Working for your health: A survey of NHS Trust staff

Health at Work in the NHS
Research Study

Foreword

Health at Work in the NHS (HAWNHS) is a long-term initiative set up to support the national strategy for health. Its strategic aim is to ensure that, as an employer, the NHS promotes healthy workplaces and thereby contributes to the health and well-being of its employees.

The NHS Executive formally commissioned the Health Education Authority (HEA) to undertake the development and delivery of the HAWNHS initiative. As part of this initiative, the NHS is required to develop workplace health programmes. The HEA research unit took this opportunity to establish workplace health research to evaluate the implementation and development of these workplace health programmes.

This research report is the third in a series being produced over the duration of the initiative. The aim of the series is to:

- disseminate research findings;
- monitor the implementation of workplace health initiatives;
- share examples of good practice of workplace health programmes in the NHS.

In July 1992, the Secretary of State for Health launched the White Paper, *The Health of the Nation*. The role of the NHS in the promotion of health and the prevention of disease was highlighted, as was the objective that the NHS should strive to become an exemplary employer. This objective was stated in the NHS Executive's *Priorities and Planning Guidance* of 1993/4 and has been restated since.

The HAWNHS initiative was launched in September 1992. The NHS employs nearly one million people and is highly dependent on its employees, therefore their well-being should be a priority. An added benefit of HAWNHS is the significant proportion of the population formed by NHS staff, and their families; an improvement in their health can but move the nation towards the achievement of the health targets set out in the White Paper.

This report presents the findings from staff surveys in 14 NHS Trusts participating in the second phase of the HEA's research study. Questionnaires were sent to a random selection of 15,000 staff in the 14 Trusts and responses were received from over 8500. The survey findings allowed individual Trusts to address the expressed needs of staff when developing their workplace health programmes. The findings also provided the HEA with baseline staff data with which to measure the impact of the workplace programmes.

Acknowledgements

This report has been prepared by Stephen Bevan and Ian Seccombe of the Institute for Employment Studies. It presents the findings of a survey commissioned by the Health Education Authority (HEA) as part of its research on the Health at Work in the NHS initiative.

The authors wish to acknowledge the significant effort and kind co-operation of staff in all the NHS Trusts participating in the survey. We recognise that conducting the surveys represented a significant undertaking, and we appreciate the effort of all those who helped us.

The statistical reweighting of the data from the survey was carried out by Colm O'Muircheartaigh (Director) and Armin Helic from the London School of Economic and Political Science, Methodology Institute.

The survey and questionnaire were developed from contributions from a number of researchers from the HEA including Christine Maguire, Iain Noble and Amanda Killoran. The final management of the survey was by Errol Walker. The Health at Work Research is managed by Errol Walker and Julie Bull.

The authors would also like to extend their thanks to numerous individuals and organisations for their assistance in the development and piloting phase of this research including Linda Seymour and Ray Adams (consultants to the HEA).

The Institute for Employment Studies

The Institute for Employment Studies (IES) is an independent, apolitical, international centre of research and consultancy in human resource issues. It works closely with employers in the manufacturing, service and public sectors, government departments, agencies, professional and employee bodies, and foundations. Since it was established over 25 years ago IES has been a focus of knowledge and practical experience in employment and training policy, the operation of labour markets and human resource planning and development. IES is a not-for-profit organisation which has a multidisciplinary staff of over 60. Its expertise is available to all organisations through research, consultancy and publications.

IES aims to help bring about sustainable improvements in employment policy and human resource management. It achieves this by increasing the understanding and improving the practice of key decision makers in policy bodies and employing organisations.

Formerly titled the Institute of Manpower Studies (IMS), IES changed its name in 1994, to better reflect its full range of activities and involvement.

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The report is also being published to provide other NHS Trusts with data with which to compare their own staff surveys. As many Trusts are embarking on these 'needs assessments' as a starting point for their workplace health programmes, these survey results will provide some means of comparison.

Previous reports in this series include a study of Health at Work activity in Hospital Trusts, a similar survey of Community and Ambulance Trusts; and a qualitative study on the interest of general practitioners in workplace health programmes for practice staff[1,2,3]. Future reports are planned on the substantive implementation of workplace health programmes, identifying some of the emerging factors that facilitate and inhibit their development.

Errol Walker
Project Manager
Health at Work – Research

Tables and figures

The *Working for your health* survey was administered to approximately 1000 staff in each of the Trusts included in the study. For the larger Trusts this number represents a small sample, whereas in smaller Trusts all the staff were included. Therefore, to rebalance the survey results, the data have been reweighted to reflect the actual proportion of staff included.

In the figures and tables, the actual number of respondents is shown as the base, and the rebalanced numbers as the weighted base. Percentages quoted are calculated using the weighted base.

Executive summary

Introduction

This report presents the findings from staff surveys in the 14 NHS Trusts participating in a Health Education Authority (HEA) study of the *Health at Work in the NHS* (HAWNHS) initiative. The surveys were all conducted in the first seven months of 1995 and form part of a wider study to evaluate and monitor the impact of the HAWNHS initiative. Individual sites have already received copies of their own survey results. This report:

- presents aggregate data across all the study sites weighted to reflect correctly the actual size of each Trust. A total of 8581 (57%) NHS employees responded to the surveys;
- examines the implications of the survey findings for the management of workplace health promotion in the NHS in general and the remainder of the Health at Work (HAW) study in particular.
- looks forward to a proposed second-wave of surveys and discusses some of the lessons which have been learned about measuring employee opinion on health promotion issues.

Profile of survey respondents

The main characteristics of the NHS employees who responded to the survey include the following:

- they were predominantly female with an average age of 38;
- 40% were nursing and midwifery staff, of whom 11% were unqualified;
- 44 hours was their average working week (64.7 hours among medical and dental staff);
- 62% reported that their pattern of work includes weekend working; 43% worked shift patterns.

Health status, lifestyle and working conditions

A number of factors affecting employee health and well-being were examined, and revealed that:

- two-thirds of respondents reported that their health had been good over the last 12 months. This view roughly matched levels of self-reported absence, although 37% of those who reported their health as 'good' had been off sick in the last six months;
- using the Office for National Statistics Body Mass Index, 57% of staff were of optimum weight. However, 27% of women and 35% of men were overweight (this includes those who were obese);
- 19% of respondents were currently cigarette smokers, 72% of whom reported that they smoke at work. Half were planning to give up in the next 12 months;
- 12% of current smokers said they do not know if smoking affects their health. Half the 'heavy' smokers in the study reported that smoking had 'little or no effect' on their health;
- just under 90% of respondents reported that they drink alcohol, 7% of women and 17% of men reported consumption in excess of the sensible drinking levels;
- 16% reported their intention to cut down their alcohol consumption in the next 12 months;
- one-third of respondents thought that they get enough exercise to keep fit. However, fewer actually meet the recommended levels of moderate activity. Over three-quarters were intending to take more exercise in the next 12 months;
- one-third of respondents reported that they 'frequently' eat while working or take no meal breaks at all. Over half were intending to change their diet in the next 12 months.

Sickness absence

For many NHS employers, reducing the level of sickness absence among staff represents an important motivation for engaging in health promotion activity. Findings include the following:

- 46% of respondents reported that they had been absent from work in the last six months. Most of these reported only one period of absence;
- most respondents reported absences of five days or fewer;
- just under half the women and 37% of the men reported a period of absence. The incidence of absence appears to decrease with age, though the average length of absence increases;
- 19% of respondents attributed one or more of their absences to injuries sustained at work or to the effects of their working conditions;

- respondents' attitudes towards absence suggest that the majority are positively disposed towards attendance.

Health at Work

The key findings to emerge concerning improving HAW and respondents' attitudes towards health promotion are as follows:

- six priority areas were identified by respondents for the improvement of their health at work. These were centred on improving communication and management; less of a priority were issues of individual health and lifestyle;
- the training of supervisors or managers to be more sensitive to employees' concerns was seen as a priority by more than a quarter of respondents;
- most respondents were moderately dissatisfied with most aspects of health promotion in their Trust. Ancillary staff were least dissatisfied and scientific, professional and technical staff the most dissatisfied.

Attitudes to working in their Trust

Employee attitudes and morale were also shown to be important contributors to feelings of well-being in the workplace. The main findings include the following:

- general and senior managers reported higher levels of satisfaction than other staff groups on most of the attitudinal questions, with maintenance and works staff consistently reporting lower levels of satisfaction;
- respondents reported a generally moderate level of commitment to their Trust, but lower levels of satisfaction with the degree of openness;
- neutral to low levels of stress were reported by most staff groups;
- most staff groups were neutral or moderately satisfied with levels of support and recognition in their Trust;
- maintenance and works and ancillary staff expressed particular concern over the possibility of redundancy;
- moderate to high levels of job satisfaction were reported by most staff groups, together with moderate levels of career satisfaction by professional groups;
- moderate levels of leaving intention were reported by all staff groups.

Lessons from the survey

A number of management and research issues were raised by this research and these are summarised below.

The organisational context

There appear to be at least three facets of the organisational context which have particular impact on the penetration and prominence of workplace health promotion measures in the study sites.

1. **The management of change** – It appears that some sites have managed these changes more comfortably than others and that, in some sites, the changes have had more significant effects on staff than in others. The success with which Trusts have been able to manage change may also have had an impact on the extent to which health and well-being in the workforce is seen as a priority.

2. **Organisational culture** – This is a term being used more frequently in some NHS Trusts, often by senior managers who consider that certain aspects of culture are more (or less) closely associated with specific organisational characteristics. Thus, some have put emphasis on encouraging a 'performance-orientated' culture which stresses the measurement of outputs, individualisation of the employment relationship, high workforce commitment and devolution to line managers.

3. **Senior management commitment** – This aspect of the organisational context is very frequently cited as being central to the success, or otherwise, of workplace health promotion.

All these factors form only part of a complex backcloth against which the operation of the HAWNHS initiative must be assessed. Other elements of the evaluation study will need to probe these issues further in order to gain a clearer understanding of how the organisational context has impact on the move towards a healthier workforce in the NHS.

Physical and psychological well-being at work

A strong message from staff in all the Trusts in the study is that psychological well-being is, for them, at least as important a consideration as physical well-being. In some sites it might be argued (with some justification) that this emphasis is, in part, a reaction to change.

This finding may have at least two important ramifications for the management of health promotion:

- an approach which comprises only a series of initiatives aimed at changing lifestyle and improving physical health might be seen by some staff groups as failing to address their key health concerns (and, indeed, those which most directly affect their performance and their attendance at work);

- health promotion initiatives which are closely integrated with broader human resource (HR) and 'business' strategy might have better medium-term prospects of bringing about sustainable change in workplace health.

The issue of 'psychological well-being' is, of course, potentially an elusive one and it would be understandable if some Trusts were tempted to consign it to the 'too difficult' pile and concentrate instead on smoking cessation and weight-loss programmes. Evidence from this survey suggests that this response is unlikely to address many of the broader health concerns of staff.

Looking at sickness absence

Given that sickness absence is seen as one of the more readily measurable indicators of workplace health, it is unsurprising that it is at the centre of the 'business case' which many Trusts make for involvement in workplace health promotion activity. However, sickness absence is not necessarily a straightforward indicator. Other IES research for the HEA has found little consistency in the measures of sickness absence being used in the NHS. In addition, the role of shift-working, domestic and caring responsibilities also needs to be taken into account.

Forming a clear view about the nature and causes of sickness absence will help managers to assess how much they can realistically expect to influence it through the introduction of health promotion initiatives.

High risk groups and behavioural intentions

Some of the most directly useful data in the surveys are those which identify staff groups who both:

- have health or lifestyle patterns which put them at particular, or multiple, risk; and
- express an intention to modify their health or lifestyle within the next 12 months.

Of course these two groups may not overlap (indeed, some of our data suggest that a good proportion of those intending to change are in lower risk groups). However, if Trusts have limited resources for health promotion, it could be that targeted action which seeks to have impact on high risk staff groups might bear most fruit.

The stress debate

The surveys are interesting for both what they *do* and *do not* tell us about stress. On one hand it is clear that no single staff group stands out as having higher (or, indeed, lower) levels of self-reported stress than any other. On the other hand, none of the levels reported appears particularly high.

Whatever the reasons for this, it is clear that the issue of stress is likely to remain on the agenda. Indeed, 'stress management' ranks high among the health promotion initiatives suggested by survey respondents across all sites in the study.

The next steps

The surveys have provided a rich set of benchmark data which:

- allows the 14 Trusts involved in the study to reflect on, and plan, their priorities for the future;
- ensures a solid basis for comparative analysis if the second-wave surveys are conducted;
- helps set the agenda for more detailed case study work during the rest of the evaluation project.

The remainder of the study will be well-placed to examine the impact on staff of a range of workplace health promotion initiatives and to further understanding of how such initiatives can successfully be introduced and sustained.

Introduction

This report presents the findings from staff surveys in the 14 NHS Trusts participating in a Health Education Authority (HEA) study of the *Health at Work in the NHS* (HAWNHS) initiative. The surveys were all conducted in the first seven months of 1995 and form part of a wider study to evaluate and monitor the impact of the HAWNHS initiative. Individual sites have already received copies of their own survey results. This report:

- presents aggregate data across all the study sites weighted to reflect correctly the actual size of each Trust;
- examines the implications of the survey findings for the management of workplace health promotion in the NHS in general and the remainder of the Health at Work (HAW) study in particular;

It also looks forward to a proposed second wave of surveys and discusses some of the lessons which have been learned about measuring employee opinion on health promotion issues.

1.1 The HAWNHS research programme

In November 1993, the HEA commissioned a programme of research from the Institute for Employment Studies (IES) to monitor the effects of HAW in NHS Hospital Trusts. The research programme has five main objectives:

- to monitor the implementation of structures and processes necessary for health promotion in the workplace;
- to collect and monitor data on employee awareness of, and participation in, site health promotion activities;
- to collect and monitor employee lifestyle data;
- to review systems for recording staff sickness absence;
- to suggest process and outcome indicators that can be used at a local level to monitor the effectiveness of the project.

Fifteen NHS Hospital Trusts were selected to participate in the research programme following an initial national baseline survey[1] of HAW activity levels. In each of the 14 Trusts which agreed to take part in the study, employee surveys were conducted. In addition, face-to-face semi-structured interviews were undertaken with key staff. These interviews focused on:

- identifying HAW strategies
- mechanisms for staff consultation
- plans for evaluation and monitoring
- current use of health promotion activities
- barriers to implementation.

1.2 The participating NHS Trusts

The 14 sites involved in this part of the research were selected on the basis of their responses to a national baseline survey[1] of HAW activity conducted in 1994. This allowed Trusts to be selected which are illustrative of a range of criteria, for example, teaching/non-teaching, urban/rural, high/moderate HAW activity.

1.3 The HAWNHS staff survey

A detailed self-completion questionnaire was designed and piloted in late 1994; a copy appears in Appendix 1.

The objectives of the staff survey were to:

- assess the attitudes of staff toward HAW;
- record employee perceptions of factors influencing HAW;
- assess employee needs in relation to their place of work;
- collect lifestyle data.

As a result, the survey provided each Trust with an opportunity to consult with staff in identifying priorities for HAW and information that could be used as a benchmark for monitoring the impact of HAW initiatives.

The survey was designed to give a representative picture of staff characteristics and attitudes across each Trust. A key intention was to collect information from all staff groups and from all locations.

Survey sample

In all but one Trust the aim was to distribute questionnaires to approximately 1000 employees. In some cases this represented the whole workforce, in others it meant devising a stratified sample.

Survey launch and administration

In the first six months of 1995 a total of 15,000 questionnaires was despatched to staff in each of the study sites. In most Trusts the questionnaires were distributed (with a covering letter and a reply-paid envelope) on a confidential basis. This meant that non-respondents could be identified by the IES for targeted reminders. In a few Trusts the survey was anonymous and a blanket reminder was subsequently issued. The survey was widely publicised in each Trust where possible.

Response rates

By the close of the surveys a total of 8581 questionnaires had been returned, representing a crude response rate of 57%. Response rates in individual sites ranged from 35% to 73%. It is clear that pre-publicity about the survey and the use of targeted reminders to non-respondents had a positive impact on response rates.

1.4 Working for your health: A survey of NHS Trust staff

This report is based on the 8581 responses to the survey, weighted to give each Trust an effect proportional to its size in the overall analysis.

The demographic and social characteristics of the survey respondents – their current jobs, employment status, working hours and shifts, and travel to work – are looked at in Chapter 2. Chapter 3 then examines the health, lifestyle and working conditions of the respondents, with particular reference to smoking, alcohol consumption, exercise, diet and workplace hazards. Respondents' reported intentions to change these aspects of their lifestyle are also presented here. The survey findings on sickness absence and attendance at work are reported in Chapter 4. Chapter 5 reports the respondents' views of changes which their Trust could make to improve their health at work, and it describes their attitudes towards working in their Trust and their views of health promotion in the Trust. The attitudes of respondents to various aspects of their current jobs and of working in the NHS are explored in Chapter 6. The final chapter draws out the lessons from these surveys and other work in the 14 Trusts.

2. Workforce profile

2.1 Introduction

The purpose of this chapter is to describe the overall profile of those responding to the survey. By relating biographical information, for example age, to aspects of lifestyle or health status, for example smoking, patterns of health need within the workforce can be identified. This chapter provides a factual background by detailing the following items, against which the health, lifestyle and attitudinal data presented subsequently may be measured:

- profile of respondents
- employment details
- working patterns.

2.2 Profile of respondents

Age and sex

Over three-quarters (76%) of the staff responding to the survey were women and less than a quarter (24%) were men. Of these, 44% were under the age of 35 and 31% were aged 45 or more. At the extremes, 9% were under 25 and 9% over 55.

The average (mean) age of survey respondents was 38 (women 38 and men 40). There is some variation between staff groups in average age, the extremes being nursing and midwifery and Professions Allied to Medicine (PAMs) at 36 years and maintenance and works at 47. The age distribution is more variable at the extremes. For example, the majority of PAMs and nursing and midwifery staff were aged under 35 (57% and 52% respectively), but only 16% of maintenance and works staff were in this age group. At the upper age bands, the majority (61%) of maintenance and works staff were aged 45 and over, compared with only 23% of nursing and midwifery and 22% of PAMs staff.

Marital status and dependants

Of the respondents 69% were married or living with a partner, 23% were single and 9% widowed, divorced or separated. One-third (34%) of respondents had children under 16 years of age living at home, while 4% of respondents had dependent adults (people who are sick, disabled or older) living at home.

Accommodation and travel to work

Three-quarters (74%) of respondents reported living in a home that they own or are buying, with 10% renting in the private sector and 7% renting in the public sector; 5% of respondents were living with parents, and 2% in nurses' homes.

The majority (61%) of staff travelled to work by car, while 19% used public transport and 12% walked – 69% had a journey time of 30 minutes or less (including 30% with journeys of 15 minutes or less).

Other characteristics

The survey showed that 1% of respondents were registered disabled (either with the Employment Service or with local Social Services) and 9% were from minority ethnic groups. Because of the small numbers involved, these variables are not used in the subsequent analysis.

2.3 Employment details

Staff groups

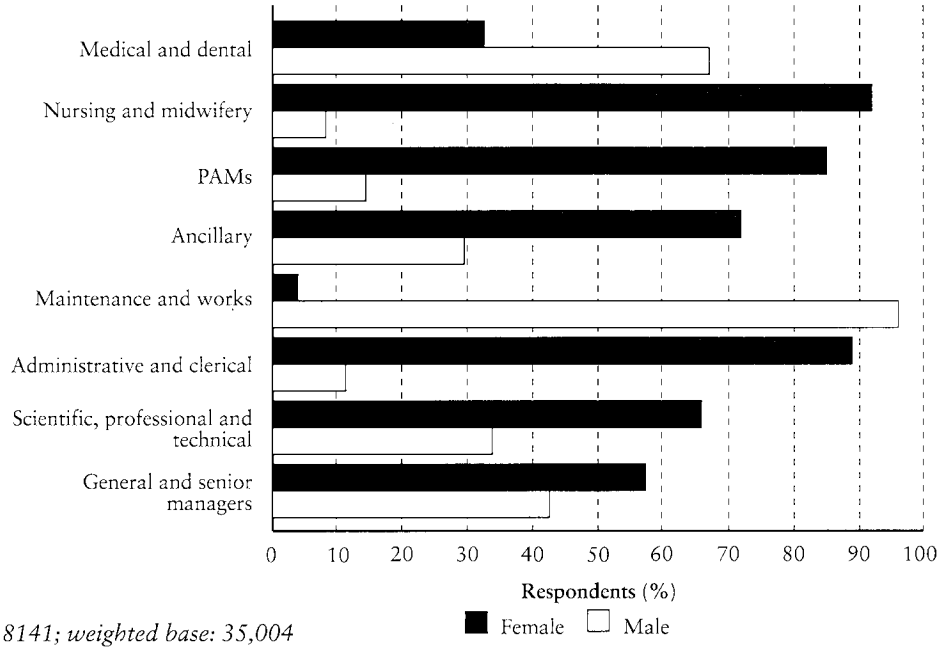
Nurses and midwives made up two-fifths (40%) of all respondents. Of the remaining respondents, 17% were administrative and clerical staff, 12% ancillary, 12% medical and dental, 11% scientific, professional and technical, 4% PAMs, 2% general and senior managers, and 2% maintenance and works staff.

Figure 2.1 gives a percentage breakdown of gender of respondents within each staff group. With two exceptions, the majority of respondents in each staff group were women. The exceptions are maintenance and works where 96% were men, and medical and dental where 67% were men.

Of the nursing and midwifery staff 11% were unqualified (that is clinical grade A or B), 24% were Grade D, 33% Grade E and 25% Grades F and G.

Of the medical and dental staff 45% were consultants and 36% were junior doctors.

Figure 2.1 Staff group by gender



Base: 8141; weighted base: 35,004

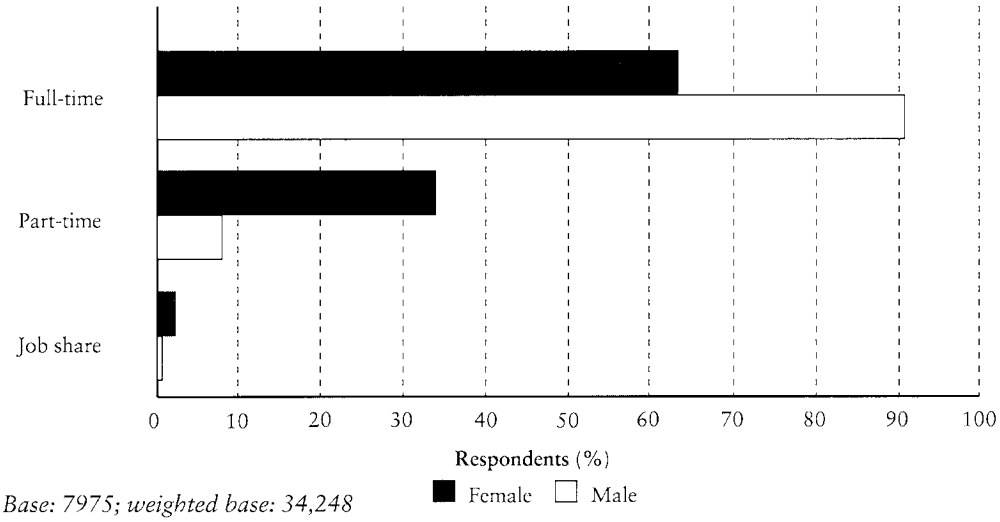
Source: IES Survey, 1997

Employment status

Overall, 70% of staff worked full-time, 28% part-time and 2% worked as part of a job share or other arrangement.

Figure 2.2 presents the information on employment status separately for men and women. This shows that there are differences in the working patterns of men and women. Almost all men (91%) worked full-time, while one-third of women (34%) were part-timers.

Figure 2.2 Employment status by gender



Base: 7975; weighted base: 34,248

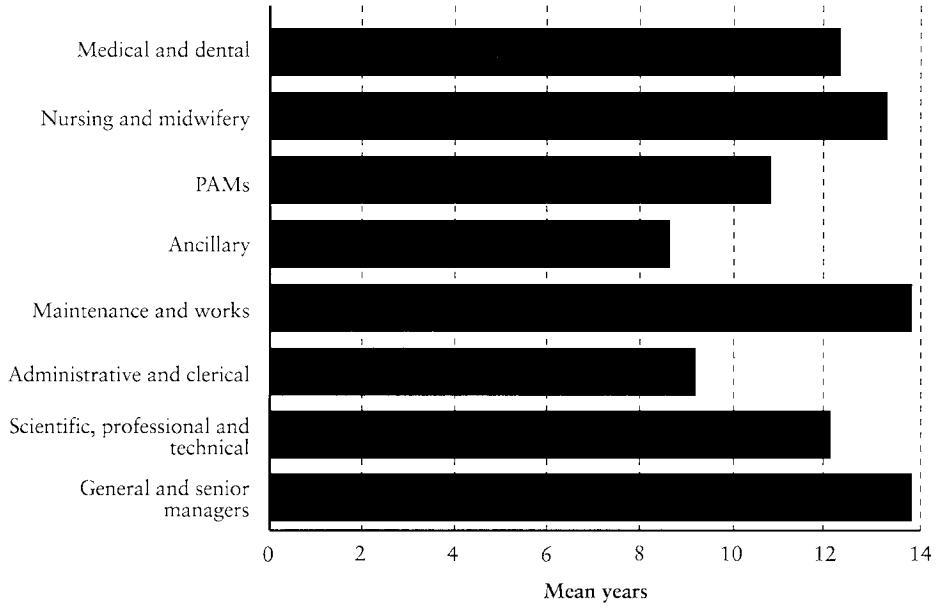
Source: IES Survey, 1997

Length of service

One-fifth (22%) of respondents had worked for less than five years in the NHS and a further fifth (20%) had worked for 20 years or more. One-quarter of the staff (25%) had worked in the NHS for five to nine years, 20% for 10 to 14 years and 14% for 15 to 19 years. There is considerable variation in the length of service between staff groups: 36% of ancillary, 30% of administrative and clerical and 31% of medical and dental staff had less than five years service, while 27% of general and senior managers, 23% of maintenance and works staff and 26% of medical and dental staff had worked 20 years or more in the NHS.

Figure 2.3 shows the average length of NHS service by staff group. Average length of service in the NHS was 12 years; there is some variation in this figure between staff groups, with the highest being maintenance and works staff and general and senior managers, both with almost 14 years.

Figure 2.3 Staff group by average (mean) number of years in the NHS



Base: 7882; weighted base: 33,901

Source: IES Survey, 1997

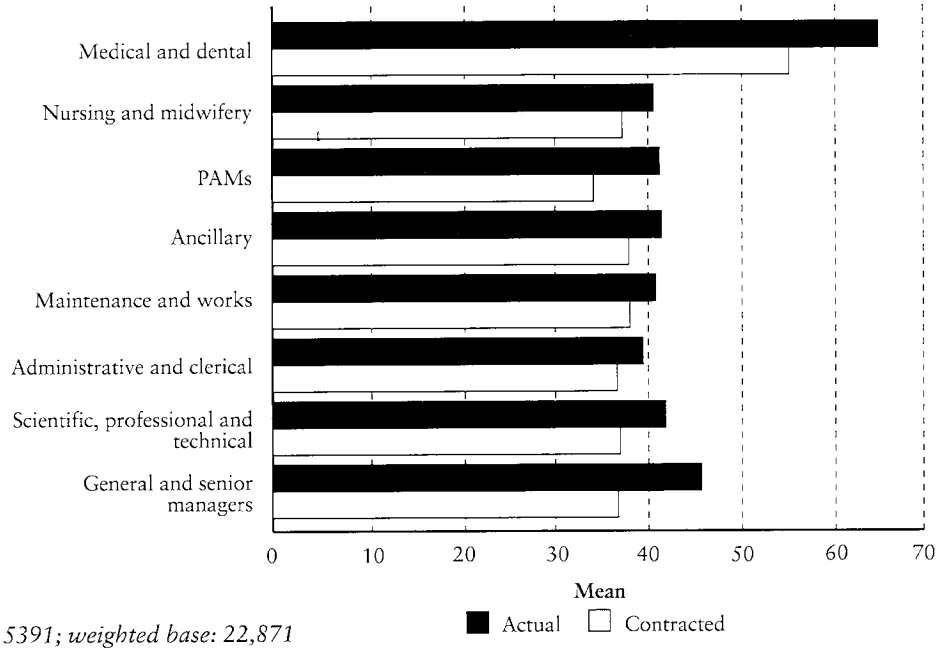
2.4 Working patterns

Working hours

The survey asked respondents to state their contracted and actual working hours. Respondents (full-time only) reported working an average of 44 hours per week, compared with average contracted hours of 38.9 per week. The largest differences between actual and contracted hours worked were among medical and dental staff, with an average of 64.7 actual hours (55.1 contracted) and

general and senior managers, with an average of 45.7 actual hours (36.8 contracted). The longest reported actual working hours were among medical and dental, nursing and midwifery, ancillary and staff groups (with up to 98 hours in each of the three groups). Figure 2.4 compares the mean contracted and actual working hours reported by staff group.

Figure 2.4 Contracted and actual working hours by staff group



Base: 5391; weighted base: 22,871

Source: IES Survey, 1997

Weekend working and on-call

More than three-fifths (62%) of respondents reported that their pattern of work includes weekends. The pattern of weekend working is strongly associated with occupational group. The proportion who worked weekends varied from 13% among administrative and clerical staff to 82% among nursing and midwifery respondents.

Almost a third (30%) of respondents reported that their pattern of work includes being on-call. This was highest for medical and dental staff of whom 88% reported being on-call. Among nursing and midwifery staff this figure was 19%.

Shift patterns

Over half (57%) of respondents worked days only, with 43% working some form of shift pattern. Shift working was most common in nursing and midwifery (where 79% of staff worked shifts).

Of those who worked shifts, 54% of the nursing and midwifery respondents reported working a full rotation (that is earlies, lates and nights).

2.5 Key findings

The main findings concerning the workforce profile include the following:

- respondents were predominantly female with an average age of 38;
- 40% of survey respondents were nursing and midwifery staff, of whom 11% were unqualified;
- the respondents' average length of service in the NHS was 12 years;
- respondents reported working 44 hours per week on average (64.7 hours among medical and dental staff);
- 62% of respondents reported that their pattern of work includes weekend working; 43% worked shift patterns.

3. Health status, lifestyle and working conditions

3.1 Introduction

This chapter reports the survey findings related to respondents' health status, lifestyle and working conditions. In particular, it examines six of the 12 key activity areas highlighted in the HAWNHS initiative. These are:

- awareness of HAWNHS
- smoking behaviour
- healthy eating
- alcohol awareness
- physical exercise and fitness
- hygiene and safety.

3.2 Health promotion and health status

Health promotion

Respondents were asked to indicate whether they had heard of two HEA initiatives – the earlier *Look After Your Heart* (LAYH) campaign and HAWNHS. While 15% of respondents reported that they had heard of LAYH, awareness of HAWNHS was slightly higher, with 29% of respondents claiming to have heard of it. Of respondents who know of LAYH, most also knew of HAWNHS (60%).

Reported levels of awareness vary considerably by staff group. Only 14% of medical and dental staff were aware of HAWNHS and even fewer (9%) were aware of LAYH. In contrast, 46% of senior and general managers were aware of HAWNHS. Approximately a third of the maintenance and works, ancillary, and nursing and midwifery respondents were also aware of HAWNHS. Figures are lower for LAYH; consistently less than half (36%) of general and senior managers had heard of it. The figures vary from 9% to 19% in the other staff groups.

Health status

Respondents were asked to rate their own health status over the past 12 months as 'good', 'fairly good or 'not good'. Two-thirds (65%) said that on the whole their health had been 'good', just under a third (31%) 'fairly good' and 5% 'not good'. These proportions are fairly similar across all staff groups, with the highest proportions rating their health as 'not good' being among maintenance and works staff (8%).

Self-reported health status matches reasonably closely with self-reported sickness absence from work. That is, 83% of those who rated their health as 'not good' had been off sick at least once in the previous six months. In comparison, 37% of those who rated their health as 'good' had been off sick.

Nearly one in five (18%) respondents indicated that they have a long-standing illness, disability or infirmity although, as stated in the previous chapter, only 1% of respondents were registered disabled. Of those with a long-standing illness or disability, just over half (56%) indicated that it sometimes limits their activity at work in some way; 48% of those with a long-standing illness, disability or infirmity had been absent from work in the previous six months compared to 44% of those who had no such illness or disability.

Body mass index

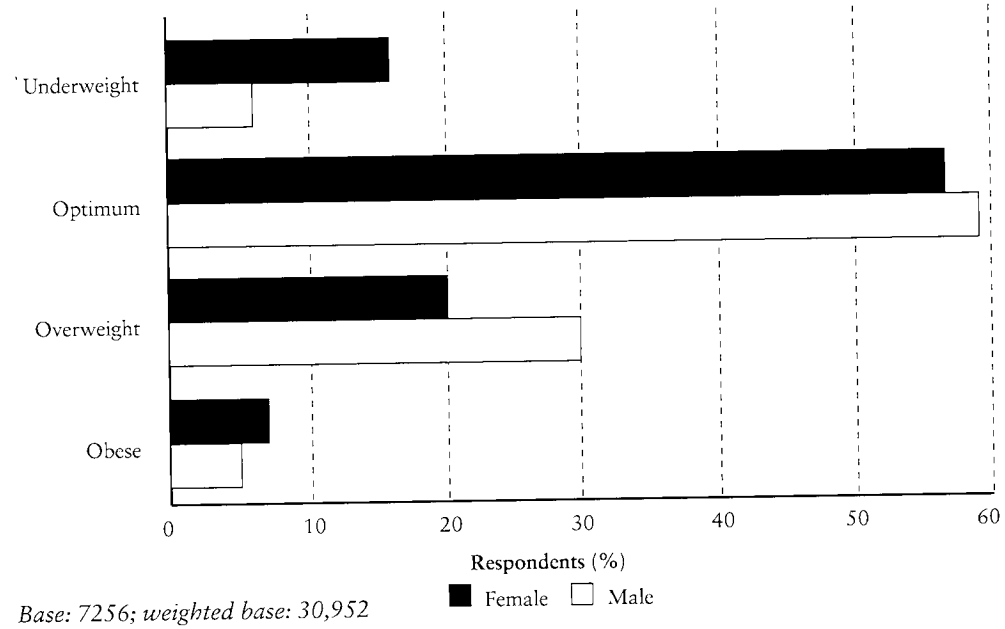
The standard Office for National Statistics (ONS) body mass index (BMI) was calculated for each respondent who provided details of their weight and height. The BMI is an expression of the ratio of weight to height, where the body weight in kilograms is divided by the square of the height in metres (W/H^2). This ratio is used widely and represents the current approach to estimating body fat in clinical practice and nutritional surveys. The BMI is usually presented in four categories as follows:

Descriptor	**BMI**
underweight	20 or less
optimum	over 20 to 25
overweight	over 25 to 30
obese	over 30

Being overweight is associated with raised blood pressure, raised blood cholesterol, and decreased physical activity. It is widely recognised as a major factor in coronary heart disease.

Figure 3.1 shows that over half (57%) of staff were of optimum weight. Almost a quarter (20% of women and 30% of men) responding to the survey were overweight. In addition, some 7% of women and 5% of men were obese. Additionally, 16% of women and 6% of men were classed as underweight.

Figure 3.1 Body mass index by sex



Base: 7256; weighted base: 30,952

Source: IES Survey, 1997

Table 3.1 shows the variation in the proportion of staff who were classed as overweight or obese by staff group. Over half the respondents (57%) said that they have *tried* to lose weight in the last 12 months, and two-thirds (65%) that they *plan* to lose weight in the next 12 months. The proportion planning to lose weight rises with their BMI category, so that 95% of obese respondents and even 18% of those who were underweight, planned to lose weight.

Table 3.1 Staff group by body mass index

Staff group	*Underweight*	*Optimum*	*Overweight*	*Obese*
Medical and dental	12.0	60.4	25.8	1.8
Nursing and midwifery	15.8	56.8	19.8	7.6
PAMs	19.0	59.5	15.5	5.9
Ancillary	9.7	50.8	30.1	9.5
Maintenance and works	2.4	57.3	33.5	6.8
Administrative and clerical	13.0	59.5	22.0	5.5
Scientific, professional and technical	15.7	58.3	20.5	5.5
General and senior managers	10.8	58.4	24.1	6.7

Base: 7200; weighted base: 30,773

Source: IES Survey, 1997

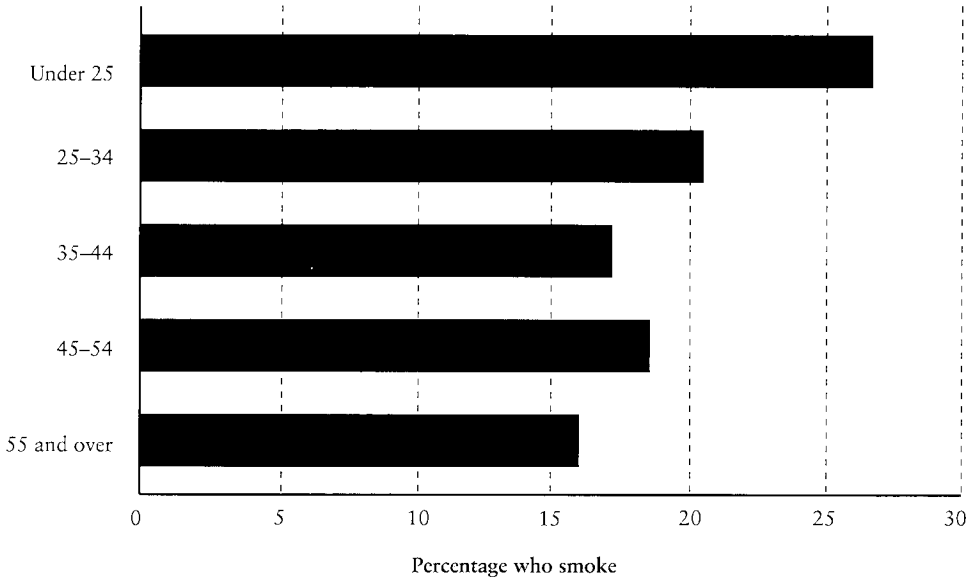
3.3 Smoking

Smoking behaviour

Just under one in five (19%) respondents reported that they were currently cigarette smokers. The figure for men was 22%, compared with 19% for women.

Figure 3.2 shows smoking behaviour by age group. The under 25 age group reported the highest proportion of smokers and the over 55 group the lowest.

Figure 3.2 Smoking behaviour by age group



Base: 8047; weighted base: 35,109

Source: IES Survey, 1997

Table 3.2 shows that the prevalence of smoking varies by staff group, the highest incidence being among ancillary staff (31% smokers) and nursing and midwifery staff (21% smokers). In contrast, only 9% of the PAMs respondents smoked.

At the end of May 1993 the NHS implemented a policy directive aimed at making the NHS smoke-free. Despite this, nearly three-quarters (72%) of the current smokers reported that they smoke at work. In all staff groups, except for PAMs, the majority of smokers reported that they smoke at work. Further analysis shows that the majority (63%) of workplace smokers actually smoked in 'designated areas'. Just under a third (30%) reported smoking outside hospital buildings and 15% of respondents reported smoking 'in the staff room'.

Table 3.2 Incidence of smoking by staff group

Staff group	*Percentage*
Medical and dental	10
Nursing and midwifery	21
PAMs	9
Ancillary	31
Maintenance and works	28
Administrative and clerical	18
Scientific, professional and technical	14
General and senior managers	19

Base: 8124; weighted base: 34,963

Source: IES Survey, 1997

Consumption of cigarettes

The *General household survey, 1994*[4] classifies individuals who currently smoke as follows:

- light smokers – fewer than 20 per day
- heavy smokers – 20 to 29 per day
- very heavy smokers – 30 or more per day.

Using this classification and the self-reported consumption figures in the IES survey, the majority (79%) of smokers in these Trusts can be described as 'light smokers', with 18% 'heavy' and a further 3% 'very heavy' smokers. Analysis by sex reveals that over a third of the male smokers (35%) can be classed as 'heavy' or 'very heavy' smokers, compared to fewer than a fifth of the female smokers (16%).

Smokers consumed on average 11 cigarettes on working days and 13 cigarettes on non-working days. However, this average disguises a considerable range in smoking levels, with a maximum reported figure of 90 cigarettes per working day and 98 per non-working day. The heaviest smokers were those in the maintenance and works staff group, who averaged 17 cigarettes on working days.

Health consequences of smoking

Two in five (41%) of respondents reported that they are 'very' or 'quite' worried about the effects of other people's tobacco smoke at work on their health. The level of concern is greatest among maintenance and works staff where over half (52%) were concerned about passive smoking.

Over half (58%) of current smokers responding to the survey indicated that they thought smoking had little or no effect on their health. Only 4% thought that it affects their health 'a great deal' and 27% 'a fair amount'; 12% of current smokers said that they do not know if smoking affects their health.

Nine per cent of 'very heavy' smokers and 7% of 'heavy' smokers felt that smoking affects their health 'a great deal'. Half of these smokers indicated that smoking has little or no effect on their health. Over half (60%) of 'light' smokers believed that smoking has little or no effect on their health.

Smoking cessation

Fewer than two in five (39%) of current smokers reported that they have 'seriously' *tried* to give up smoking in the last 12 months. The proportion who had tried to stop smoking varies a little by age. One-third (34%) of those aged 45 years and over had tried to give up in the last 12 months, compared to 40% of those aged under 45.

Of the current smokers 50% said that they *plan* to give up over the next 12 months. The proportion of female respondents planning to give up was slightly higher (51%) than male respondents (49%). The proportion who planned to stop smoking varies by age; 54% of those aged under 45 planned to give up, compared to 40% of those aged 45 and over.

Of the 'heavy' smokers and 'very heavy' smokers who responded, 39% and 40% respectively said that they have *tried* to give up smoking in the last 12 months; 45% of 'heavy' smokers and 47% of 'very heavy' smokers reported that they *plan* to give up in the next 12 months, and 55% of 'light' smokers also planned to give up in the next 12 months.

3.4 Alcohol

Alcohol consumption

Nine out of ten staff (88%) reported that they drink alcohol. Those that do drink alcohol were asked to indicate how many drinks, from a list of different types, they had consumed in the previous seven days. Data from those who had consumed alcohol in the past week were converted into standard alcohol units.

The *General household survey, 1994*[4] groups individuals who drink alcohol into the following consumption categories:

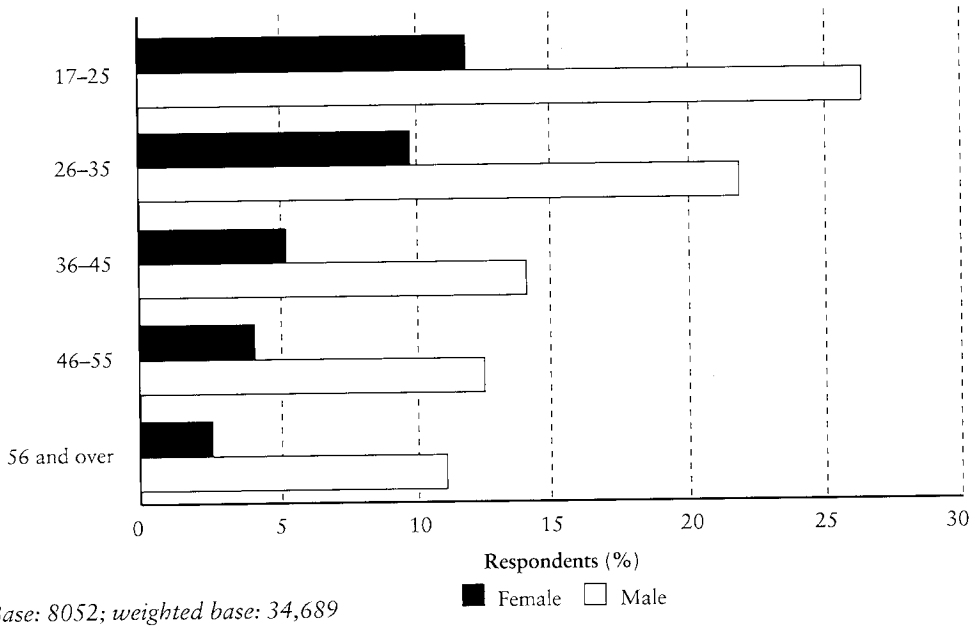
Descriptor	*Men (units per week)*	*Women (units per week)*
Very low	fewer than 1	fewer than 1
Low	1–10	1–7
Moderate	11–21	8–14
Fairly high	22–35	15–25
High	36–50	26–35
Very high	more than 50	more than 35

One of the aims of *The Health of the Nation* is to reduce the number of adults drinking in excess of the weekly recommended levels. Its target is 'to reduce the proportion of men drinking more than 21 units of alcohol per week from 28% in 1990 to 18% by 2005, and the proportion of women drinking more than 14 units of alcohol per week from 11% in 1990 to 7% by 2005'.

Over three-quarters (79%) of women respondents who had an alcoholic drink in the past week and over half (62%) of the men fall into the 'very low' or 'low' consumption categories. However, 7% of women respondents and 17% of men reported consumption in excess of the sensible drinking levels (that is in the 'fairly high', 'high' or 'very high' categories).

Analysis by age and sex shows that alcohol consumption decreases with age. Figure 3.3 shows the percentage drinking above sensible limits by age group and sex.

Figure 3.3 Respondents exceeding sensible drinking units by age and sex



Base: 8052; weighted base: 34,689

Source: IES Survey, 1997

It is well known that self-reported drinking levels tend to produce much lower alcohol consumption figures than excise data. The main reason for this is a tendency for people, especially heavy drinkers, to underestimate their own consumption and for higher non-response rates among heavy and problem drinkers. Nevertheless, such surveys are useful for observing behaviour among different population groups (age, gender, occupation etc.).

The recorded average alcohol consumption of 6.5 units per week is lower than the national adult average of 10.6 units reported in the 1994 *General household survey*[4] and the 12.4 units reported in *Health in England 1995*[5]. The mean number of units varies considerably by sex, with men consuming 12.5 units per week, compared with 4.7 units for women. The mean number of units also varies by staff group, with managerial staff having the highest average (10.3 units) followed by medical and dental (9.7 units) and maintenance and works staff (8.9 units). Lowest averages were found among ancillary staff (5.1 units) and administrative and clerical staff (5.3 units).

Alcohol and workplace stress

Nearly one-third (32%) of respondents reported that they sometimes drink more than they would otherwise because of stress resulting from their work. Responses to this question vary considerably by staff group: 47% of general and senior managers and 40% of medical and dental staff reported drinking more because of workplace stress, as did 36% of nursing and midwifery staff. For all other staff groups, the proportion is less than one-third.

Alcohol and health

Respondents were asked to indicate the extent to which they think the amount they usually drink might affect their health (either now or in the future). The vast majority (88%) indicated that the amount they drink would have hardly any or no effect on their health. It is interesting to note that the small number of individuals who felt that the amount they drink would affect their health 'a great deal' were mostly drinking within the sensible limits, while nearly two-thirds, (63%) of those exceeding the sensible levels said that the amount they drink has no, or hardly any, effect on their health.

Reducing consumption

Around 15% of respondents who drink reported that they have seriously *tried* to cut down the amount of alcohol they drink in the last 12 months. Overall, 16% reported that they *plan* to cut down on the amount of alcohol they drink in the next 12 months.

Among those drinking in excess of sensible limits, 28% of women and 44% of men said they plan to reduce their alcohol consumption.

3.5 Exercise

Activity levels

Physical activity has been shown to help reduce obesity, blood cholesterol and blood pressure, and to reduce the risk of coronary heart disease. Improvements in fitness and cardiovascular health depend on the intensity, duration and frequency of activity. The optimum level of physical activity for conferring protection from coronary heart disease has historically been defined as activity which is regular (three or more times a week), intense (40 to 60% of maximal capacity) and of at least 20 minutes' duration per session.

New guidelines recognise the health benefits of frequent, moderate, activity levels. The *5 by 30* prescription, that is, moderately intense activity of 30 minutes' duration or more at a frequency of five or more days per week, is recommended to achieve health benefits related to minimising mortality. This is intended to complement the previous *3 by 20* recommendations for vigorous intense activity lasting 20 minutes or more, at least three times a week, which is aimed at maximising aerobic fitness.

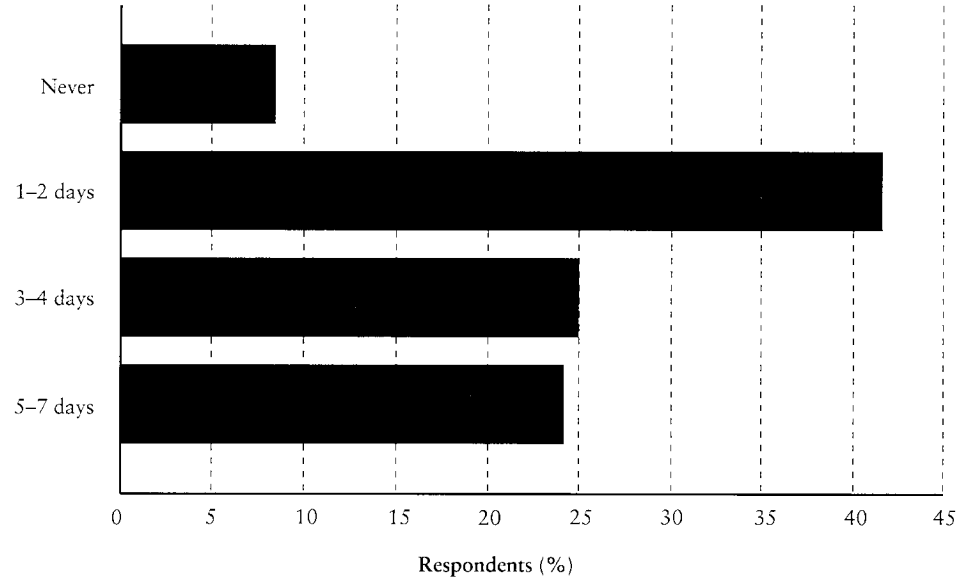
One-fifth (22%) of respondents indicated that, in terms of physical effort, they think that their work is 'very demanding' and a further two-fifths (43%) rated their work as physically 'fairly demanding'. Similarly, over half the staff (63%) indicated that they have to lift (21%), or lift and carry (42%), items (including people) which they find heavy.

One-third (33%) of respondents thought that they get enough exercise to keep fit. However, fewer actually meet the recommended levels of moderate activity. Figure 3.4 shows the distribution of staff by the number of days on which they take moderate physical activity (including activity during the course of work) in an average week. Just under a quarter (24%) of respondents meet the current recommendations on moderate exercise. Analysis by staff group shows considerable variation. Only 17% of medical and dental staff meet the recommendations on moderate physical activity, compared to 34% of maintenance and works staff.

However, the picture is less clear when energetic activity levels are examined. Of respondents 17% indicated that they take energetic physical exercise at least three times a week. Maintenance and works staff reported the highest proportion (24%) taking sufficient exercise to maximise aerobic fitness compared to 15% of respondents in the nursing and midwifery and administrative and clerical staff groups.

On both measures, levels of activity were higher for men than for women. A higher proportion of men reported three or more periods of energetic physical activity (22%) and five or more periods of moderate physical activity (25%), compared with women (15% and 24% respectively).

Figure 3.4 Frequency of 'moderate' physical activity



Base: 8286; weighted base: 35,529

Source: IES Survey, 1997

Analysis by age shows that almost a quarter of respondents in all of the age bands took sufficient exercise to meet the minimum recommended moderate exercise level. In terms of energetic physical exercise, there is a decline in the proportion reporting three or more occasions per week from 23% of those aged under 25 years to 13% of the 45 years and over age group.

Analysis by other health and lifestyle variables shows no particular differences. For example, the proportion of smoking and non-smoking respondents who meet the minimum moderate physical activity level is similar; BMI categories also display minimal differences. There are no significant differences in activity levels by employment characteristics (such as day/shift working and full-/part-time hours).

Exercise intentions

Nearly two-thirds of respondents (63%) reported that they have seriously tried to take more exercise in the past 12 months. More than three-quarters (77%) of these did not currently meet the recommended minimum level of moderate physical activity. Similarly, more than three-quarters (78%) of respondents planned to take more exercise in the next 12 months. Of these, 80% did not currently take the minimum recommended; this compares with 65% of those respondents who did not plan to take more exercise in the next 12 months.

3.6 Health status and lifestyle comparisons with other data

The findings in the preceding sections can be compared with other published health and lifestyle data such as the HEA's *Health in England 1995* report (HiE)[5] which investigates similar topics. Additionally, there is also the *National Fitness Survey* (NFS)[6] conducted in 1990 for both the HEA and the Sports Council which discusses body mass index within the population. 'The results of the HAW study are now compared with the findings from these sources.

When considering these comparisons, it should be borne in mind that the other surveys were intended to represent the *whole* population, whereas the HAW survey was only dealing with those that are employed. The influence of being employed on attitudes to health and on available time and income should not be overlooked. It has been possible to correct the external data to exclude people over 65 years so that only those of working age are considered.

Overall the health service workers in the HAW study appear to have healthier lifestyles. The key dimensions are described below.

View of own health

Describing their own health, 5% of NHS staff said that it was 'not good' compared to a similar figure in the HiE report who felt that their health was 'bad' or 'very bad'. In both samples this did not vary by gender.

Smoking

In the HiE survey 28% of employed respondents smoked compared with the lower figure of 19% of NHS employees. The difference is maintained when gender is considered – 26% of the general female population were estimated to be smokers in the HiE report compared with 19% in the HAW study. Similarly, among men, 29% in the general population smoked compared with 22% among NHS staff. All age groups in the HAW study have fewer smokers, especially among those aged under 25 years (27% compared with 42% in the HiE report). Nationally, 23% of women reported being 'heavy' to 'very heavy' smokers, compared with 16% in the HAW sample. For men this figure was 35% in both studies.

Alcohol consumption

Of NHS staff 12% reported that they did not drink alcohol while 7% in the HiE study claimed not to do so. In both reports the figures differ by gender: 95% of men in the general population reported consuming alcohol compared with 89% among male hospital workers. For women the pattern is the same, since 92% in the HiE study reported drinking alcohol compared with 88% among female health employees. Those drinking beyond moderate levels, based on the definitions used at the time of the research, were 7% of women in the HAW

study compared with 17% in the HiE report and 17% of male health staff compared with 32% in the general population.

Exercise and activity levels

Those in the NHS sample, according to self-reports, were less likely to be achieving enough activity to minimise mortality than people generally. One in four NHS staff was reaching this level compared with an estimate of one in three for the overall population. The difference is greatest for men with 41% in the HiE report attaining this level, but only 25% of male hospital staff. The figures for women are closer, with 24% in the HAW report compared with 30% in the HiE research.

Interestingly, when activity to maximise aerobic fitness is considered, the NHS staff had higher proportions attaining these levels, 17% compared with 12%. Twice as many female NHS workers reached aerobic fitness than women generally, that is 15% compared with 7%. For men the figures are much closer, with 19% in the HiE study and 22% in the HAW population.

Examining the data by age group shows a similar pattern with all groups having a lower proportion achieving enough activity to minimise mortality among health staff, but for aerobic fitness NHS workers consistently reached higher levels.

Body mass index

The body mass index comparisons are made with the NFS, which show that a higher proportion of staff in the HAW study were at optimum weight, with 56% of women achieving this against 42% in the NFS. Of men in the HAW study 59% were of optimum weight compared with a general estimate of 47%. The HAW study shows that one in four women and one in three men were above their optimum weight, but that this is better than the national estimates of about half of all men and all women needing to lose weight.

Summary

Comparing the three sets of data has shown that the health and lifestyle of NHS employees in the HAW study, based on self-reports, is broadly favourable compared with that of the population in general. They smoke and drink less and fewer of them are overweight. However, they are less likely to be achieving exercise and activity levels which will minimise mortality but, within this, there is a significant proportion of men and women who are reaching activity levels that promote aerobic fitness.

3.7 Diet

The survey asked a number of questions about the respondents' eating patterns and diet.

Eating patterns

The majority (78%) of respondents indicated that a normal lunch (or equivalent meal on shifts) is a sandwich or snack, while 13% had a meal and 5% had nothing. These proportions vary somewhat by staff group, with staff in the ancillary, maintenance and works, and general and senior manager groups being more likely to have a meal.

Most respondents (59%) ate at their workplace, office or ward, with 24% using the staff canteen or restaurant, and 17% eating outside work altogether or making other arrangements.

One-third (34%) of respondents reported that they 'frequently' eat while working or take no meal breaks at all, with a further 40% saying that this happens occasionally. The proportion of respondents who frequently ate while working or did not take meal breaks is particularly high among general and senior managers (59%) and medical and dental staff (53%).

Healthy options and harmful diets

Asked about the choice of healthy food available for staff in their Trust, most respondents rated choice as 'satisfactory' (30%), 'quite good' (19%) or 'very good' (7%). However, 25% said it is 'quite poor' or 'very poor'. There was quite a range of responses by staff group, with 52% of medical and dental staff rating choice of food as 'satisfactory' or better, compared with over 60% of staff in the ancillary, maintenance and works, and administrative and clerical staff groups.

Respondents were also asked to indicate the extent to which they think their present diet or eating habits may be harmful to their health. The majority (54%) said 'not at all harmful' with 31% responding 'quite harmful' and 2% 'very harmful'. Thirteen per cent did not know how harmful their diet or eating habits might be. The proportions who thought their diet was harmful vary by staff group, being highest among nursing and midwifery staff (43%) and medical and dental staff (38%).

Changing diets

Almost three-fifths (58%) of respondents reported that they have *tried* to change their diet in the last 12 months and 55% that they *plan* to change their diet in the next 12 months. Further analysis shows that 60% of female respondents planned to change their diet compared with 39% of male respondents. Similarly, 69% of female respondents planned to lose weight compared with 52% of men.

3.8 Working conditions

This final section is concerned with health and safety hazards and unpleasant working conditions. Respondents were asked to indicate the extent to which particular hazards and working conditions caused them a problem in their job. The five-point scale used ranges from 'not at all' through to 'a considerable extent'. A list of 19 hazards and unpleasant working conditions was presented and respondents could list other hazards if they wanted to.

A number of hazards or unpleasant working conditions were of 'considerable' concern to more than 10% of respondents. These are:

- air quality (26%)
- temperature (22%)
- risk of physical strain (22%)
- poor workspace (20%)
- sharps or needlestick injury (17%)
- biological agents or infectious diseases (15%).

Additionally, well over half the respondents were concerned to a 'considerable extent' or 'some extent' by temperature (67%) and by air quality (65%). Just under half the respondents were concerned to a 'considerable extent' or 'some extent' by risk of physical strain (48%) and poor workspace (42%).

The extent to which staff were concerned about particular hazards or working conditions varies considerably by staff group. The particular concerns were as follows:

Staff group	*Hazard*	*% who were particularly concerned*
Medical and dental	sharps or needlestick injury	31%
	biological agents or infectious diseases	22%
Nursing and midwifery	physical strain	32%
	air quality	26%
	sharps or needlestick injury	23%
	temperature	23%
PAMs	air quality	28%
	physical strain	26%
Ancillary	physical strain	29%
	air quality	29%
	temperature	25%
Maintenance and works	physical strain	27%

Administrative and clerical *(This is the only group in which over 20% displayed considerable concern about workspace, eyestrain and RSI.)*	air quality	29%
	eyestrain	28%
	poor workspace	27%
	temperature	23%
	repetitive strain injury (RSI)	21%
Scientific, professional and technical	air quality	29%
	temperature	24%
	biological agents or infectious diseases	20%

Appendix 3 shows the proportion who were concerned to a 'considerable extent' for each hazard by staff group.

Those hazards or working conditions where the majority of staff were 'not at all concerned' are listed below (the percentage who said that they are 'not at all concerned' is indicated in brackets):

- working with colleagues under the influence of drugs or alcohol (91%)
- risk of RSI (67%)
- unsafe equipment or machinery (62%)
- X-rays or radiation (61%)
- risk of eyestrain (60%)
- risk of electrical hazards (58%)
- risk of fire or explosion (57%)
- risk of dangerous chemicals (54%)

3.9 Key findings

The findings on health status, lifestyle and working conditions reveal that:

- 29% of respondents had heard of the HAWNHS initiative. Lowest awareness was reported among medical and dental staff;
- two-thirds of respondents reported that their health had been good over the last 12 months. This view roughly matched levels of self-reported absence, although 37% of those who reported their health as 'good' had also been off sick in the last six months;
- using the ONS BMI, 57% of staff were of optimum weight. However, 27% of women and 35% of men were overweight (this includes those who were obese);
- 19% of respondents were currently cigarette smokers, 72% of whom reported that they smoke at work. Half planned to give up in the next 12 months;

- two in five respondents reported that they are 'very' or 'quite' worried about the effects of other people's tobacco smoke at work on their health, but 12% of current smokers said they do not know if smoking affects their health. Half the 'heavy' smokers in the study reported that smoking had 'little or no effect' on their health;
- just under 90% of respondents reported that they drink alcohol; 7% of women and 17% of men reported consumption in excess of the sensible drinking levels;
- 16% reported their intention to cut down their alcohol consumption in the next 12 months;
- one-third of respondents thought that they get enough exercise to keep fit. However, fewer actually meet the recommended levels of moderate activity. Over three-quarters stated their intention to take more exercise in the next 12 months;
- one-third of respondents reported that they 'frequently' eat while working or take no meal breaks at all. Over half intended to change their diet in the next 12 months.

4. Sickness absence

4.1 Introduction

This chapter reports the survey findings on staff sickness absence. The questionnaire asked respondents to report on the incidence, duration and cause of any non-attendance at work in the previous six months. The chapter is divided into eight sub-sections:

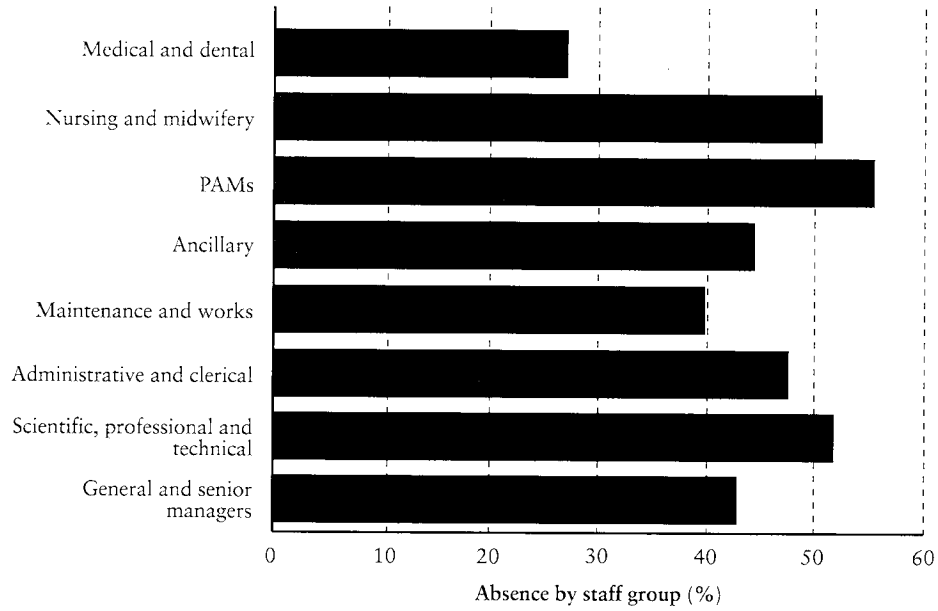
- incidence
- frequency and duration
- age and sex
- shift patterns and employment status
- kinship responsibilities
- workplace injuries and absences
- absence, health and lifestyle
- attitudes towards absence.

4.2 Incidence

A little under half (46%) of all respondents reported that they had been absent from work because of their own sickness or injury in the previous six months (excluding maternity leave).

Figure 4.1 shows some variation in the reported incidence of sickness absence by staff group. This ranges from less than three in ten (27%) medical and dental staff having time off compared with more than five in ten (53%) PAMs staff.

Figure 4.1 Percentage of respondents reporting time off work due to sickness absence/injury, by staff group



Base: 8164; weighted base: 35,165

Source: IES Survey, 1997

4.3 Frequency and duration

The majority (57%) of those respondents who have taken time off reported only one period of sickness absence in the past six months, with a further 27% being absent on two occasions.

The majority (68%) of reported absences were for five days or fewer, with 15% for one day, 21% for two days and 13% for three days. A small number of respondents reported absences of longer duration. For example, 5% were away for 20 working days or more on their last absence, and 0.5% were away for 100 working days or more.

The mean number of reported working days lost on the last absence occasion was nine. Mean absence values are, however, strongly influenced by the small number of very long absences. The overall average number of working days lost on the last absence occasion, using the median as a measure, was two.

4.4 Age and sex

Just under half (49%) the women had been absent from work compared with 37% of the men. The average (mean) number of days away on the last occasion was six for both women and men.

The incidence of absence appears to decrease with age. Of the youngest age group, 62% of those under 25 years and 52% of those aged 25 to 34 had been

absent compared with 44% of those aged 35 to 44, 40% of 45 to 54-year-olds and 32% of those aged 55 and over. However, the average (mean) number of days away on the last occasion tends to increase with age. The average days lost on the last occasion was six for the 25 to 34 age group and 12 for the over 55 age group.

4.5 Shift patterns and employment status

The survey shows a difference in the incidence of absence between those staff working full-time and those working part-time. Of full-time staff 48%, as opposed to 43% of part-time staff, were absent from work in the last six months.

Some differences in absence rates emerge according to the shift pattern of respondents. Thus 44% of staff working only nights reported absence in the last six months, compared with 51% of staff working a combination of earlies/lates/nights or 49% earlies/lates.

4.6 Kinship responsibilities

The questionnaire also asked respondents to indicate how many times, if any, they had been away from work because of someone else's sickness or injury, that is, they were absent through having to care for a child or relative. Overall, 7% of staff reported being absent as 'carers' in the previous six months.

The majority (81%) of those who were absent as carers were women. The incidence of absence for this reason was double for those working part-time than for those working full-time. The mean days away as a carer was four (with the most frequent period of absence being one day).

Half of those carers with dependent children, who reported being absent for this reason, said that the availability of childcare or parenting cover would have an effect on their absence.

4.7 Workplace injuries and absences

Nearly one in five (19%) respondents attributed one or more of their absences in the previous six months to injuries sustained at work or to the effects of their working conditions. Respondents were asked to provide details of any such injuries or working conditions. Four main types of response can be identified:

- cross-infection from patients (20%)
- back injuries (20%)
- workload (14%)
- stress (13%).

4.8 Absence, health and lifestyle

Analysis of absence by BMI shows very little difference in absence incidence among BMI groups. Less than half of most BMI groups reported absence in the last six months; the exception was the obese group where 52% had been absent.

Differences are apparent between the BMI groups in the duration of absence. Those that were underweight have a mean of seven days rising to 13 days for the obese group.

There is some difference between the sickness absence patterns of current smokers and those of non-smokers. Of current smokers, 53% reported being absent in the previous six months compared with 45% of non-smokers. On average the number of days of absence was slightly higher for smokers than non-smokers (that is nine days compared to eight). Among the population of current smokers there are also differences, as 56% of the 'very heavy' and 'heavy' smokers had been absent in the previous six months compared with 53% of the 'light' smokers. On average the number of days absent was higher for 'heavy' and 'very heavy' smokers (12 and 11 days) than for 'light' smokers (eight days).

4.9 Attitudes towards absence

Among the questions which respondents were asked about their attitudes towards working in their Trust were four which were specifically designed to elicit views about absence. They were included to help establish whether specific staff groups have different views or dispositions towards absence, and whether these views are linked to actual absence behaviour. The questions (which respondents were asked to rate on a five-point scale ranging from 'strongly agree' to 'strongly disagree') are:

1. *'I feel guilty about taking time off even when I am ill'*, with which 77% of respondents agreed or strongly agreed;

2. *'I could never stay off work if I wasn't really ill'*, with which 85% of respondents agreed or strongly agreed;

3. *'I feel entitled to take days off sick once in a while'*, with which 12% of respondents agreed or strongly agreed;

4. *'I often come to work when I should be off sick'*, with which 58% of respondents agreed or strongly agreed.

Several points emerge when the responses to these questions are analysed.

- Female respondents (81%) were more likely than male respondents (67%) to report feeling guilty about taking time off, even when ill. There are some differences in attitude between the age groups, with the tendency to feel guilty about taking time off decreasing with age: 80% of the under 25s compared with 70% of the over 55s reported feeling guilty. Variation is also apparent by staff group, with over 80% of medical and dental staff and

nursing and midwifery feeling guilty about time off when ill, compared with 63% of maintenance and works staff and 69% of ancillary staff.

- Slight gender differences appear when respondents were asked if they felt they could stay off work if they were not really ill: 86% of women and 87% of men indicated that they could not. However, there are increases in the numbers who could not stay off work if they were not ill from 79% among under 35s, to 88% for the 35 to 44 age group, to 92% for the 45s and over. There are no notable differences by staff group on this question, with over 80% of staff in all groups feeling unable to stay off work if not ill.
- When asked if they felt entitled to take occasional days off sick, there was a slightly greater (though not statistically significant) tendency for men to agree with the statement (13% compared with 11% among women). There are no major differences by staff group; less than 15% of staff in all groups felt that they are entitled to take occasional days off sick. The figure for general and senior managers was particularly low, at 7%.
- More women (60%) than men (54%) reported that they frequently come to work when are sick. This view was shared by 50% or more of all staff groups except for general and senior managers (46%). Nearly two-thirds of ancillary staff (65%) and maintenance and works staff (66%) reported that they come to work when they are sick. There are no notable differences by age.

The overall picture is of a workforce which is generally positively disposed towards attendance. Analysis has also been conducted to establish whether attitudes to absence are related in any way to self-reported absence.

Relationship between absence disposition and self-reported absence

This analysis confirms the view that the workforce of the participating Trusts appears not to be psychologically disposed to be absent. The following data support this view:

- those respondents who had a recent period of absence were more likely to report feeling guilty about having sick leave;
- this same group was no more likely to feel entitled to take occasional days of sick leave than those who had had no time off sick;
- those with a recent period of absence were more likely to report coming to work when they were sick.

4.10 Key findings

The key findings concerning sickness absence include the following:

- 46% of respondents reported that they had been absent from work in the last six months. Most of these reported only one period of absence;
- most respondents reported absences of five days or fewer;
- just under half the women, and 37% of the men reported a period of absence. The incidence of absence appears to decrease with age, though the average length of absence increases;
- 19% of respondents attributed one or more of their absences to injuries sustained at work or to the effects of their working conditions;
- respondents' attitudes towards absence suggest that the majority are positively disposed towards attendance.

5. Health at Work

5.1 Introduction

This chapter is concerned with the respondents' views on what steps their Trust could take to improve their HAW, and the extent to which they are satisfied with aspects of health promotion at work.

5.2 Improving HAW

Respondents were asked to indicate what actions their Trust could take to improve their HAW. A list of 19 possible actions was presented and respondents were asked to tick all those which they felt would be helpful to them personally. The actions ranged from aspects of work organisation (for example, 'introduce more flexible working hours') to health surveillance (such as 'provide work-based health screening for staff'). Respondents were also asked to indicate which of the items they had chosen were most important to them.

HAW actions

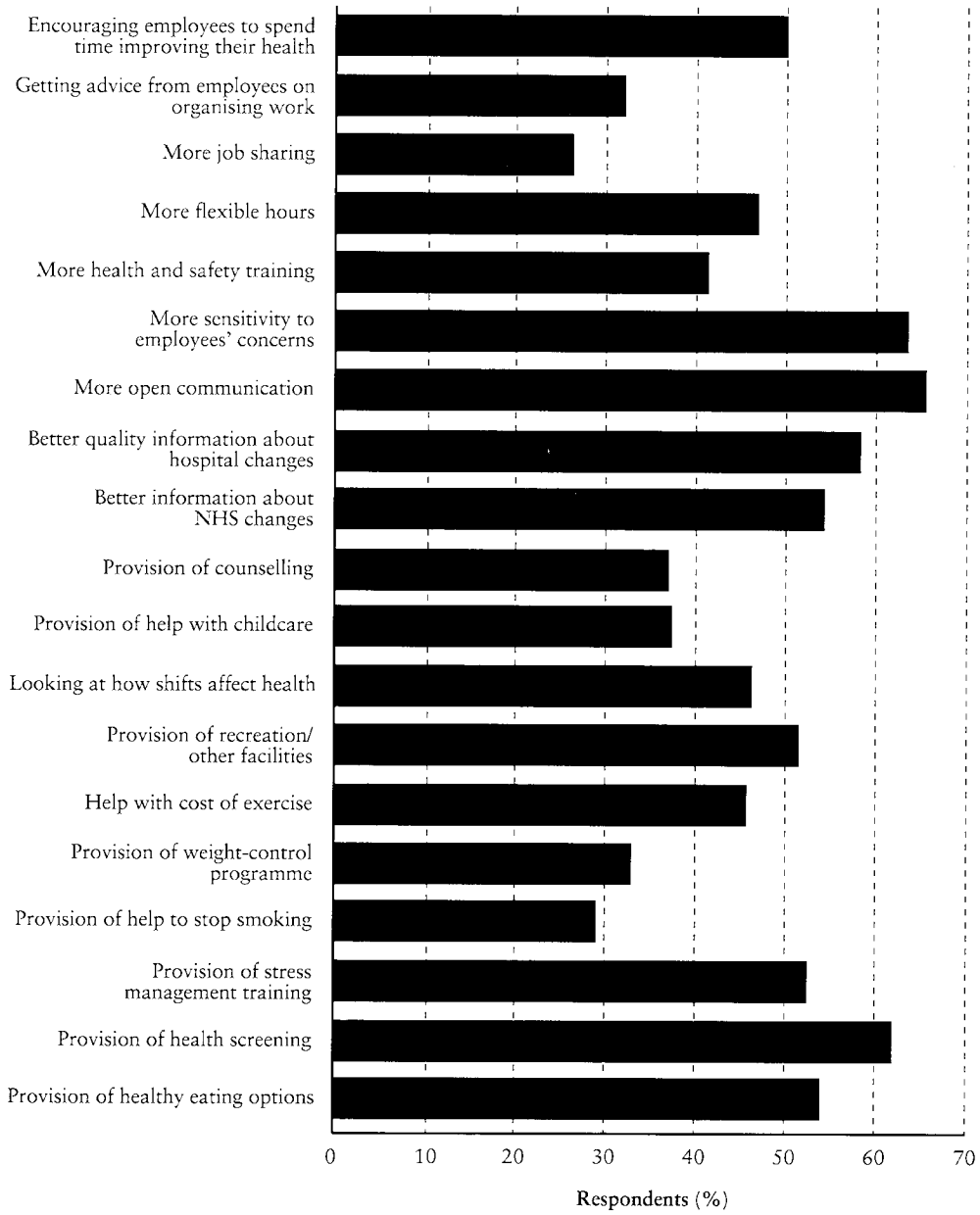
Figure 5.1 shows, for each action listed, the proportion of respondents who indicated that it would be helpful to them. Seven areas emerge as important to the majority of respondents:

- communicate more openly with employees (66%)
- train supervisors or managers to be more sensitive to employees' concerns (64%)
- provide work-based health screening for all staff (62%)
- provide better quality information about changes in the running of the hospital (58%)
- provide or support stress management training (53%)
- provide healthy eating options in restaurants/staff canteens (54%)
- give better information about changes in the NHS (54%).

Those items which comparatively few staff (that is under 30%) indicated would be helpful to them are:

- provide help to stop smoking (29%)
- introduce more job sharing (27%).

Figure 5.1 Percentage of respondents rating HAW actions as potentially helpful



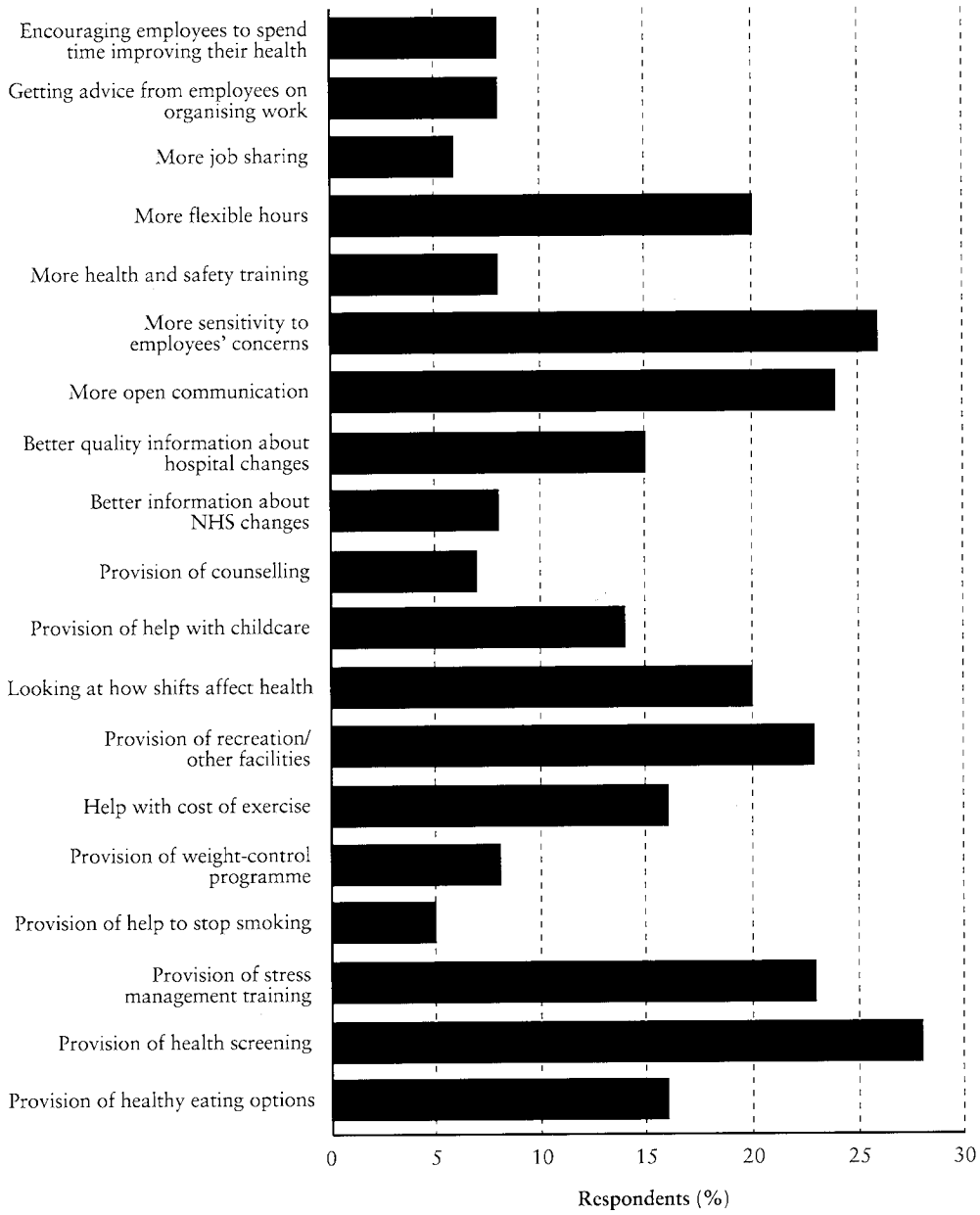
Base: 8351; weighted base: 35,853

Source: IES Survey, 1997

Staff priorities

Respondents were also asked to rank the three items of most importance to them personally. Figure 5.2 shows the results.

Figure 5.2 Most important improvements



Base: 8351; weighted base: 35,853

Source: IES Survey, 1997

Six priorities were identified by 20% or more of the respondents:

- provision of work-based health screening for all staff (28%)
- training of supervisors or managers to be more sensitive to employees' concerns (26%)
- more open communication with employees (24%)
- provision of work-based recreation or other facilities (23%)
- provision or support of stress management training (23%)
- looking at how current shift schedules affect employees' sleep and health (20%).

These priorities vary somewhat by staff group. For example, nursing and midwifery staff identified looking 'at how current shift schedules affect employees' sleep and health' as their top priority (34%), but this did not feature in the top three priorities of any other staff group. The provision of work-based health screening was the top priority for staff in the PAMs (35%), administrative and clerical (37%) and scientific, professional and technical (32%) groups, but was not in the top three priorities for medical and dental, nursing and midwifery and maintenance and works staff.

Some areas were seen as a priority by comparatively few (8% or fewer) staff:

- advice on organising work (8%)
- provision of counselling on personal, financial or other problems (7%)
- introduction of more job sharing (6%)
- provision of help to stop smoking (5%).

5.3 Attitudes towards health promotion

Respondents were asked how satisfied they were with a number of aspects of health promotion activity within their Trust.

Level of information given to staff

Most staff groups reported broadly neutral satisfaction scores on this issue, although scientific, professional and technical staff were somewhat less satisfied, and ancillary staff somewhat more satisfied, than other staff groups.

Involvement in planning health promotion activities

Overall, all staff groups were moderately dissatisfied with their involvement. Scientific, professional and technical staff were least satisfied.

Involvement in reviewing health promotion activities

Again, all staff groups were moderately dissatisfied, with the scientific, professional and technical staff group being least satisfied.

Priority given to staff health by hospital management

Again, all staff groups were moderately dissatisfied. The least satisfied groups were nursing and midwifery, scientific, professional and technical, medical and dental and PAMs staff. This is the area attracting least satisfaction overall.

Opportunities for training in HAW

Once more, all staff groups were moderately dissatisfied. The least satisfied groups were nursing and midwifery and scientific, professional and technical. Overall, these health promotion issues did not draw out from respondents any seriously negative views, although modest dissatisfaction prevailed, and scientific, technical and professional staff emerge as the most dissatisfied. However, the tendency towards neutrality by some staff groups on some of the questions might reflect a lack of awareness or, indeed, lack of interest.

5.4 Key findings

The key findings to emerge concerning improving HAW and attitudes towards health promotion are:

- six areas were identified by respondents as priority areas for the improvement of their health at work. These were centred on improving communication and management; less of a priority were issues of individual health and lifestyle;
- the training of supervisors or managers to be more sensitive to employees' concerns was also seen as a priority by more than a quarter of respondents;
- most respondents were moderately dissatisfied with most aspects of health promotion in their Trust. Ancillary staff were least dissatisfied and scientific, professional and technical staff the most dissatisfied.

6. Attitudes towards working in their Trust

6.1 Introduction

The purpose of this chapter is to present and discuss the views which respondents reported on a range of aspects of working in their Trust. The range of attitudinal questions which were asked in the questionnaire were intended to gather data on the following themes:

- attitudes towards working in their Trust itself;
- views on a range of general work satisfaction issues.

Results from the survey data will be presented on both themes for each of the main staff groups. The aim is to explore general levels of 'psychological well-being' among staff and to look in more detail at those factors influencing critical concerns such as job satisfaction, morale and occupational stress.

6.2 Working in their Trust

With such a large number of individual attitude questions in the questionnaire, the analysis has sought to categorise them into broad sets of factors or 'clusters' which reflect staff attitudes. Using standard statistical procedures, including cluster and reliability analysis (see Appendix 2 for technical data on these procedures), four clusters of attitudes have been constructed to examine staff attitudes to working in their Trust:

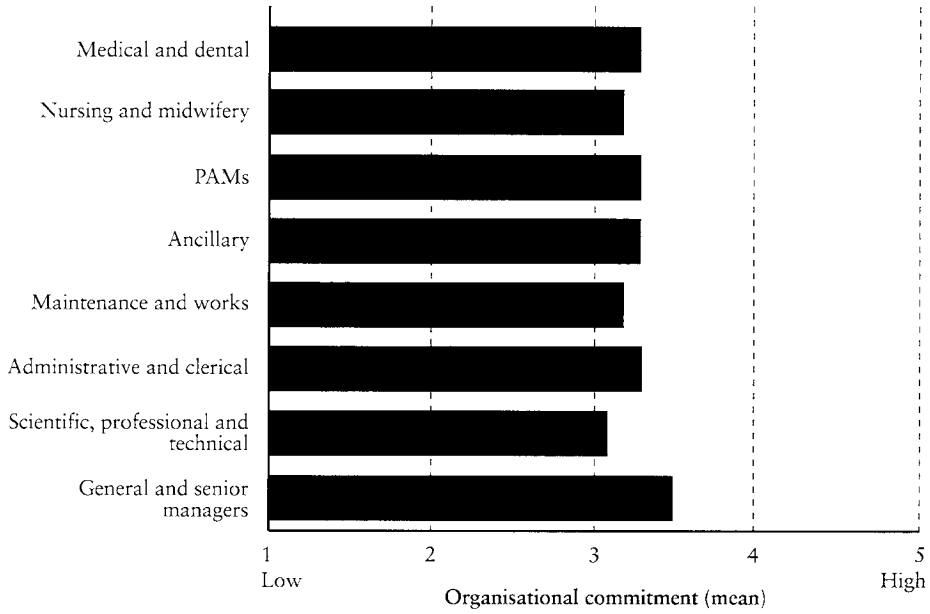
- organisational commitment – this reflects the degree to which individuals identify with the values of their Trust and have a sense of pride about working in it;
- openness – this is a measure of the extent to which staff feel the culture of their Trust is open, consultative and nurturing of free flow of information;
- stress – this is a measure of self-reported workplace stress which includes items on work pressure, 'resource adequacy' and procedural clarity;
- workplace support – this reflects the extent to which the respondents' immediate manager and close colleagues are felt to be supportive, sympathetic and approachable. Considerable research evidence exists to suggest that individuals who are happy with workplace support arrangements are better able to deal with workplace stress.

Data for each of these four clusters, analysed by staff group, are presented and discussed in the following sections.

Organisational commitment

Figure 6.1 shows mean organisational commitment scores for each main staff group. It is clear that respondents in each staff group reported moderate levels of commitment, loyalty and pride in their Trust. The group with the highest score was general and senior managers, with the lowest scores reported by maintenance and works and scientific, professional and technical staff. Further analysis suggests no significant gender differences on this issue, though good evidence that commitment levels increase with age.

Figure 6.1 Levels of organisational commitment by staff group



Base: 8118; weighted base: 34,988

Source: IES Survey, 1997

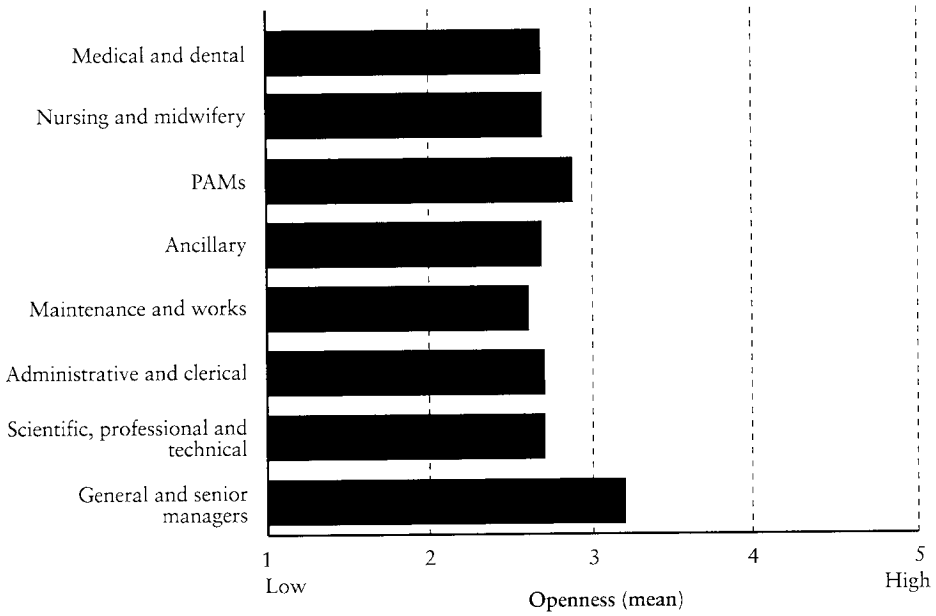
In terms of the psychological well-being of the workforce, these findings are broadly encouraging as they reinforce the view that staff are generally fairly well disposed towards working in their Trust and have some pride in being associated with its work.

Openness

Respondents in many staff groups (see Figure 6.2) produced broadly negative and neutral scores on the issue of openness within their Trust, with the exception of general and senior managers, who might be expected to report higher scores given their more ready access to information and their more direct control over both the culture and the information flows. Maintenance and works reported the lowest score. There are no gender differences on this issue, but some indication that negative perceptions decrease slightly with age.

These findings suggest that there is a gap between the perceptions of general and senior managers and all other staff groups on the issue of openness.

Figure 6.2 Levels of openness by staff group



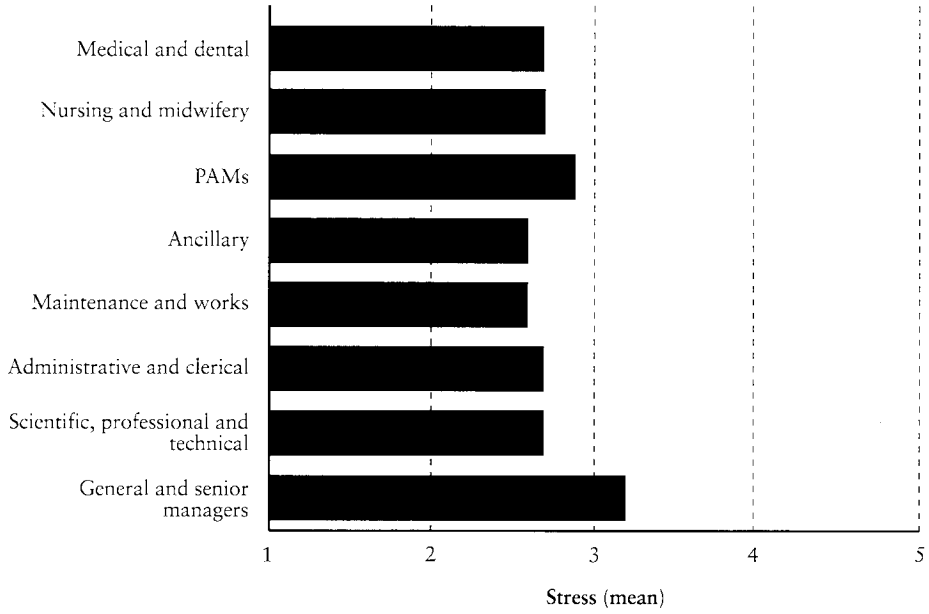
Base: 7993; weighted base: 34,523

Source: IES Survey, 1997

Stress

Self-reported stress levels were broadly neutral to low for all staff groups as shown in Figure 6.3. No groups stand out as reporting significantly higher levels of stress than others although general and senior managers and PAMs reported highest scores overall. Even so, these were around the scale mid-point. Lowest scores were among ancillary, and maintenance and works staff. No clear gender or age differences emerged in further analysis.

Figure 6.3 Levels of stress by staff group



Base: 7755; weighted base: 33,544

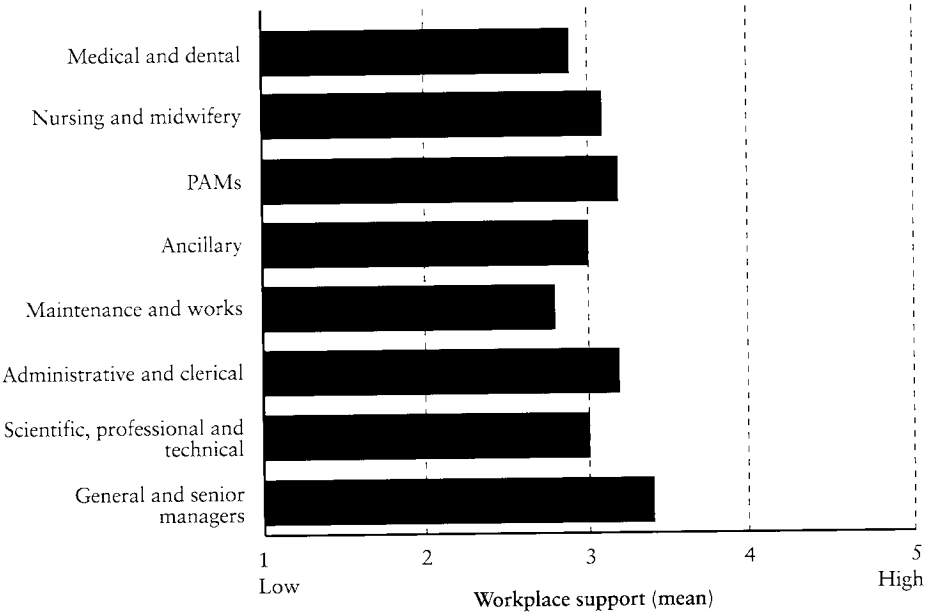
Source: IES Survey, 1997

It is not possible from these data to establish the extent to which the levels of stress reported are likely to cause problems of either psychological or physical health.

Workplace support

Figure 6.4 suggests that respondents in most staff groups were neutral or reasonably satisfied with the levels of support and recognition they get from their immediate managers and colleagues. General and senior managers reported the highest levels of satisfaction on this cluster. Maintenance and works and medical and dental staff were least satisfied. Overall, female respondents reported the same levels of satisfaction as their male counterparts. There is very little difference among age groups.

Figure 6.4 Levels of workplace support by staff group



Base: 7992; weighted base: 34,475

Source: IES Survey, 1997

Other questions

Two questions were asked in this section (also using a five-point scale) which have not been included in the attitude clusters reported above. These were both on the topic of job security: *'I worry that I am going to be made redundant'* and *'The NHS will continue to provide me with a secure job for several years'*.

Table 6.1 presents the mean scores on both these questions for each main staff group. It shows that medical and dental staff reported least concern over redundancy, while the most concerned groups were maintenance and works, ancillary, and nursing and midwifery, all of whom scored below the scale mid-point.

The only staff group reporting confidence that the NHS will provide a secure job for several years was medical and dental. All other groups expressed a level of disagreement, with general and senior managers and scientific, professional and technical staff reporting most concern.

Table 6.1 Mean scores by staff group*

Staff group	*I worry that I am going to be made redundant*	*The NHS will continue to provide me with a secure job for several years*
Medical and dental	3.39	2.68
Nursing and midwifery	3.04	3.36
PAMs	3.22	3.35
Ancillary	3.00	3.12
Maintenance and works	2.86	3.36
Administrative and clerical	3.17	3.19
Scientific, professional and technical	3.13	3.34
General and senior managers	3.03	3.40

**Low scores denote agreement with the statement*

Base: 8087 weighted base 34,870

Source: IES Survey, 1997

6.3 Work satisfaction

Again, the number of questions asked on this broad theme have lent themselves to further analysis and clustering. The clusters within which these data will be reported are:

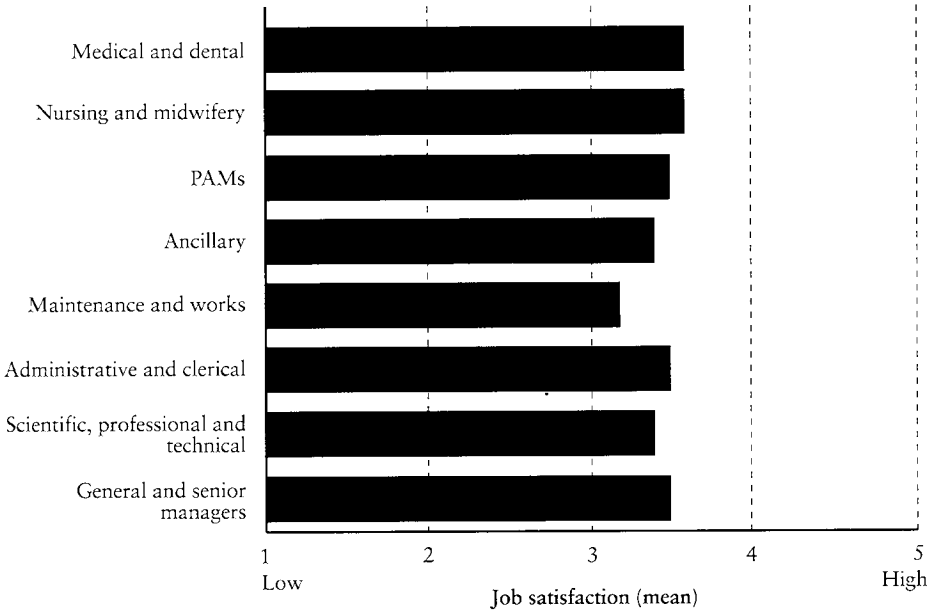
- job satisfaction – this reflects the degree to which respondents gain satisfaction, enjoyment and a sense of accomplishment from their jobs;
- career satisfaction – here respondents' feelings about career direction, career prospects and the degree to which they can influence their career development are collected;
- turnover intention – a measure of the degree to which respondents harbour an intention to leave their Trust.

Job satisfaction

As a general indicator, job satisfaction is usually a reliable measure of 'psychological well-being' among staff.

Figure 6.5 presents data on the levels of job satisfaction reported by respondents. All staff groups appeared to be satisfied with their jobs, with the highest satisfaction being expressed by medical and dental and nursing and midwifery staff. Maintenance and works staff reported the lowest levels of job satisfaction, although this group still scored well above the mid-point. Overall, satisfaction increases with age and women reported slightly higher levels of job satisfaction than men.

Figure 6.5 Levels of job satisfaction by staff group



Base: 8054; weighted base: 34,722

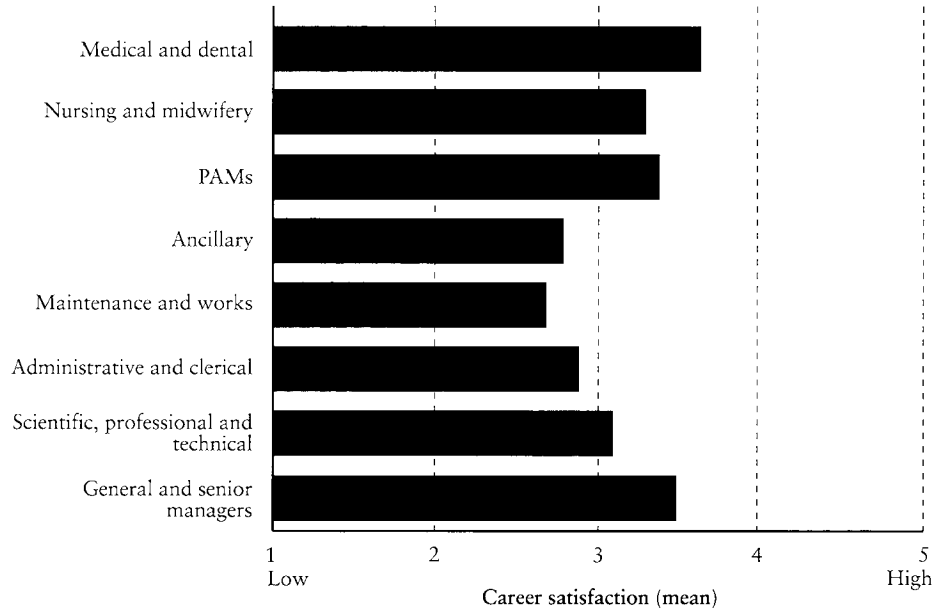
Source: IES Survey, 1997

Career satisfaction

The results of the survey for this cluster of questions, as shown in Figure 6.6, show considerable diversity among staff groups, revealing a divergence of views between those staff on professional career ladders and those in more explicit support roles. Thus, maintenance and works, ancillary and administrative and clerical staff reported markedly lower levels of career satisfaction than the other staff groups.

There is no gender difference in career satisfaction, although there is evidence that career satisfaction decreases slightly with age.

Figure 6.6 Levels of career satisfaction by staff group



Base: 8086; weighted base: 34,759

Source: IES Survey, 1997

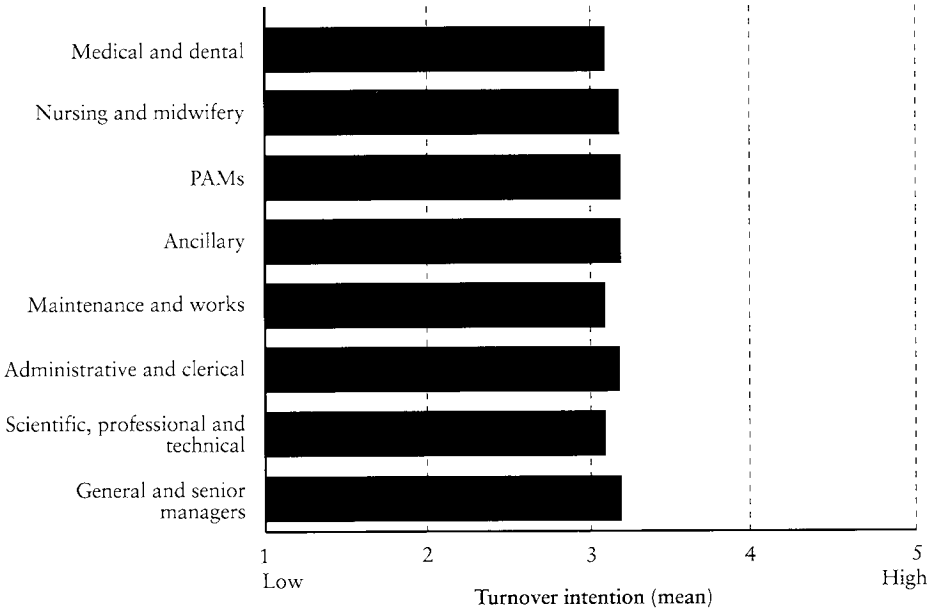
Turnover intention

As with job satisfaction, turnover intention has frequently been found to be a good general barometer of morale in organisations. In this instance, the data (see Figure 6.7) must be interpreted in the context of other factors, such as:

- the extent to which there has, in recent years, been low turnover owing to a depressed labour market, resulting in unusually high 'latent' turnover among staff;
- the extent to which the labour market is likely to become more buoyant in the next year or so;
- the extent to which those employees who have been dissatisfied and have wanted to leave, have been unable to do so because of reduced external opportunities.

These data show that there is very little difference in turnover intention between staff groups, although they all reported scores above the mid-point. Women reported very slightly higher intentions to leave than men and levels tend to increase slightly with age, until the oldest age group is reached, when leaving intentions decline.

Figure 6.7 Levels of turnover intention by staff group



Base: 8029; weighted base: 34,627

Source: IES Survey, 1997

6.4 Key findings

The main findings concerning attitudes to working in their Trust are:

- general and senior managers reported higher levels of satisfaction than other staff groups on most of the items, with maintenance and works staff consistently reporting lower levels of satisfaction;
- respondents reported a generally moderate level of commitment to their Trust, but lower levels of satisfaction with the degree of openness;
- neutral to low levels of stress were reported by most staff groups;
- most staff groups were neutral or moderately satisfied with levels of support and recognition in their Trust;
- maintenance and works and ancillary staff expressed particular concern over the possibility of redundancy;
- moderate to high levels of job satisfaction were reported by most staff groups, together with moderate levels of career satisfaction by professional groups;
- moderate levels of leaving intention were reported by all staff groups.

7. Lessons from the survey

7.1 Introduction

This report has examined the employee surveys which form part of the HAWNHS research study. A second wave of surveys has been proposed for 1998 which would allow detailed comparisons to be made.

Conducting surveys in the 14 NHS Trust sites participating in this study has been both a major task and a significant opportunity for learning. This final chapter aims to summarise the key issues which have emerged. These reflections should not be taken as definitive research findings by themselves; rather, they serve to illustrate issues which the rest of the HAW study might reasonably be expected to take note of as it draws to a close. In addition, this chapter points ahead to areas on which the proposed second wave of opinion surveys might usefully focus.

The issues which will be discussed in this chapter are:

- the impact of organisational context
- physical and psychological well-being at work
- looking at sickness absence
- high risk groups and behavioural intentions
- the stress debate.

7.2 The organisational context

The planning, introduction and management of workplace health promotion initiatives cannot be viewed in isolation from their organisational context. From the evidence of our case study research it is clear that, in some NHS Trusts, the HAWNHS initiative represents little more than yet another national campaign where compliance is expected. In others, the HAWNHS iniative dovetails with a range of other processes which have been put in place to improve employee welfare and well-being.

There appear to be at least three facets of the organisational context which have particular impact on the penetration and prominence of workplace health promotion measures in the study sites.

The management of change

It goes without saying that all 14 of the sites in the study have been through (and continue to experience) significant changes in structure, culture and management processes. It appears that some sites have managed these changes more comfortably than others and that, in some sites, the changes have had more significant effects on staff than in others. The success with which Trusts have been able to manage change may also have had an impact on the extent to which health and well-being in the workforce is seen as a priority.

Organisational culture

This is a term being used more frequently in some NHS Trusts, often by senior managers who consider that certain aspects of culture are more (or less) closely associated with specific organisational characteristics. Thus, some have put emphasis on encouraging a 'performance-orientated' culture which stresses the measurement of outputs, individualisation of the employment relationship, high workforce commitment and devolution to line managers.

The strength of this 'push' towards cultural change may, in part, help explain variations in the priority given to health promotion interventions in Trusts and the extent to which these interventions appear to be integrated into a coherent approach to managing the workforce.

Senior management commitment

This aspect of the organisational context is frequently cited as being central to the success, or otherwise, of workplace health promotion. Again, the study sites represent a wide range of experience on this dimension. In some, chief executives and members of Trust boards show a keen interest in HAW and give it their personal endorsement. In others, HAW activity takes place in a Trust, probably without the chief executive being any the wiser. However, it seems that endorsement or knowledge by the chief executive may be a necessary, but not sufficient, condition in the success of health promotion. It seems that commitment often needs to be a stage on from endorsement. More than one of the study sites has very public chief executive endorsement for the HAWNHS initiative, while at the same time no financial support has been forthcoming to help fund specific health promotion activity.

The results of the surveys reflect the variety of trust-specific circumstances which have been in operation during the study to date. Some of the findings reflect frustration or satisfaction with the way change, and communication about change, has been managed. Others suggest that some employees are concerned about the extent to which senior managers take account of the impact of change on the workforce.

All these factors form only part of a complex backcloth against which the operation of the HAWNHS initiative must be assessed. Other elements of the evaluation study will need to probe these issues further in order to gain a clearer

understanding of how the organisational context has impact on the move towards a healthier workforce in the NHS.

7.3 Physical and psychological well-being at work

One of the clearest messages from these survey findings is the importance of distinguishing between the concepts of physical and psychological well-being in the workplace. This is a distinction which is, of course, acknowledged by the HEA and the HAWNHS initiative itself. However, apart from a number of trust-level initiatives on workplace stress, it is not a distinction which appears prominently in the health promotion plans of many Trusts. Yet a strong message from staff in all the Trusts in the study is that psychological well-being is, for them, at least as important a consideration as physical well-being. In some sites it might be argued (with some justification) that this emphasis is, in part, a reaction to change.

This finding may have at least two important ramifications for the management of health promotion:

- an approach which comprises only a series of initiatives aimed at changing lifestyle and improving physical health might be seen by some staff groups as failing to address their key health concerns (and, indeed, those which most directly affect their performance and their attendance at work);
- health promotion initiatives which are closely integrated with broader human resource (HR) and 'business' strategy might have better medium-term prospects of bringing about sustainable change in workplace health.

The issue of 'psychological well-being' is, of course, potentially an elusive one and it would be understandable if some Trusts were tempted to consign it to the 'too difficult' pile and concentrate instead on smoking cessation and weight-loss programmes. Evidence from this survey suggests that this response is unlikely to address many of the broader health concerns of staff.

The next publication in this series looks directly at the organisation of workplace health programmes and the factors which have facilitated and inhibited their development in Trusts.

7.4 Looking at sickness absence

One of the factors that many managers in the NHS cite as central to their concerns in the field of health promotion is the level of sickness absence among some staff groups. Changes in Statutory Sick Pay (SSP) regulations have made high levels of sickness absence more expensive for employers. In addition, high sickness absence can also have an impact on the quality and continuity of care. Given that sickness absence is also seen as one of the more readily measurable indicators of workplace health, it is unsurprising that it is at the centre of the 'business case' which many Trusts make for involvement in workplace health promotion activity.

The survey has looked in some detail at self-reported sickness absence among respondents. These data suggest that at least four facets of sickness absence are worthy of further study.

Incidence

Since less than half of the survey respondents account for all the self-reported sickness absence in the survey across all sites, it would seem important to examine the characteristics of those who have been absent compared with those who have not.

Frequency

Some respondents reported frequent, but short, bouts of sickness absence. Further analysis might shed light on the factors which affect such patterns of absence.

Duration

The survey results suggest that certain aspects of employee lifestyle (such as smoking and alcohol consumption) may have more impact on the duration of absence than on its frequency. If sickness absence is to be used as a criterion measure for the effectiveness of health promotion activity, this facet of absence might be worthy of further analysis.

Disposition

Although some managers might believe that some sickness absence can be attributed to negative attitudes towards attendance by some staff groups, the survey results suggest that theories about an absence 'culture' might have no factual basis.

Sickness absence is not necessarily a straightforward indicator. Other IES research for the HEA has found little consistency in the measures of sickness absence being used in the NHS.[6,7] In addition, the role of shift-working, domestic and caring responsibilities also needs to be taken into account.

Forming a clear view about the nature and causes of sickness absence will help managers to assess how much they can realistically expect to influence it through the introduction of health promotion initiatives.

7.5 High risk groups and behavioural intentions

Some of the most directly useful data in the surveys are those which identify staff groups who both:

- have health or lifestyle patterns which put them at particular, or multiple, risk; and
- express an intention to modify their health or lifestyle within the next 12 months.

Of course, these two groups may not overlap (indeed, some of our data suggests that a good proportion of those intending to change are in lower risk groups). However, if Trusts have limited resources for health promotion, it could be that targeted action which seeks to have impact on high risk staff groups might bear most fruit.

It is not clear from the survey data whether the expressed intentions to change lifestyle are likely to result in tangible changes – some degree of response bias in these data must be assumed.

7.6 The stress debate

The issue of workplace stress has become a major research topic in its own right. With legal cases against employers raising awareness of their responsibilities in this respect, case study evidence suggests that most Trusts in the study are active in understanding, and seeking to manage, the causes and effects of stress.

The surveys are interesting for both what they *do* and *do not* tell us about stress. On one hand it is clear that no single staff group stands out as having higher (or, indeed, lower) levels of self-reported stress than any other. On the other hand, none of the levels reported appears particularly high. This could be for a combination of reasons:

- the sources of stress across staff groups are different (for example, for junior doctors they may be skewed toward workload issues, while for ancillary staff job security may be a concern;
- levels of stress may be higher among certain groups of individuals, but these may have been 'smoothed' by being aggregated into an overall measure of stress, analysed by staff group;
- the measure of stress used in the questionnaire is not a clinical indicator, rather, it emphasises aspects of workload and feelings about the adequacy of resources.

Whatever the reason, it is clear that the issue of stress is likely to remain on the agenda. Indeed, 'stress management' ranks high among the health promotion initiatives suggested by survey respondents across all sites in the study.

7.7 The next steps

The surveys have provided a rich set of benchmark data which:

- allows the 14 Trusts involved in the study to reflect on, and plan, their priorities for the future;
- ensures a solid basis for comparative analysis if the proposed second-wave surveys are conducted;
- helps set the agenda for more detailed case study work during the rest of the evaluation project.

The remainder of the study will be well-placed to examine the impact on staff of a range of workplace health promotion initiatives and to further understanding of how such initiatives can successfully be introduced and sustained.

Appendix 1. The survey approach letter and questionnaire

HAMILTON HOUSE · MABLEDON PLACE · LONDON WC1H 9TX · TEL 0171 383 3833 · FAX 0171 387 0550

Dear NHS Colleague,

I am writing to ask for your help in an important initiative to improve the NHS as a place to work.

The HEA is supporting an initiative called 'Health at Work in the NHS'. Its aim is to ensure that, as an employer, the NHS promotes healthy workplaces and thereby contributes to the health and well being of its employees.

If we are to succeed in making the NHS a better place to work, it is crucial that we find out the views and experiences people working in the NHS. We have asked an independent research organisation -the Institute for Employment Studies- to find out the views of people who work in your hospital.

We have made considerable efforts to make sure the survey deals with the issues that really matter to people who work in the NHS. Among the organisations that we have consulted are the British Medical Association, the Royal College of Nursing and UNISON, all of which strongly support this study.

For this survey to be worthwhile, it is really important for you to complete and return your questionnaire. It will only take a short time and **everyone's** views are of interest and use to us. Anything you say will, of course, be completely confidential. The results of the survey will be used in making decisions about the best ways to improve working conditions in your hospital. If the people making these decisions are properly informed about the views and experiences of those who work there -people like yourself- it is far more likely that they will make the decisions you want.

I thank you for your help.

Jane Greenoak
Human Resources Director

WORKING FOR YOUR HEALTH

Confidential to the Institute for Employment Studies

Please answer the following questions as fully as you are able by ticking the boxes or writing in the spaces provided. Please return the completed questionnaire direct to IES in the reply-paid envelope provided. If you have any queries, please contact Ian Seccombe or Monica Haynes at IES, Telephone: 01273 686751. Thank you for your cooperation.

FOR OFFICE USE ONLY

Section A — Your Health

The questions in this first section ask about your health, lifestyle and aspects of your working conditions that may affect your health.

1. Before you received this questionnaire, had you heard of:

   'Health at Work in the NHS'? Yes ☐ No ☐ (11)

   'Look After Your Heart Workplace Project' or 'LAYH'? Yes ☐ No ☐ (12)

2. Over the last 12 months, would you say that your health has been on the whole:

   Good? ☐ 1 Fairly good? ☐ 2 Not good? ☐ 3 (13)

3. Do you have any long standing illness, disability or infirmity? Yes ☐ No ☐ (14)
   (Long standing means anything that has troubled you over a period of time in the past or that is likely to affect you over a period of time in the future).

   If **YES**: Does this illness or disability ever limit your activities in any way?

   Yes - at home only ☐ 1 Yes - at both home and work ☐ 3

   Yes - at work only ☐ 2 No ☐ 4 (15)

4. Do you smoke **cigarettes** at all nowadays? Yes ☐ No ☐ **Go to Q.7** (16)

   If **YES**: About how many cigarettes **a day** (including hand rolled ones) do you usually smoke at weekends or on non working days? ☐ (17-18)

   About how many cigarettes **a day** (including hand rolled ones) do you usually smoke on weekdays or working days? ☐ (19-20)

5. Do you smoke at work? Yes ☐ No ☐ (21)

   If **YES**: Where do you smoke? *(Please tick all that apply)*

   Office ☐ Outside ☐ (22-23)

   Staff room ☐ Designated room/area ☐ (24-25)

   Corridor/open space indoors ☐ Other *(Please specify)* _____ ☐ (26-27)

6. How much, if at all, would you say your smoking affects your health? (28-29)

   A great deal ☐ 1 A fair amount ☐ 2 Hardly/Not at all ☐ 3

   Don't know ☐ 4 (30)

7. How worried are you about your health being affected by other people's tobacco smoke at work? | FOR OFFICE USE ONLY

Very worried ☐ 1 Quite worried ☐ 2 Hardly/Not at all ☐ 3

Don't know ☐ 4 _____ (31)

8. Do you ever have alcoholic drinks (including only very occasionally or drinks you brew or make at home)? Yes ☐ No ☐ **Go to Q.12** _____ (32)

9. Below is a list of different alcoholic drinks. For each one please write in how many you have had of each in the past seven days. If you have had none of any particular drink, please write 0 for that item.

Write in amount for each one (None=0)

Pints of extra strength beer, lager or cider? *(2 bottles = 1 pint)* ☐ _____ (33-34)

Pints of normal strength beer, lager or cider? *(2 bottles = 1 pint)* ☐ _____ (35-36)

Pints of shandy? *(Not bottled or canned)* ☐ _____ (37-38)

Glasses of wine? *(1 bottle = 6 glasses; including Babycham, Champagne)* ☐ _____ (39-40)

Single measures of spirits? *(eg. Whisky, Gin, Vodka, Brandy, Rum, Advocaat)* ☐ _____ (41-42)

Glasses of sherry, port or vermouth? *(including Martini, Cinzano, Dubonnet)* ☐ _____ (43-44)

10. Do you ever find yourself drinking more than you would otherwise because of stress resulting from your work? *(Please tick one box)*

Yes - frequently ☐ 1 Yes - occasionally ☐ 2 No - never ☐ 3 _____ (45)

11. How much do you think the amount **you** usually drink might affect your health (either now or in the future)?

A great deal ☐ 1 A fair amount ☐ 2 Hardly/Not at all ☐ 3

Don't know ☐ 4 _____ (46)

12. When you are at work are you **mainly**: *(Please tick one box)*

Sitting down? ☐ 1 Standing up? ☐ 2 Walking about? ☐ 3 _____ (47)

13. Does your work involve you moving between floors? Yes ☐ No ☐ _____ (48)

If **YES**: Do you **mainly**: Use the lift? ☐ Use the stairs? ☐ _____ (49)

14. Do you have to lift or carry things (including people) at work which you find heavy? *(Please tick one box)*

Yes - lifting only ☐ 1 Yes - both lifting and carrying ☐ 2 No ☐ 3 _____ (50)

15. Overall, would you say that in terms of physical effort your work is: *(Please tick one box)*

Very demanding? ☐ 1 Fairly demanding? ☐ 2 Not very demanding? ☐ 3 _____ (51)

16. In the average week, how often do you engage in any **energetic** physical activity (excluding activity during the course of your work), similar to jogging, cycling, exercising or playing sport for long enough to work up a sweat – say for 20 minutes:

a) 3 or more times a week ☐ 1
b) 1 or 2 times a week ☐ 2
c) Less than once a week ☐ 3
d) Never ☐ 4 _____(52)

17. Thinking about **moderate** physical activity (including activity during the course of your work) like taking a brisk walk, cycling, light swimming, gardening, or something similar which involves physical activity but does not leave you feeling exhausted, on how many days a week do you do something like this for **at least 30 minutes**?

a) 5, 6 or 7 days a week ☐ 1
b) 3 or 4 days a week ☐ 2
c) Once or twice a week ☐ 3
d) Never ☐ 4 _____(53)

18. Do you think you get enough exercise at present to keep you fit?

Yes ☐ 1 No ☐ 2 Don't know ☐ 3 _____(54)

19. In the last 12 months have you **seriously** tried to *(if applicable)*:

give up smoking?	Yes ☐	No ☐	_____(55)
cut down the amount of alcohol you drink?	Yes ☐	No ☐	_____(56)
take more exercise?	Yes ☐	No ☐	_____(57)
change your diet?	Yes ☐	No ☐	_____(58)
lose weight?	Yes ☐	No ☐	_____(59)

20. Over the next 12 months do you plan to *(if applicable)*:

give up smoking?	Yes ☐	No ☐	_____(60)
cut down the amount of alcohol you drink?	Yes ☐	No ☐	_____(61)
take more exercise?	Yes ☐	No ☐	_____(62)
change your diet?	Yes ☐	No ☐	_____(63)
lose weight?	Yes ☐	No ☐	_____(64)

21. In the next 12 months are you planning to change your lifestyle in any other way to improve your health? Yes ☐ No ☐ _____(65)

If **YES**, please describe briefly: _____ _____(6667)

_____ _____(6869)

_____ _____(7071)

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22. Which of the following **best** describes a normal lunch (or equivalent meal on shifts) for you when working?

A meal ☐ 1 A sandwich or snack ☐ 2 Nothing ☐ 3

Something else *(Please specify)* _____ ☐ 4

23. When you have lunch, where do you **usually** eat it? *(Please tick one box)*

a) At workplace, office or ward ☐ 1

b) In staff canteen or restaurant ☐ 2

c) Outside work altogether ☐ 3

d) Other *(please specify)* _____ ☐ 4

24. How often do you either eat while working or not take a meal break at all?

Frequently ☐ 1 Occasionally ☐ 2 Never/hardly ever ☐ 3

25. Is the meal you eat at lunchtime on workdays (or its equivalent when working shifts) ever your main meal of the day? Yes ☐ No ☐

If **YES**: Think just about your last working week, how many times was your lunchtime meal (or its equivalent on shifts) your main meal of the day? ☐ times

26. How would you describe the choice of healthy food available for staff in your hospital? *(Please tick one box)*

Very good ☐ 1 Quite good ☐ 2 Satisfactory ☐ 3 Quite poor ☐ 4 Very poor ☐ 5

Don't know ☐ 6

27. How harmful do you think your present diet or eating habits may be to your health?

Very harmful ☐ 1 Quite harmful ☐ 2 Not at all harmful ☐ 3

Don't know ☐ 4

28. Approximately how much do you weigh? ☐ stones ☐ pounds **or** ☐ kilos

29. Approximately how tall are you (without shoes)? ☐ feet ☐ inches **or** ☐ metres

30. Below is a list of health and safety hazards and unpleasant working conditions. Please use the scale below to show how much each causes **YOU** a problem in your job.
(Please tick one box for each item)

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	Considerable extent	Some extent	Little extent	Not at all	
Temperature (too hot or too cold)	☐	☐	☐	☐	(36)
Air quality (too stuffy, not enough fresh air, *etc.*)	☐	☐	☐	☐	(37)
Problems with noise or vibration	☐	☐	☐	☐	(38)
Poor workspace/not enough workspace	☐	☐	☐	☐	(39)
Lighting problems (too dim, too bright, *etc.*)	☐	☐	☐	☐	(40)
Dangers from patients/members of the public	☐	☐	☐	☐	(41)
Not enough safety training	☐	☐	☐	☐	(42)
Fire or explosion hazards	☐	☐	☐	☐	(43)
Litter or mess in work areas	☐	☐	☐	☐	(44)
Working with **colleagues** who are under the influence of drugs or alcohol	☐	☐	☐	☐	(45)
Risk of physical strain (like a back injury)	☐	☐	☐	☐	(46)
Risk of repetitive strain injury (RSI) from use of keyboards	☐	☐	☐	☐	(47)
Risk of eyestrain (eg from video display terminals)	☐	☐	☐	☐	(48)
Dangerous chemicals	☐	☐	☐	☐	(49)
Biological agents or infectious diseases	☐	☐	☐	☐	(50)
Unsafe equipment or machinery	☐	☐	☐	☐	(51)
X-rays or other radiation	☐	☐	☐	☐	(52)
Sharps or needlestick injuries	☐	☐	☐	☐	(53)
Electrical hazards	☐	☐	☐	☐	(54)
Other *(please specify)* _____	☐	☐	☐	☐	(55)
					(56-57)

31. Have you been away from work because of **your own** sickness or injury in the last six months?
(Exclude maternity/paternity leave)

Yes ☐ No ☐ **Go to Q.32** (58)

If **YES**: How many **times** in the last six months have you been away/off work due to **your own** sickness or injury? ☐ times (59-60)

In the last six months approximately how many working **days** were you away/off work in total because of **your own** sickness or injury? ☐ days (61-63)

Thinking about the **last time** you were off work in the last six months due to **your own** sickness or injury, how many working days were you away for? ☐ days (64-66)

Were any of your absences in the last six months caused either by injuries sustained at work or by you being affected by your working conditions?

Yes ☐ No ☐

If **Yes**, please give details: _____

_____

_____

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_____ (67)
_____ (8869)
_____ (7071)
_____ (14)
_____ (5-9)

32. In the last 6 months have you been away from work (exclude maternity/paternity leave) because of **someone else's** sickness or injury (that is through having to provide care for a child or relative)?

3 (10)

Yes ☐ No ☐ _____ (11)

If **YES**: How many days in total were you away for? ☐ days _____ (1213)

Would the availability of childcare or parenting cover have had an affect on your absence?

Yes ☐ No ☐ _____ (15)

Section B - Health at Work

This section asks what the hospital can do to improve your health at work, your experience of working in this hospital and your opinions on how health at work is promoted.

33. In what ways could your employer improve **YOUR** health?
*(Please tick **all** the items that you think would be helpful to you personally)*

1) Encourage employees to spend time improving their health ☐ _____ (16)
2) Get more advice from employees on how to organise work here ☐ _____ (17)
3) Introduce more job sharing ☐ _____ (18)
4) Introduce more flexible working hours ☐ _____ (19)
5) Provide more workplace health and safety training ☐ _____ (20)
6) Train supervisors or managers to be more sensitive to employees' concerns ☐ _____ (21)
7) Communicate more openly with employees ☐ _____ (22)
8) Provide better quality information about changes in the running of the hospital ☐ _____ (23)
9) Provide better information about changes in the NHS ☐ _____ (24)
10) Provide counselling on personal, financial or other problems ☐ _____ (25)
11) Provide or help with the cost of childcare provision ☐ _____ (26)
12) Look at how current shift schedules affect employees' sleep and health ☐ _____ (27)
13) Provide work based recreational or other facilities ☐ _____ (28)
14) Help with the cost of exercise facilities outside work ☐ _____ (29)
15) Provide weight-control programmes ☐ _____ (30)
16) Provide help to stop smoking ☐ _____ (31)

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17) Provide or support stress management training ☐ _____(32)

18) Provide work based health screening for staff ☐ _____(33)

19) Provide healthy eating options in restaurants/staff canteen ☐ _____(34)

20) Other *(please specify)* _____ ☐ _____(35)

_____(36-37)

34. Which three items from Q.33 would be of most use to you personally? *(please write their numbers below)* _____(38-39)

Most important ☐ Second most important ☐ Third most important ☐ _____(40-41)

_____(42-43)

35. The following questions ask how you feel about working for this hospital. There are no right or wrong answers. Please indicate how far you agree or disagree with each statement by ticking the appropriate box.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	
I feel guilty about taking time off even when I am ill	☐	☐	☐	☐	☐	_____(44)
I have to work very hard in my job	☐	☐	☐	☐	☐	_____(45)
I often think about leaving this hospital	☐	☐	☐	☐	☐	_____(46)
I rarely get conflicting job requests from work colleagues	☐	☐	☐	☐	☐	_____(47)
I know what procedures to use to get my job done	☐	☐	☐	☐	☐	_____(48)
I am likely to stay with this hospital for some time yet	☐	☐	☐	☐	☐	_____(49)
I feel I am under too much work pressure	☐	☐	☐	☐	☐	_____(50)
I could never stay off work if I wasn't really ill	☐	☐	☐	☐	☐	_____(51)
I have adequate equipment to do my job	☐	☐	☐	☐	☐	_____(52)
My workload is too heavy	☐	☐	☐	☐	☐	_____(53)
I am likely to leave this hospital quite soon	☐	☐	☐	☐	☐	_____(54)
My immediate manager is willing to listen to my work-related problems	☐	☐	☐	☐	☐	_____(55)
I worry that I am going to be made redundant	☐	☐	☐	☐	☐	_____(56)
I am noticed when I do a good job	☐	☐	☐	☐	☐	_____(57)

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	FOR OFFICE USE ONLY
I get conflicting job requests from my managers	☐	☐	☐	☐	☐	_____(58)
My immediate manager is helpful to me in getting my job done	☐	☐	☐	☐	☐	_____(59)
I feel entitled to take days off sick once in a while	☐	☐	☐	☐	☐	_____(60)
My manager supports me when things go wrong	☐	☐	☐	☐	☐	_____(61)
The NHS will continue to provide me with a secure job for several years	☐	☐	☐	☐	☐	_____(62)
I am very friendly with one or more of my work colleagues	☐	☐	☐	☐	☐	_____(63)
My manager always praises me if I do good work	☐	☐	☐	☐	☐	_____(64)
I have enough support from competent work colleagues to do my job	☐	☐	☐	☐	☐	_____(65)
I know the standards of work expected of me	☐	☐	☐	☐	☐	_____(66)
I rarely discuss important personal problems with my work colleagues	☐	☐	☐	☐	☐	_____(67)
I often come to work when I should be off sick	☐	☐	☐	☐	☐	_____(68)
						_____(1-4)
						_____(5-9)

6. Overall, how satisfied are you with the following things being done to promote **YOUR** health at work in this hospital? *(Please tick one box per line)*

	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	
						4 (10)
The level of information supplied to staff	☐	☐	☐	☐	☐	_____(11)
Staff involvement in planning health promotion activities	☐	☐	☐	☐	☐	_____(12)
Staff involvement in reviewing existing health promotion activities	☐	☐	☐	☐	☐	_____(13)
The level of priority given to staff health by hospital management	☐	☐	☐	☐	☐	_____(14)
Opportunities for training in health at work	☐	☐	☐	☐	☐	_____(15)

Section C - Work Satisfaction

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37. The following questions ask how you feel about the job you are doing and your work in the NHS. There are no right or wrong answers. Please indicate how far you agree or disagree with each statement by ticking the appropriate box.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	
I am doing work that is well suited to my abilities	☐	☐	☐	☐	☐	(16)
I have a considerable say in the way my career develops	☐	☐	☐	☐	☐	(17)
I find enjoyment in my job	☐	☐	☐	☐	☐	(18)
I am proud to tell others that I am part of the NHS	☐	☐	☐	☐	☐	(19)
I am paid fairly for the work I do	☐	☐	☐	☐	☐	(20)
Suggestions I make are listened to by management	☐	☐	☐	☐	☐	(21)
I feel dissatisfied in my job	☐	☐	☐	☐	☐	(22)
I have been well trained since I started working here	☐	☐	☐	☐	☐	(23)
I am kept informed about what is going on in this hospital	☐	☐	☐	☐	☐	(24)
I don't know where my career is going	☐	☐	☐	☐	☐	(25)
My working hours are not flexible enough	☐	☐	☐	☐	☐	(26)
I speak highly of this hospital to my friends	☐	☐	☐	☐	☐	(27)
Management is very secretive	☐	☐	☐	☐	☐	(28)
Most days I am enthusiastic about my job	☐	☐	☐	☐	☐	(29)
I get a feeling of accomplishment from my job	☐	☐	☐	☐	☐	(30)
I am unable to get time off work for training	☐	☐	☐	☐	☐	(31)
I am in a dead end job	☐	☐	☐	☐	☐	(32)
Many of my skills are not used in this job	☐	☐	☐	☐	☐	(33)
This hospital provides me with the opportunity to keep up with new developments related to my job	☐	☐	☐	☐	☐	(34)

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	FOR OFFICE USE ONLY
Senior managers do not seem to know what is going on around here	☐	☐	☐	☐	☐	(35)
The shift system causes me problems *(if applicable)*	☐	☐	☐	☐	☐	(36)

Section D - Your Work

These questions ask about your current job and will help us to compare the situations of different groups of staff.

38. Please specify your occupation/staff group using the following list and **write** your grade and job title alongside in the space provided. *(Please tick one box)*

		Grade & Job Title	
Medical/Dental	☐ 01	_____	
Nurse/Midwife	☐ 02	_____	
Profession allied to medicine	☐ 03	_____	
Ancillary staff	☐ 04	_____	
Maintenance and works	☐ 05	_____	
Ambulance	☐ 06	_____	
Administration and clerical staff	☐ 07	_____	
Scientific, Professional and Technical	☐ 08	_____	(37-38)
General/Senior manager	☐ 09	_____	(39-41)
Other _____ *(please specify)*	☐ 10	_____	(42-44)
			(45-46)

39. **For Doctors and Nurses only**: What speciality do you mainly work in? *(Please tick one box)*

Medical/Surgical	☐ 01	Paediatric	☐ 08
Orthopaedic	☐ 02	Elderly care	☐ 09
Gynaecology/obstetrics	☐ 03	Out patients	☐ 10
Theatre	☐ 04	Mental Health	☐ 11
Accident and Emergency	☐ 05	Learning disability	☐ 12
Intensive care	☐ 06	Midwifery	☐ 13
Coronary care	☐ 07	Other _____ *(please specify)*	☐ 14

(47-48)

(49-50)

40. **For Nurses only:** Are you employed at **this hospital** as: *(Please tick all that apply)*

NHS Nurse? ☐ Bank Nurse? ☐ Agency Nurse? ☐ (51-53)

Other? ☐ *(Please specify)* _____ (54-55)

41. How many people are you in charge of at work (including those directly and indirectly under your supervision - exclude students/trainees)? *(Please tick one box)*

None ☐ 1 One ☐ 2 2 to 4 ☐ 3 5 to 10 ☐ 4
11 to 49 ☐ 5 50 to 99 ☐ 6 100 or more ☐ 7

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42. To the nearest year, how many years in **total** have you worked in the NHS? *(Please include all spells of NHS employment)*

Number of years ☐☐ Less than 1 year ☐ _____(57-58)

43. When did you begin working at this hospital? Month . . . . ☐☐ Year . . . . ☐☐ _____(59-60)
(Jan=01, Feb=02 etc.)

*(If you have had two or more spells of working here - other than breaks because of maternity or sick leave - please give the date your **current** spell of working here began. If the only breaks you have had were because of maternity or sick leave give the date you first worked here)* _____(61-62)

44. Do you work: Full-time? ☐ 1 Part-time? ☐ 2 Job share? ☐ 3 _____(63)
Other *(please specify)* ☐ 4 _____ _____(64-65)

45. How many hours are you contracted to work each week? ☐☐ hours _____(66-67)

46. How many hours do you actually work in a typical week? ☐☐ hours _____(68-69)

47. Does your pattern of work include:

Weekend working? Yes ☐ No ☐ _____(70)

Being on call (evenings/nights/weekends)? Yes ☐ No ☐ _____(71)

48. Do you work: Days only - 9am to 5pm or equivalent (including flexitime)? ☐ 1
Shifts? ☐ 2 _____(72)

If you work shifts, what pattern do you work? *(Please tick one box)*

Shiftwork - mix of earlies, lates and nights ☐ 1
Shiftwork - mix of earlies and nights ☐ 2
Shiftwork - nights only ☐ 3
Shiftwork - split shifts ☐ 4
Shiftwork - mix of earlies and lates ☐ 5
Shiftwork - earlies only ☐ 6
Shiftwork - lates only ☐ 7 _____(73)
Other *(please specify)* _____ _____ ☐ 8 _____(74-75)

49. What is your **main** method of travelling to work (your main method is the one by which you travel the greatest distance)? *(Please tick one box)*

Public Transport *(eg. bus, train, underground)* ☐ 1 Motorcycle ☐ 2 On foot ☐ 3 Car ☐ 4 _____(76)

Bicycle ☐ 5 Other *(please specify)* _____ ☐ 6 _____(77)

50. How long does it usually take you to travel (one way) to work each day?

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Less than 15 minutes	☐ 1	Between 15 and 30 minutes	☐ 2	(7-8)
30 minutes to 1 hour	☐ 3	More than 1 hour	☐ 4	(1-4)

Section E - Background Information

(5-9)

Finally, in order to help us understand your views we would like to know something about you. 5 (10)

51. Are you: Female? ☐ Male? ☐ (11)

52. What was your age last birthday? ☐ years (12-13)

53. What is your current marital status? *(Please tick one box)*

Widowed/Divorced/Separated	☐ 1	Married/Living with Partner	☐ 2
Single (never married)	☐ 3		

(14)

54. Which of the following best describes the accommodation you (and your household) currently live in? *(Please tick one box)*

Owned/buying house or flat	☐ 1	Live with parents	☐ 4
Rented from private landlord	☐ 2	Nurses' Home	☐ 5
Rented house or flat from Council or Housing Association	☐ 3	Other *(Please give details)*	☐ 6

(15)

_____ (16-17)

55. Do you have any children under 16 living with you (either your own or those of your spouse/partner)? Yes ☐ No ☐ (18)

56. Is there anyone living with you who is sick, handicapped or elderly whom you look after or give special help to? Yes ☐ No ☐ (19)

57. Are you registered as disabled either with the Employment Service (ie. with a 'Green Card') or with your local Social Services Department? *(Please tick one box)*

No - neither	☐ 1	Yes - Employment Services only	☐ 3
Yes - Social Services only	☐ 2	Yes - both	☐ 4

(20)

58. Which of the following best describes you? *(Please tick one box)*

White	☐ 01	Black - African	☐ 02	Black - Caribbean	☐ 03
Black Other	☐ 04	Indian	☐ 05	Bangladeshi	☐ 06
Pakistani	☐ 07	Chinese	☐ 08	Other *(please specify)*	☐ 09

(21-22)

_____ (23-24)

59. If you would like to make additional comments about factors which influence your health at work or the Health at Work initiative, please do so on a separate sheet of paper. (25)

Thank you for completing this questionnaire

Please return this questionnaire to: The Institute for Employment Studies, Mantell Building, University of Sussex, Falmer, Brighton, BN1 9RF in the reply paid envelope provided.

Appendix 2. Scale items and key characteristics

This appendix lists the items that make up each of the seven scales used in the analysis presented in this report. For each scale, key scale characteristics are also listed. These include the mean (average) score, the standard deviation (a measure of scale variability) and the alpha coefficient (a measure of the internal consistency of the scale). It is generally recommended that a scale should have an alpha coefficient of 0.7 or greater if it is to be used for comparing groups of respondents.

The purpose of constructing scales is to make comparisons between groups of respondents more meaningful. Replies from individual items are less reliable than scores derived from scales comprised of items that have been shown to be related by item analysis.

Stress

Scale characteristics

Mean	2.93
Standard deviation	0.91
Coefficient alpha	0.64
Base	7766
Weighted base	33427

Items

1. My workload is too heavy.

2. I feel I am under too much work pressure.

3. I have to work very hard in my job.

4. I rarely get conflicting job requests from work colleagues.

5. I get conflicting job requests from my managers.

6. I know the standards of work expected of me.

7. I know what procedures to use to get my job done.

8. I have adequate equipment to do my job.

9. I have enough support from competent work colleagues to do my job.

Support and recognition

Scale characteristics

Mean	2.93
Standard deviation	1.01
Coefficient alpha	0.86
Base	8 077
Weighted base	34 642

Items

1. My immediate manager is willing to listen to my work-related problems.

2. My immediate manager is helpful to me in getting my job done.

3. My manager supports me when things go wrong.

4. I am noticed when I do a good job.

5. My manager always praises me if I do good work.

Job satisfaction

Scale characteristics

Mean	2.48
Standard deviation	1.02
Coefficient alpha	0.84
Base	8 148
Weighted base	34 934

Items

1. I find enjoyment in my job.

2. I feel dissatisfied in my job.

3. Most days I am enthusiastic about my job.

4. I get a feeling of accomplishment from my job.

Career satisfaction

Scale characteristics

Mean	2.85
Standard deviation	0.97
Coefficient alpha	0.62
Base	8 042
Weighted base	34 552

Items

1. I have a considerable say in the way my career develops.

2. I don't know where my career is going.

3. I am in a dead-end job.

Organisational commitment

Scale characteristics

Mean	2.75
Standard deviation	0.96
Coefficient alpha	0.69
Base	8 240
Weighted base	35 385

Items

1. I am proud to tell others that I am part of the NHS.

2. I speak highly of this hospital to my friends.

Openness

Scale characteristics

Mean	3.27
Standard deviation	0.92
Coefficient alpha	0.67
Base	8 161
Weighted base	35 042

Items

1. Suggestions I make are listened to by management.

2. I am kept informed about what is going on in this hospital.

3. Management is very secretive.

4. Senior managers do not seem to know what is going on around here.

Turnover intention

Scale characteristics

Mean	2.83
Standard deviation	0.96
Coefficient alpha	0.82
Base	8 161
Weighted base	35 046

Items

1. I often think about leaving this hospital.

2. I am likely to leave this hospital quite soon.

3. I am likely to stay with this hospital for some time yet.

Appendix 3. Work hazards

This diagram shows staff concerned to a 'considerable extent' about work hazards, by percentage of staff group

Staff group	Temperature	Air quality	Noise	Workspace	Lighting	People	Safety training	Fire or explosion	Litter or mess	Drugs or alcohol
Medical and dental	16	16	11	18	6	5	5	1	5	1
Nursing and midwifery	23	26	10	20	10	9	8	4	6	2
PAMs	23	28	6	16	7	4	7	2	4	1
Ancillary	25	29	9	12	9	8	14	7	7	3
Maintenance and works	15	18	13	19	8	4	12	3	12	8
Administrative and clerical	23	29	12	27	14	3	6	2	6	1
Scientific, professional and technical	24	29	8	21	8	3	7	3	7	1
General and senior managers	16	16	8	11	6	1	3	3	3	1

	Physical strain	RSI	Eye strain	Chemicals	Biological agents/ infectious diseases	Unsafe equipment or machinery	Radiation	Sharps/ needlestick injury	Electrical hazards
Medical and dental	9	1	2	7	22	3	9	31	2
Nursing and midwifery	32	2	3	7	18	4	6	23	3
PAMs	26	4	7	9	6	4	13	6	5
Ancillary	29	5	3	9	17	6	4	17	5
Maintenance and works	27	3	3	12	15	8	4	13	13
Administrative and clerical	7	21	28	0	2	1	1	1	2
Scientific, professional and technical	14	7	9	12	20	3	5	13	4
General and senior managers	1	6	6	0	0	0	0	0	0

Base: 8351; weighted base: 35,853

Source: IES Survey, 1997

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