealtimes, many indicated that the re-distribution of staff and working hours had eased the pressures faced (particularly in the dining room area).

### **10.5 East Central NHS Trust Children's Services (Senior Nursing Staff)**

This case study focused on the managerial aspects of the role of senior nursing staff – and how these interfaced with the clinical tasks. Approximately 80 staff were involved in this project, all of who worked within the large Children's Services area.

This group of staff was satisfied with many aspects of work. The group as a whole indicated that there were strong working relationships between colleagues, facilitating a supportive environment for emotional, clinical and managerial issues. The quality and availability of advice within the department was regarded as a positive aspect of work. The degree of autonomy within the Children's Services was highly regarded; respondents noting adequate levels of control over the management of both their personal time and that of their staff. The group as a whole also reported clarity of roles and targets as a positive aspect of work. These strong aspects of work design were supported by good management practices.

However, there were some 'clusters' of problems. Achieving a balance when dealing with managerial and administrative tasks was significant problem, specifically the amount of time to complete complex managerial task and the availability of support to complete these tasks. Training and development arrangements regarding both funding and the time available were not rated highly. There were problems with communication systems that created tensions between staff and management, and between staff working in different wards. Concerns were also noted at the work-home interface, with the group as a whole indicating that the impact of work on home life was a problem, since they had to do substantial amounts of work at home. The most senior grades of staff also reported an inadequate level of understanding of their roles by other staff.

The design of a package of interventions was driven by intensive consultation with employees. Most interventions were suggested, developed and implemented by staff from within the group. The interventions were in place for only a short time (at most, six months) when they were evaluated.

To give staff more time to balance their clinical and managerial workload, a review of office hours was undertaken and increases in the time staff were allowed to use for office work followed. Computer facilities were placed on most wards to allow staff to complete administrative work more easily. Many wards also appointed housekeeping staff to ease the peripheral demands placed on staff in their clinical role. The impact of these interventions varied; in some wards it was extremely positive, but in others there were problems in implementing the changes (e.g. where there were low staffing levels). These problems were being tackled at the time of the evaluation. Where they had an impact, the interventions eased time pressures on staff, and freed up time to deal with the managerial aspects of the job.

The policy for managing study leave was re-vamped to ensure that feedback was given by staff who had been on training courses, to speed up the approval of training and to make the allocation of training more equitable. There was evidence that these changes were having the desired impact.

A staff forum was set-up to allow staff from across the service to meet with management on a monthly basis to address issues that were of concern to staff. Regular problem-solving workshops also continued for groups of staff working at the same grade. A staff newsletter was also set up to ease the flow of information around the service and between wards. A new problem-solving and service development strategy (Shared Governance) was also in the early stages of its implementation. There was some evidence that these interventions had speeded up problem-solving, improved the sharing of good practice, and improved inter-ward and peer communications. A number of interventions to pass managerial control over to ward staff were also implemented and were well-received. Some interventions were also implemented to improve the physical working environment in several of the wards – the success of these varied from ward to ward.

## 11. REFERENCES & BIBLIOGRAPHY

The reader should note that the style of this report means that it does not refer frequently to other published materials: it is deliberately 'self-contained'. For instance, the investigation and discussion of specific technical measurement issues lies outside of the remit of this research. Our previous work for the Health and Safety Executive discusses these methodological and scientific issues:

Cox, T., Griffiths, A., Barlow, C., Randall, R., Thomson, L., & Rial-Gonzalez, E. (2000a). *Organisational interventions for work stress: A risk management approach*. Sudbury: HSE Books.

Below we provide a brief bibliography that will allow the interested reader to 'read around' some of the issues raised by, and discussed within, this report. Listed are a mixture of scientific papers, books (and book chapters) that cover various aspects of stress management within the work setting.

Beale, D., Fletcher, B., Leather, P., & Cox, T. (1998). *Review on violence to NHS staff working in the community*. Nottingham: University of Nottingham.

British Psychological Society (2000). *Code of conduct, ethical principles and guidelines*. Leicester: The British Psychological Society.

Cox, T. (1993) *Stress research and stress management: Putting theory to work*. Sudbury: HSE Books.

Cox, T., & Ferguson, E. (1994). Measurement of the subjective work environment. *Work and Stress*, 8, 98-109.

Cox, T., & Griffiths, A. J. (1995a). *The assessment of psychosocial hazards at work*. In M. J. Shabracq, J. A. M. Winnubst and C. L. Cooper (Eds.) *Handbook of Work and Health Psychology*. Chichester: John Wiley and Sons.

Cox, T., & Griffiths, A. J. (1995b). *The nature and measurement of work stress: theory and practice*. In Wilson, J. and Corlett, N. (Eds.) *The Evaluation of Human Work: A Practical Ergonomics Methodology*. London: Taylor and Francis.

Cox, T., Griffiths, A. J., Barlow, C. A., Gustafsson, E. & Cox, S. (1996). *Work-related stress in manual workers: A heavy load*. London: UNISON.

Cox, T., Griffiths, A. J. & Rial-Gonzalez, E. (2000b). *Research on Work-related Stress*. Report for the European Agency for Safety and Health at Work. Luxembourg: Office for Official Publications of the European Communities. Available through <http://osha.eu.int>.

Cox, T., Thirlaway, M., Gotts, G., & Cox, S. (1983). The nature and assessment of general well-being. *Journal of Psychosomatic Research*, 27, 353-359.

Griffiths, A. (1999). Organizational interventions: Facing the limits of the natural science paradigm. *Scandinavian Journal of Work, Environment and Health*, 25, 589-596.

Health and Safety Commission (1999). *Management of Health and Safety at Work: Management of Health and Safety at Work Regulations 1999, Approved Code of Practice and Guidance*. Sudbury: HSE Books.



Hodgson, J. T., Jones, J. R., Elliot, R. C. and Osman, J. (1993). *Self-reported work-related illness*. Sudbury: HSE Books.

Jones, J. R., Hodgson, J. T., Clegg, T. A. and Elliot, R. C. (1998). *Self-reported work related illness in 1995: Results from a household survey*. Sudbury: HSE Books.

Israel, B. A., Baker, E. A., Goldenhar, L. M., Heaney, C. A., & Schurman, S. J. (1996). Occupational stress, safety and health: Conceptual framework and principles for effective prevention interventions. *Journal of Occupational Health Psychology, 1*, 261-286.

Jackson, S. E. (1983). Participation in decision-making as a strategy for reducing job-related stress. *Journal of Applied Psychology, 68*, 3-19.

Karasek, R. & Theorell, T. (1990). *Healthy Work*. New York: Basic Books.

Kompier, M. & Kristensen, T. (2000). *Organisational work stress interventions in a theoretical, methodological and practical context*. In J. Dunham (Ed.), *Stress in the Workplace: Past, Present and Future*. London: Whurr Publishers.

Leather, P., Brady, C., Lawrence, C., Beale, D., & Cox, T. (Eds.) (1998). *Work-related violence: Assessment and intervention*. London: Routledge.

Mikkelsen, A., Saksvik, P. O., & Landsbergis, P. (2000). The impact of a participatory organizational intervention on job stress in community health care institutions. *Work and Stress, 14*, 156-170.

Nytrø, K., Saksvik, P. O., Mikkelsen, A., Bohle, P., & Quinlan, M. (2000). An appraisal of key factors in the implementation of occupational stress interventions. *Work and Stress, 14*, 213-225.

Parker, S., & Wall, T. (1998). *Job and work design: Organizing work to promote well-being and effectiveness*. Thousand Oaks, CA: Sage.

Tabachnick, B. G., & Fidell, L. S. (1989). *Using multivariate statistics*. New York: Harper-Collins.

Wang, M., Eddy, J. M., & Fitzhugh, E. C. (1995). Application of odds ratio and logistic models in epidemiology and health research. *Health Values, 19*, 59-62.



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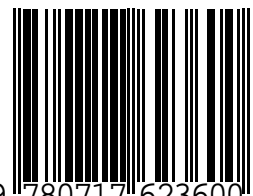
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