Work-related stress

A good practice guide for RCN representatives
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Work-related stress

* A good practice guide for RCN representatives

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Work-related stress has overtaken musculoskeletal disorders as the main cause of absence and ill health in the health sector. Nursing is often seen as one of the most stressful occupations. In successive annual NHS staff opinion surveys, a significant proportion of respondents reported feeling unwell due to work-related stress.

Work-related stress is therefore a major concern for RCN safety representatives. In a 2007 survey, they placed work-related stress as the issue they often deal with, and the most important health and safety issue in terms of protecting RCN members. Bullying, harassment, violence and aggression – issues closely linked to stress – were also highlighted as key concerns in the survey.

However, action can and has been taken to address work-related stress. There is a legal requirement on employers to identify the causes of work-related stress and to implement measures to reduce these causes. The Health and Safety Executive (HSE) has developed management standards to help employers meet the requirements of health and safety law. The standards are a useful tool and can help in addressing issues such as workload, work patterns and organisational change.

Yet the need to address work-related stress goes beyond legal duties. There is a moral duty to stop people being made ill by work and a business case for doing more. There is also a growing body of evidence linking issues related to staff health and well-being with impact on patient experiences and quality of care.

This guidance

Work-related stress: A good practice guide for RCN representatives takes RCN representatives through the HSE’s management standards and the process of conducting a stress risk assessment. It details how RCN safety representatives can get involved in each stage of the risk assessment process. A number of case studies illustrate how RCN representatives have implemented the HSE management standards in their own workplaces (these are shown in full in Appendix 4, and extracts are included throughout the document).

Primarily aimed at safety representatives, the guidance may also be useful for stewards and learning representatives when they are supporting RCN members who are returning to work following a stress-related illness or when negotiating learning and development opportunities for members.

As the management standards are used by both the Health and Safety Executive for Britain and the Health and Safety Executive for Northern Ireland, this guide can be used across the UK. What’s more, the legislative requirements to risk assess stress apply equally to the independent sector as they do to the NHS.
What is work-related stress?

The word stress is commonly used in everyday language, but it is often ill defined or misunderstood. Some argue that an over-usage of the word means stress is trivialised and has lost its recognition as significant cause of ill health.

While stress is not a recognised illness, it can lead both to physical and mental ill health. A number of studies, notably the Whitehall study, have linked stress with conditions such as heart disease, hypertension, diabetes, depression and anxiety (Stansfield et al, 2000; Smith et al, 2000).

There are a number of different theories and concepts of stress, leading to various definitions of the word. Most agree, however, that stress is caused when there is an imbalance between the demands placed upon an individual and their resources or capacity to deal with the demands.

The HSE (2007) defines stress as: *The adverse reaction people have to excessive pressure or other types of demand placed on them.*

The HSE’s message is that pressure is good and is part of everyday life, but that excessive pressure can lead to stress, which can make people ill.

Cox et al (2002) describe stress as a simple balance mechanism in the work context. When demands and resources are usually in balance, work design and management can be described as healthy. If demands and resources are frequently out of balance, the experience of work stress is more likely.

Figure 1: Stress as a balance mechanism
It is important to recognise that a lack of pressure or lack of demand can equally cause stress. The chart (above), known as the ‘stress curve’ illustrates how an imbalance of demands and resources can affect individuals.

The European Commission (2002) define stress as:

*The emotional, cognitive, behavioural and physiological reaction to aversive and noxious aspects of work, work environments and work organisations. It is a state characterised by high levels of arousal and distress and often by feelings of not coping.*

This definition recognises the wider effects of stress and how it manifests itself in individuals.
Stress in health care

Health care is seen as one of the most stressful sectors to work in. A number of studies have looked into the causes of stress in health care and in nursing.

A major study on work-related stress commissioned by the HSE (Cox et al., 2002) identified the following factors as the key sources of stress to NHS employees:

- shortage of specialist staff, and teams working short of just one or two members
- peripheral workloads placed on staff due to lack of administrative support
- high levels of patient demand
- verbal abuse and aggression towards staff

Some of these factors have been recognised in other studies which have also identified the following factors (Allen, I, 2001):

- an erosion of autonomy or lack of control over work
- lack of a work life balance
- a rigid hierarchy
- lack of the right tools to do the job, or broken tools
- organisational confusion
- colleagues not understanding each others’ roles and competences
- lack of management support

The RCN’s own survey found that nurses’ psychological wellbeing is lower than the general population. Poor psychological wellbeing in nurses is particularly linked to bullying and harassment and to working shifts which are not a nurse’s preferred pattern of work (RCN, 2005). A further survey of members found that stress related to workload demands was a major reason for leaving their current employer (RCN, 2007).

Along with violence and aggression, bullying and harassment is also a key cause of stress. A number of studies have identified bullying as being prevalent in health care environments (Quine L, 1999; Quine L, 2001; Randle J, 2003).

Pressures from beyond the work environment such as major life events and financial difficulties can also impact on an individual’s working life. While an employer will have little control over external pressures, a good employer will recognise the interface between external and internal causes of stress and support their member of staff through a difficult time. Flexible working, special leave policies and access to counselling or employment assistance programmes can all help support staff who are experiencing external sources of stress.
The case for addressing work-related stress

There is clearly a moral and ethical case for addressing work-related stress. Nobody should be made ill by work, and the prevention and management of work-related stress should be given a high priority alongside the prevention of back injuries and other causes of occupational ill health.

Legal imperatives

Sadly, we often need more than moral arguments to get some employers to act. Health and safety law places a broad duty on employers to reduce the effects of work on health and to provide safe and healthy working environments.

Specifically, under Regulations 3 and 4 of the Management of Health and Safety at Work Regulations 1999, employers are required to carry out a suitable and sufficient assessment of health and safety risks in order to identify preventative and protective measures necessary to reduce these risks. This requirement to carry out a risk assessment on stress is explained in more detail on page 12.

The HSE has taken punitive action against health care organisations who have failed to carry out stress risk assessments. In 2003, West Dorset General Hospitals Trust and in 2008, United Lincolnshire Hospitals NHS Trust were served with Improvement Notices requiring them to take action within a set period to address work-related stress. An Improvement Notice is a legal notice and failure to comply with one can lead to prosecution.

Other key pieces of health and safety law relevant to work-related stress:

The Workplace (Health Safety and Welfare Regulations) 1992. These require the physical working environment to have reasonable temperatures, adequate space and provide adequate welfare facilities (e.g. toilets, washrooms and restrooms).

The Health and Safety (Display Screen Equipment) Regulations 1992. These require employers to ensure that workstations meet minimum standards which include ensuring software is appropriate to the task and the requirement to disclose any monitoring systems to staff.

The Working Time Regulations 1998. These offer protection to employees from the ill health effects of working long hours and offer a degree of work life balance. The key requirements of the regulations include:

- a minimum daily consecutive rest period of 11 hours
- a minimum rest break of 20 minutes when the working day exceeds six hours
- a minimum rest period of 24 hours in each seven day period (or 48 hours in 14 days)
- a minimum of four weeks’ paid annual leave
- an average of an eight hour night shift in a 24 hour period, averaged over 17 weeks
- a maximum of 48 working hours per week averaged over 17 weeks.

You will find more information on these requirements at www.berr.gov.uk, and in the Agenda for Change Handbook at www.nhsemployers.org

Consultation

Under the Safety Representatives and Safety Committee Regulations 1977, employers have a duty to consult safety representatives in ‘good time’ on matters related to health and safety. A lack of consultation is frequently cited as a cause of stress, particularly concerning organisational change – for example, redesign of working environments, changes to working patterns or the introduction of new technology. Safety representatives can use this right to consultation to represent members concerns and anxieties about proposed changes and to suggest actions to address problems or concerns.
In workplaces where the RCN is not recognised, employers still have a duty to consult with employees on health and safety matters under the Health and Safety Consultation of Employees Regulations 1997.

**The business case**

The business case is a key driver to protecting employees from work-related stress. There is a growing body of evidence linking quality working environments with quality patient outcomes. Research by the Care Quality Commission found that self-reported stress amongst NHS staff in England was associated with poorer patient experience across a range of factors. An association was also made between good levels of managerial support and more positive patient experiences (NHS Employers, 2009).

The HSE has also linked good management of work-related stress with improved customer satisfaction. The HSE also point out that too much pressure, particularly when coupled with poor design, can lead to errors, accidents or injuries (HSE, 2009).

NHS staff surveys and national standards contain questions about the health, safety and wellbeing of staff and link to the quality rating of an organisation. If health care organisations want to be seen as providing quality services, then there is clearly a business driver to protect staff from workplace hazards.

Reputational risk is another business factor. A poor reputation can be caused by a failure to address stress in staff. Media coverage surrounding cases of stress or bullying and harassment can have a negative impact, as can HSE action against an organisation. Enforcement action taken against West Dorset General Hospitals Trust in 2003, for example, resulted in extensive media coverage including reports in the national press.

The business case is also linked to financial costs. Addressing work-related stress can save much needed finance which can be re directed to patient care. NHS Employers (2009) report that stress is responsible for 30% of sickness absence in the NHS in England, costing the service and estimated £300 to £400 million every year, with an average of 29 days lost for each case of stress.

Cutting absence caused by stress and retaining staff by providing safe and healthy work environments clearly has financial benefits. In addition to the cost of absence, there is growing acknowledgement of the cost of reduced productivity among people who work despite being unwell; so-called ‘presenteeism’. A report by the Sainsbury Centre for Mental Health (2007) found that presenteeism attributable to poor mental health accounts for 1.5 times as much working time lost as absenteeism.

Health care insurers, including the NHS Litigation Authority, are taking an increased interest in issues such as stress and bullying and harassment at work. They recognise, by providing discounts on insurance premiums, those employers who put measures in place to protect the health and safety of staff.
Stress management standards

Following high profile legal judgements concerning stress at work and after extensive lobbying by trade unions, the HSE developed its Management Standards. These outline a set of states to be achieved by organisations. The standards provide a yardstick by which organisations can measure their performance in managing the key causes of stress. The standards and associated tools developed by the HSE also help simplify the stress risk assessment process.

The HSE undertook extensive research to develop the Management Standards and they have been recognised as best practice in Europe and internationally.

The standards cover six areas:
- demands
- control
- support
- relationships
- role
- change.

Organisations do not have to follow the Management Standards approach but are required by law to carry out stress risk assessments. The RCN supports the use of the Management Standards approach.

The HSE Management Standards

Demands
Includes issues such as workload, work patterns and the work environment.

Standard: employees indicate that they are able to cope with the demands of their jobs; and systems are in place locally to respond to any individual concerns.

States to be achieved:
- the organisation provides employees with adequate and achievable demands in relation to the agreed hours of work
- people's skills and abilities are matched to the job demands
- jobs are designed to be within the capabilities of employees
- employees' concerns about their work environment are addressed.

Control
How much say an individual has in the way they do their work.

Standard: employees indicate that they are able to have a say in the way they do their work; and systems are in place locally to respond to any individual concerns.

States to be achieved:
- where possible, employees have control over their pace of work
- employees are encouraged to use their skills and initiative to do their work
- where possible, employees are encouraged to develop new skills to help them undertake new and challenging pieces of work
- the organisation encourages employees to develop their skills
- employees have a say over when breaks can be taken and are consulted over their work patterns.

Support
Includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.

Standard: employees indicate that they receive adequate information and support from their colleagues and superiors; and systems are in place locally to respond to any individual concerns.

States to be achieved:
- the organisation has policies and procedures to
provide adequate support to employees
systems are in place to enable and encourage
managers to support their staff
systems are in place to enable and encourage
employees to support their colleagues
employees know what support is available and how
and when to access it
employees know how to access the required
resources to do their job
employees receive regular and constructive
feedback.

**Relationships**
Includes promoting positive working to avoid conflict
and dealing with unacceptable behaviour.

**Standard:** employees indicate that they are not
subjected to unacceptable behaviours, such as bullying
at work; and systems are in place locally to respond to
any individual concerns.

**States to be achieved:**
the organisation promotes positive behaviours at
work to avoid conflict and ensure fairness
employees share information relevant to their work
the organisation has agreed policies and
procedures to prevent or resolve unacceptable
behaviour
systems are in place to enable and encourage
managers to deal with unacceptable behaviour
systems are in place to enable employees to report unacceptable behaviour.

**Change**
How organisational change (large or small) is managed
and communicated in the organisation.

**Standard:** employees indicate that the organisation
engages them frequently when undergoing an
organisational change; and systems are in place locally
to respond to any individual concerns.

**States to be achieved:**
the organisation provides information to enable
employees to understand their role and
responsibilities
the organisation ensures that, as far as possible,
the requirements it places upon employees are clear
systems are in place to enable employees to raise
concerns about any uncertainties or conflicts they
have in their role and responsibilities.

**Role**
Whether people understand their role within the
organisation and whether the organisation ensures that
a person does not have conflicting roles.

**Standard:** employees indicate that they understand
their role and responsibilities; and systems are in place
locally to respond to any individual concerns.

**States to be achieved:**
the organisation ensures that, as far as possible,
the different requirements it places upon
employees are compatible
the organisation provides information to enable
employees to understand their role and
responsibilities
the organisation ensures that, as far as possible,
the requirements it places upon employees are clear
systems are in place to enable employees to raise
concerns about any uncertainties or conflicts they
have in their role and responsibilities.
Stress management competences

Following the development of the Management Standards, the HSE worked in partnership with the Chartered Institute of Personnel and Development (CIPD) and occupational psychologists to develop a set of management competences to support the Standards. The competences identify positive and negative management behaviours related to the causes of stress in employees. Line management behaviours are key in addressing work-related stress.

Health care organisations should implement the management competences alongside or in addition to existing frameworks (such as appraisals, 360 degree feedback and the Knowledge and Skills Framework (KSF)). Organisations should also support and develop managers in meeting the competences.

### The HSE’s Stress Management Competences

<table>
<thead>
<tr>
<th>Competence</th>
<th>Sub Competence</th>
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<tbody>
<tr>
<td>Respectful and responsible:</td>
<td>Integrity</td>
</tr>
<tr>
<td>Integrity</td>
<td>Being respectful and honest to employees</td>
</tr>
<tr>
<td>Managing emotions and having integrity</td>
<td>Managing emotions</td>
</tr>
<tr>
<td></td>
<td>Behaving consistently and calmly around the team</td>
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<tr>
<td></td>
<td>Considerate approach</td>
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<td></td>
<td>Being thoughtful in managing others and delegating</td>
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<tr>
<td>Managing and communicating existing and</td>
<td>Proactive work management</td>
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<tr>
<td>future work</td>
<td>Monitoring and reviewing existing work, allowing future prioritisation and</td>
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<tr>
<td></td>
<td>planning</td>
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<td></td>
<td>Problem solving</td>
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<tr>
<td></td>
<td>Dealing with problems promptly, rationally and responsibly</td>
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<tr>
<td></td>
<td>Participative/empowering</td>
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<td></td>
<td>Listening to, meeting and consulting with the team, providing direction,</td>
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<tr>
<td></td>
<td>autonomy and development opportunities to individuals</td>
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<tr>
<td>Managing the individual within the</td>
<td>Personally accessible</td>
</tr>
<tr>
<td>team</td>
<td>Available to talk to personally</td>
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<tr>
<td></td>
<td>Sociable</td>
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<tr>
<td></td>
<td>Relaxed approach, such as socialising and using humour</td>
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<td></td>
<td>Empathetic engagement</td>
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<td></td>
<td>Seeking to understand each individual in the team in terms of their health and</td>
</tr>
<tr>
<td></td>
<td>satisfaction, motivation, point of view and life outside work</td>
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<tr>
<td>Reasoning/Managing difficult situations</td>
<td>Managing conflict</td>
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<tr>
<td></td>
<td>Dealing with conflicts decisively, promptly and objectively</td>
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<tr>
<td></td>
<td>Use of organisational resources</td>
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<td></td>
<td>Seeking advice when necessary from managers, HR and Occupational Health</td>
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<tr>
<td></td>
<td>Taking responsibility for resolving issues</td>
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<tr>
<td></td>
<td>Having a supportive and responsible approach to issues and incidents in the</td>
</tr>
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<td></td>
<td>team</td>
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Stress risk assessment

Work-related stress is no different from any other workplace hazard. Under the Management of Health and Safety at Work Regulations 1999, an employer has a duty to carry out a risk assessment to identify risks related to stress.

So the principles outlined in the HSE’s five steps to risk assessment can equally be applied to carrying out a stress risk assessment. The five steps are:

Step 1: identify the hazards and risks
Step 2: decide who may be harmed and how
Step 3: evaluate the risk
Step 4: record your findings
Step 5: monitor and review.

This section explores these five steps in more detail, including the role and contribution of safety representatives in the stress risk assessment process. The steps include case studies showing how RCN representatives have worked in partnership with their employers to address this key issue.

Following a review of the implementation of the Management Standards, the HSE added another step to support the implementation of stress risk assessments, namely preparing the organisation. They found that effective preparation is a key element to success and is now central to the process.

The HSE’s publication Managing the Causes of Work-related Stress can be used as a reference guide to support the work of the organisation in reducing stress. Safety representatives should have access to this publication and the extensive material and information available on the HSE’s website.

Preparing the organisation

The HSE identifies the following issues as being important to address before moving to Step 1 of the risk assessment:

Secure commitment at all levels of the organisation
The organisation will need to set aside adequate resources to implement the assessment. For example: providing an identified lead person with time and skills to take the project forward; providing facilities time for safety representative and staff involvement, including completing questionnaires and attending focus groups; identifying skilled facilitators to run focus groups (this expertise may be internal or brought in); fund the implementation of solutions and measures to reduce the risks (some of which may be simple and cost neutral, others may involve investment).

Appoint project lead

Develop project plan
The project plan should be agreed by all parties.

Appoint representative steering group to take forward the action plan. The group may include representatives from the human resources department, occupational health, health and safety, a senior management champion, communications, IT, and staff side representatives.
Develop communication plan
Communication is a key element throughout the process, including regular updates of progress and feedback so that staff know their concerns are being addressed.

Commitment to partnership working
This must be clear from the outset and be at all levels of the organisation. A jointly agreed policy between management and staff side representatives on work-related stress is a good starting point.

Safety representatives’ role in preparing the organisation
At the outset safety representatives should be involved in the process, and a staff side lead identified. As well as the steering group’s board/director level champion, you may wish to negotiate a position for a staff side champion.

Any steering group should include union representation. The steering group should provide updates and reports to the health and safety committee and, where they exist, the wider partnership forum or joint consultative committee.

Engagement and involvement is likely to involve extra facilities time for the representative on the steering group and for dealing with local representatives involved in local implementation plans. This time should be agreed in advance and reviewed at regular intervals through the risk assessment process.

Any communication about the project could be jointly badged or signed by unions and employers. Staff who feel this is a management-driven initiative may be less likely to engage in the process. Information about the project could also go on the RCN noticeboard or any other local union communication routes.

Where there are difficulties in achieving commitment from a senior level, the issue should be raised at the partnership forum or similar committee. You could use both the business and legal case for action to convince senior managers of the need for action. Use evidence such as absence levels, bullying and harassment complaints, results of staff surveys and grievance cases to support your case.

Make sure that you are consulted on the stress policy and that it is jointly agreed and signed off. Appendix I details what should be included in a stress policy.

Make sure that the organisation is committed to introducing the management competences alongside the management standards. These can be stand alone or integrated into existing frameworks such as appraisals.

Step 1: Identify the hazards
Step 1 of the stress risk assessment process covers familiarisation with the HSE’s Management Standards, which identify workplace stressors and establish goals for the organisation to achieve. The steering group should take time to review the standards and states to be achieved.

The HSE recommends that the steering group knows exactly how the stress risk assessments will be carried out. The group must understand the overriding principle that the process is one of primary prevention and management of stress at an organisational level, rather than treating individuals who are subject to stress.

Safety representatives’ role in identifying the stress risk factors
Familiarise yourself with the HSE’s six Management Standards and states to be achieved. Consider how well you and the members you represent think the employer is meeting each of the six standards.

Make sure that the steering group is committed to approaching the issue at an organisational level, based on the prevention and management of stress.
Good communication, top level commitment and the importance of securing resources

Cheshire and Wirral Partnership
Following fears that those who reported stress might be stigmatised in some way, the chief executive issued a statement acknowledging that workplace stress was a problem at Cheshire and Wirral Partnership, and that the organisation was genuine in wanting to find out what its causes were.

Anthony, the RCN representative, felt that organisation-wide support made staff feel more confident about talking about the issue. Considering that this is a mental health care trust, Anthony said staff had a sense that, “If we can’t look after our own, who can we look after?”

Appropriate facilities time to deal with the stress risk assessment process was agreed for the safety representatives. Anthony advises any safety representative about to embark on a similar piece of work to make sure that a reasonable amount of time is given to deal with it.

Securing resources and the importance of partnership work

NHS Highland
NHS Highland appointed a stress prevention manager to work full time on stress management. The trust established a stress steering group, which includes staff representatives and reports to the health and safety committee. Stephen, the stress prevention manager, recognises that the role of the staff side representative has been invaluable in helping to spread the message of the importance of stress reduction and facilitate two-way communication. He stresses that implementing the HSE standards is not a one-off event and is part of the ongoing safety management system.

The importance of planning and resourcing

County Durham and Darlington NHS Foundation Trust
County Durham and Darlington set up a steering group to work towards adopting the HSE Management Standards. It was chaired by the director of estates and facilities and included members of the health and safety committee and staff side representatives. Before the work started, the steering group met several times to discuss the process with the HSE.

While the unions were considered key players, in practice they found it very difficult to get time to attend all the meetings. They learned that it is important to prepare and gather resources properly before the process began. RCN steward and Safety representative Kath says, “You need a team who can be mutually supportive and who understand the project, otherwise things can grind to a halt.” Kath points out that detailed planning is absolutely critical in large organisations.
Step 2: Decide who might be harmed and how

This is the information-gathering stage, where data can be used to inform the process. This will help an organisation identify areas or departments where staff are more at risk from stress (often called hot spots) or identify areas of good practice. It can also help identify those staff groups who may be more at risk.

Examples of data:
- sickness absence data
- number of grievances
- turnover
- information from exit interviews
- information from team meetings/focus groups
- bullying and harassment cases/complaints
- anonymised information on use of counselling services
- appraisals
- incident data/serious untoward incident investigations
- staff survey results.

The HSE has developed a stress survey tool (known as the ‘indicator tool’) to help with data gathering. The tool has an accompanying manual and analysis tool. The manual gives advice on how and who to survey. All these materials can be downloaded from the HSE’s website.

The RCN supports the use of the indicator tool as a useful way of identifying hotspots and benchmarking an organisation against the stress management standards.
The steering group and project lead need to gather the data and plan for distributing the indicator tool (survey) among staff, and analysing the results of the indicator tool. If they are going to use HSE’s indicator tool, the group will need IT support and communications support to circulate it and explain what it is and how to use it.

Once the results of the indicator tool are ready and other data is collected, the steering group should carry out preliminary analysis. The HSE recommends that the project lead produce a report at this stage. This report should identify:

- data used
- hot spots
- areas of good practice with potential for translation to other areas of the organisation
- benchmark or traffic light data on how the organisation is performing against the states to be achieved within the HSE Standards
- the next steps to take to evaluate the risks.

**Safety representatives’ role in gathering data**

Share data that you hold with the steering group while respecting RCN members’ confidentiality

Negotiate the use of the indicator tool across the organisation and make sure that all groups and departments are represented in any sample

Check that confidentiality is protected and if the survey is administered through an online questionnaire, all staff have easy access to IT equipment

Make sure that staff are given protected time to complete the indicator tool

Support the organisation in communicating the importance of completing the indicator tool and reassure RCN members on confidentiality

Make sure that a report on the data is presented to the steering group and the next steps are jointly agreed

Make sure that an update is given to staff on the progress of the project and they are thanked for completing the survey.

**Step 3: Evaluate the risks**

This stage involves further exploration of the problem areas identified in Step 2 and the development of solutions. The HSE advises setting up focus or discussion groups to confirm and validate the Step 2 findings. Focus groups should be between six and 10 people and can be made up of staff from one department or staff doing similar work across the organisation. The facilitator should be skilled, independent and familiar with the HSE Management Standards and states to be achieved. For example, ACAS provide a facilitation service which has been used by a number of organisations to support focus group assessments.

Attendees can be self-selected or invited to attend by the steering group, but the steering group should ensure that focus groups represent the diversity of staff working in the organisation.

The facilitator should keep discussion focused on solutions to problems in meeting the ‘states to be achieved’. Staff involved should feel able to contribute toward finding solutions.

The HSE provides examples of methods which an organisation could use to meet the standards.

The discussions and solutions arising from the focus groups should be documented and fed into the next stage of action planning. The steering group should share outcomes and reports from the focus groups with focus group participants.

**Safety representatives’ role in evaluating the risks**

Check that hot spots or at risk groups of staff identified in step 2 are given priority for action and that focus groups are run in these areas

Check that RCN representatives are invited to focus groups in the areas they cover (this ensures that those who are unable to attend a focus group have an opportunity to have their say through their RCN representative)

Check that members are given time to attend focus groups and that representation is fair
STEP 3: CASE STUDIES

Focus groups and facilitators

County Durham and Darlington NHS Foundation Trust
The Trust established a series of focus groups for Step 3 of the assessment. 120 staff in total attended the focus groups, which used different combinations of staff groups and junior, middle and senior managers; some mixed, some site-specific. Focus groups containing peer groups – that is, staff with common experiences and similar problems - were considered to be the most successful.

Every group had the same initial question: “What is it like to work in this trust?” The discussion then covered the HSE six key areas (demands, control, support, relationship, role and change) to find out what the issues were for particular groups. The notes from all of the focus groups were fed back to the steering group for consideration.

The analysis of this and other data showed pockets of workplace stress in County Durham and Darlington, including pharmacy and general medicine. The steering group set up specially facilitated focus groups for staff in the problem areas to find out more about the causes of stress and to help them to develop action plans to solve them. The facilitators for these groups were drawn from a range of backgrounds in the trust and undertook a two-day ACAS training course, which was considered very successful.

It proved difficult to get staff away from the general medicine wards to tackle these issues. So the facilitators went instead onto the ward and arranged focus groups around the workflow of the shift, so that most people could get involved in the discussions at some point.

The importance of focus groups

NHS Highlands
The results of the HSE indicator tool were sent to each ward or department manager so that they could see the particular stressors their area faced and could devise an action plan with their staff. All the ward results collectively built up a picture for a whole hospital which allowed the hospital manager to compare wards against each other, helping identify areas of good practice or any problem hot spots.

Stephen, the stress prevention manager, stressed that it is important not to focus purely on the indicator tool. He points out that the tool is merely supposed to indicate where there may be a problem with workplace stress, but it is then up to the managers to talk to staff and tease out the reasons behind the problems and work with staff to solve them together. In Stephen’s view, focus groups can play a much more important part in helping managers to communicate effectively with their teams to determine what specific actions will help to alleviate stress.

Trade union involvement in focus groups

Cheshire and Wirral Partnership
Based on the findings of a series of focus groups and of the indicator tool, the stress steering group devised an internal action plan with specific issues for each division or local area to deal with. There was a union rep on each of the local committees which fed into a central committee, and all the action plans were monitored by the steering group.
Ask questions on the skills and independence of the facilitator
Check that findings from focus groups are reported to the steering group and also fed back to participants
Make sure that learning reps and stewards are involved in the development of solutions.

**Step 4: Record your findings**

This stage is about action planning and implementation.

The HSE states that an action plan will:
- help you set goals to work towards
- help you prioritise
- demonstrate that you are serious about addressing employees concerns
- provide you with something to evaluate and review against.

The steering group should feed the findings of the focus groups and other research, particularly where there are recurrent themes requiring strategic action, into an organisation-wide action plan. It may also need to develop team or department-level action plans to address specific issues and implement solutions particular to that area.

Action plans should include:

- what the problem is
- how the problem was identified
- what you are going to do in response
- how you arrived at this solution
- some key milestones and dates for them for goals to be reached
- a commitment to provide feedback to employees on progress
- a date for reviewing actions against the plan.

It is important to ensure that actions detailed:

- are given an order of priority
- have sufficient resources allocated to them
- are assigned to an individual or function
- have an agreed timescale for completion.

The HSE encourages the use of the Management Competences (see Section 6) and plans should be made to implement these competences across the organisation, perhaps through the appraisal process or linked with the Knowledge and Skills Framework.

**Safety representatives’ role in recording the findings**

Check that organisational action plans are agreed by the steering group and partnership forum/joint consultative committee.

Check that department level action plans are shared with local staff side representatives and agreed
Check that action plans are comprehensive and include all the elements identified by the HSE
Check that action plans include the implementation of the management standards framework
Once agreed, make sure that action plans are shared with all staff and implemented.

### STEP 4: CASE STUDY

**Action planning**

**NHS Direct**

A working group developed action plans relating to the main issues which were causing stress at NHS Direct, namely the rostering system, workload, monitoring and the working environment. There is now a specific action plan for rostering so that if a member of staff is unhappy with their off-duty time, there are clear steps to take to address this.
Examples of solutions identified as part of Step 4 by our case study organisations

**County Durham and Darlington NHS Foundation Trust:**
- changing the coffee area to separate it from the working areas so that staff could relax properly on their breaks.
- better training of line managers on the use of the various policies that were already available.
- staff support officers appointed for bullying and harassment and stress issues. They help staff access occupational health and/or counselling services and union reps as appropriate.

**NHS Highlands:**
- improved communication during periods of change.
- the introduction of regular staff meetings.
- reducing inconsistencies in handover between shifts.
- encouraging staff to be mutually supportive during busy periods.
- ensuring all staff to have professional development plans and fair and equal access to training.
- getting more staff appointed to a team when there was evidence of excessive workloads.
- identification of further training needs.

**NHS Direct:**
- specific action plan for rostering.
- improving the working environment to create warmer and colder areas in the call room so that people could sit in the area that they preferred.

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**Step 5: Monitor and review**

This is an essential, but often forgotten, part of the risk assessment process. It is an important way of evaluating actions and solutions and of ensuring that the organisation is in a cycle of continuous improvement.

This stage includes monitoring progress against action plans, evaluating the effectiveness of solutions implemented, and deciding what further action is needed.

The steering group should agree, and include in the organisation’s stress management policy, how and when improvement work is to be monitored. Another group such as the health and safety committee could take on the role of ongoing review and monitoring.

**Implementing action plans**

Regular updates on progress against action plans should be submitted to the monitoring group (such as the steering group or health and safety committee). Any difficulties with implementation and any extension of timescales should be discussed and agreed in partnership between management and staff side trade unions.

**Evaluating solutions**

Some solutions put in place may have an immediate impact – for example, starting to hold regular team meetings. Others, such as training and development of local managers, may take time to impact on the management of a department. The steering group will need to agree appropriate timescales for evaluating the various measures.

Further focus groups, team and partnership meetings can provide useful qualitative data on the success of measures. Data similar to that gathered in step 2 can also be used to monitor the effectiveness of solutions, especially the staff survey used across the NHS. Some organisations use the HSE indicator tool on an annual basis as part of the continuous improvement model.
Monitor and review

**County Durham and Darlington NHS Foundation Trust**
After the action plans had been implemented, County Durham and Darlington NHS Foundation Trust used the stress indicator tool again and found improvement in some areas, but not in others - so there is still some work to do.

The most important outcome for the risk assessment project was that it not only raised awareness about the issue of workplace stress, but also showed that something can be done to reducing stress. Kath, the RCN representative, also believes that it made staff and managers realise that people like to be appreciated and that such appreciation can make a big difference to people’s working lives.

**Safety representatives’ role in monitoring and reviewing stress risk assessments**

- Ask for stress management to be a standing agenda item on the health and safety committee meeting and request regular updates on progress with action plans
- Carry out a themed ‘stress inspection’ (see Appendix 2) to review how effective the risk assessment process is
- Speak to RCN members to see whether they think things have improved following the implementation of the action plan
- Feed any concerns into the health and safety committee or steering group.

Reviewing action plans

**NHS Direct**
Monthly meetings have been set up to review action plans regularly. The stress working group has asked for absence and turnover data and will monitor this over time to see if their stress management solutions have any impact.

**Monitoring sickness levels**

**Cheshire and Wirral Partnership**
Cheshire and Wirral Partnership is now monitoring stress-related sickness levels by team and by area, so that they can pinpoint issues more quickly and take action.
Appendix 1: Stress policy

A stress policy is the foundation for any work on reducing stress in a workplace. It forms the framework for the stress risk assessment process.

A stress policy should be agreed in partnership between management, staff representatives and staff side trade unions contain a jointly agreed definition of work-related stress. The RCN recommends the use of the HSE definition (HSE, 2007: The adverse reaction people have to excessive pressure or other types of demand placed on them.) The policy should reflect partnership working throughout policy.

The information shown here on the aims, benefits, content and implementation of a stress policy is adapted from the Scottish Managing Health at Work Partnership Information Network (PIN). PIN has produced guidelines on dealing positively with stress at work and on policy development.

You will find more examples of stress policies on the HSE's website at www.hse.gov.uk/stress and the NHS Litigation Authority (NHSLA) website at www.nhsla.com

Benefits of an organisational stress policy

An organisational stress policy can bring a number of benefits, including:

- improved staff efficiency and effectiveness
- improved morale
- better working relationships
- a reduction in the waste of trained staff
- a better image for the organisation.

Aims of a stress policy

The policy should:

- encourage staff wellbeing in the organisation and discourage the stigma attached to stress
- raise awareness of ill health associated with stress, its causes and associated factors
- train managers to identify the causes of potential stress and the symptoms of stress
- change those aspects of the workplace that have been identified (through risk assessment) as increasing the risk of stress
- improve factors within the organisation that reduce the risk of stress
- educate staff in techniques for coping with pressure and stress
- provide staff with help if they have mental or physical health problems associated with stress
- through information and education, encourage everyone to recognise stress-related problems
- provide systems of support and make sure they are well publicised
- encourage staff to get help at an early stage
- offer easy access to counselling and other professional help
- make sure there is confidentiality for those who want help (from whatever source)
- as far as possible, guarantee job security, sick leave, the retention of status and make sure that there is no blame attached to those using the support mechanisms
- set up procedures for return to work, and rehabilitation in work
- make sure that these procedures are flexible enough to meet varying needs.

Content of a stress policy

A stress policy might include:

- making a commitment to a healthy workforce by placing a high value on the physical and mental health of staff
- acknowledging that stress problems have many causes – including inside the workplace and from external sources
- identifying and listing the factors that may contribute to increased levels of stress in the organisation (based on risk assessments for the organisation)
- recognising that domestic factors (housing, family problems and bereavement for example) may add to levels of stress experienced by staff
- stating that the organisation is committed to a course of action that may include:
  - increasing knowledge of the causes of stress in the organisation
  - dealing with the causes of stress and helping staff to manage stress
managing health problems associated with stress through:

- recognising symptoms early
- managing stress appropriately
- providing access to counselling
- providing advice and sources of help
- managing the return to work of those who have suffered stress-related mental or physical health problems to make sure that their skills are not lost.

**Putting the policy into practice**

To help put the policy into practice successfully, it is important to make sure that the policy:

- is part of the health and safety policy and structure within the organisation
- is linked to other elements of health promotion within the organisation
- is developed to suit the particular structure, organisation and ethos of the organisation
- is developed by a working group that represents staff of all grades and from all sections of the organisation
- applies to all staff, no matter what their age, sex, ethnic origin or grade
- makes clear statements on the roles and responsibilities of each group of staff in the organisation, including:
  - senior managers
  - line managers
  - human resources department
  - occupational health services
  - trade unions/professional organisations
  - all staff.
Appendix 2: Stress inspection tool

Safety representatives can use this inspection checklist to monitor and review the stress risk assessment process. The checklist has been adapted from the section on developing solutions in the publication Managing the Causes of Work-related Stress. The inspection checklist is not exhaustive and can be modified as appropriate.

The checklist is based on the six HSE Management Standards. As part of a stress inspection, Safety representatives can select one or two of the standards to inspect. A stress inspection will often be a mixture of examining documents and speaking to RCN members, as well as observing the workplace.

1. Demands
Includes issues such as workload, work patterns and the work environment.

Checklist
☐ Are up-to-date records kept on working hours to ensure compliance with the working time regulations?
☐ Are locally agreed policies regarding on-call conditions followed and is compensatory rest given?
☐ Are records kept of compensatory rest?
☐ Do staff regularly work more than their allotted hours?
☐ Are concerns about the physical working environment addressed (you can examine incident reports for the area to assess this)?
☐ Do staff get feedback from incident reports?
☐ Are staffing levels and skill mixes appropriate?
☐ Are there opportunities to discuss, at local level, concerns about workload?
☐ Are staff able to attend mandatory and statutory training?
☐ Do staff know how to operate equipment they use?
☐ Are staff trained in how to defuse difficult situations with patients or visitors (e.g. conflict resolution)?

2. Control
How much say the person has in the way they do their work.

Checklist
☐ Are personal development plans completed and staff offered training opportunities?
☐ Is there a policy on flexible working?
☐ Are staff given opportunities to work flexibly?
☐ Are duty rosters fair and do they give staff an opportunity to request reasonable time off?
☐ Are staff able to have rest breaks?
☐ Are there suitable areas for staff to rest away from their immediate workplace?

3. Support
Includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.

Checklist
☐ Are the HSE/CIPD Management Competences being implemented?
☐ Are all staff able to access and self-refer to occupational health and counselling services?
☐ Do RCN members know how to raise concerns?
☐ Are there confidential reporting systems in place to enable reporting of unacceptable behaviour?
☐ Do managers respond to concerns raised both formally and informally?
☐ Are appraisal systems in place?
☐ Are regular team meetings held?
☐ Do staff have a regular opportunity for a one-to-one meeting with their manager?

4. Relationships
Includes promoting positive working to avoid conflict and dealing with unacceptable behaviour.

Checklist
☐ Is there a policy on dignity at work/bullying and harassment?
☐ Are staff able to attend training on dignity at work?
☐ Are staff clear how to report incidences of bullying and harassment?
Do staff get feedback if they have reported incidents of bullying and harassment?
Are regular staff meetings held?

5. Role

Whether people understand their role within the organisation and whether the organisation ensures that a person does not have conflicting roles.

Checklist

☐ Are staff aware of the organisation’s objectives?
☐ Do staff have clear job descriptions?
☐ Is there an organisational and local induction programme for all new staff?
☐ Are new staff able to attend induction as soon as possible after starting?

6. Change

How organisational change (large or small) is managed and communicated in the organisation.

Checklist

☐ Is there effective communication about change – for example, through forums, staff link ups, in-house newsletters, intranet, or team meetings?
☐ Are timetables for changes in place and are staff made aware of timetables?
☐ Are staff given an opportunity to express their concerns and influence proposals?
☐ Are concerns acted on or responded to?
☐ Are safety representatives consulted before any building works/refurbishments (large or small) that may affect members’ working conditions?
## Appendix 3: RCN safety representative role descriptors mapped to work-related stress assessment and management

<table>
<thead>
<tr>
<th>Role</th>
<th>Work-related stress activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiates and represents the health and safety interests of RCN members at work.</td>
<td>Make sure that members are given time off to attend stress risk assessment focus groups and that their concerns are reflected in action plans.</td>
</tr>
<tr>
<td>Obtains information on health and safety issues, advising those RCN members who are being represented.</td>
<td>Communicate organisational commitment to address stress and encourage members to complete stress indicator tool and attend focus groups.</td>
</tr>
<tr>
<td>Encourages others to adhere to health and safety procedures.</td>
<td>Encourage members to report concerns relating to stress and seek support from appropriate individuals.</td>
</tr>
<tr>
<td>Contributes to the control of risk in the workplace and contributes to risk assessments.</td>
<td>Get a seat on stress steering group. Contribute to stress risk assessment process.</td>
</tr>
<tr>
<td>Carries out safety inspections in the workplace.</td>
<td>Carry out themed stress inspections and share findings with health and safety committee or stress steering group.</td>
</tr>
<tr>
<td>Represents the RCN on health and safety committees and takes action to influence the development of a positive safety culture in the workplace.</td>
<td>Make sure that stress management is a standing item on the health and safety committee agenda.</td>
</tr>
<tr>
<td>Works jointly with employers to ensure compliance with health and safety legislation.</td>
<td>Work in partnership to develop and jointly agree stress management policy.</td>
</tr>
<tr>
<td>In partnership with employers, contributes to advising, supporting, maintaining and improving the health, safety and security of members in the workplace.</td>
<td>Working in partnership to support every stage of the stress risk assessment process.</td>
</tr>
<tr>
<td>Influences the workplace organisation to work towards a healthy working environment.</td>
<td>Make sure an organisational level approach is being taken towards stress management and that organisational causes of stress are being tackled.</td>
</tr>
<tr>
<td>Investigates potential hazards and dangerous occurrences in the workplace and makes recommendations for action to prevent any future accidents.</td>
<td>Investigate complaints of excessive pressure or stress related issues.</td>
</tr>
<tr>
<td>Represents RCN members on matters related to workplace accidents/incidents.</td>
<td>Work with stewards to support members who are off sick as a result of work-related stress.</td>
</tr>
<tr>
<td>Provides information and advice to RCN members on safety-related issues.</td>
<td>Communicate the stress risk assessment process to members and signpost them to help if they are experiencing difficulties.</td>
</tr>
<tr>
<td>Identifies appropriate information to use in matters related to health and safety.</td>
<td>Visit HSE’s stress website, RCN Learning Zone and other appropriate information.</td>
</tr>
<tr>
<td>Directs RCN members to information and resources to enable RCN representatives and members to promote health and safety in the workplace.</td>
<td>Direct members towards RCN Learning Zone and RCN stress publications</td>
</tr>
</tbody>
</table>
Appendix 4: Managing stress: case studies

Cheshire and Wirral Partnership NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
NHS Direct
NHS Highland

Cheshire and Wirral Partnership NHS Foundation Trust: Taking the stigma out of workplace stress

Background
Cheshire and Wirral Partnership (CWP) NHS Foundation Trust provides mental health services for children, adults and older people, as well as learning disability services and drug and alcohol services. This case study is based on interviews with an RCN safety representative at CWP, Anthony. He has worked in the health service for 47 years and currently works as a clinical nurse practitioner in psychosexual therapy. He has been a steward, safety representative and learning representative for around 20 years and is currently staff side chair of the Health, Safety and Welfare group at CWP.

Clear communication
CWP was one of the first organisations to adopt the HSE Management Standards. After an initial visit by a local HSE inspector (‘stress partner’) and a joint partnership steering group was set up, the HSE’s stress indicator tool was sent out to all staff to find out about the extent and causes of workplace stress at CWP. The initial response to the questionnaire was not very high; after some investigation, the steering group discovered that staff had not bothered to fill in the questionnaire because they were cynical about whether anything would be done with the findings. Some staff also feared that those who reported that they suffered from stress might be stigmatised.

To remedy this, the chief executive issued a statement in the staff publication acknowledging that workplace stress was a problem at CWP, and that the organisation was genuine in wanting to find out what the causes of stress were. The steering group made it clear that they specifically wanted to find out about any mental health problems caused by workplace stress and encouraged staff to complete the confidential questionnaire. They then reissued the indicator tool, which this time generated a much higher response rate.

Then followed a series of staff focus groups. Based on the findings of these and of the indicator tool, the steering group devised an internal action plan with specific issues for each division or local area to deal with. Local committees, each of which included a staff side representative, fed information into the trust’s Health, Safety and Welfare group. All the local action plans were monitored by the steering group. There were tight deadlines set for specific actions and some planned inspections by the HSE helped to focus the activity. The weekly staff bulletin was used to communicate all the stress-reduction activities that were going on around the organisation.

Appropriate facilities time was agreed for the health and safety reps – Anthony advises any health and safety rep who is about to embark on a similar piece of work to make sure that a reasonable amount of time is given to cover it. The relationship with the local HSE inspector and ACAS officers is also very important. At CWP, they were on hand to support the steering group throughout the process. An important aspect of the relationship was that the steering group felt free to have open discussions about any of the problem areas with the HSE Inspector, even if they showed that the organisation was falling short of the ideal at times. It was explained to the group that the management standards are a series of goals, to be worked towards in a programme of continuous improvement, rather than a one-off exercise.

The issues at CWP
The evaluation at CWP found that where stress existed it was felt very acutely. Another issue was a failure to manage staffing levels effectively in response to unplanned leave.

It was also clear that the nature of workplace stress had changed because of a significant change in the way in which mental health services are delivered. Anthony explains that with early intervention and
crisis resolution services delivered by home treatment teams, patients with less acute mental health conditions often don’t warrant hospital admission. This means the patients who are admitted all have far more serious conditions than ever before. Where once mental health staff worked with a variety of patients with different levels of mental ill health, now their job feels far more intense as they are often working one-to-one with a seriously disturbed patient. Anthony believes that over a period of time, staff get worn out and there is a rise in requests for leave at short notice or an increase in sickness absence. This can have a knock on effect if the staffing levels aren’t dealt with quickly and effectively, bringing increased workload and stress levels for the remaining staff. This precipitated Brilliant Basics Review of ward staffing at CWP which led to an increase in staffing of 27 in-patient staff.

Reducing sickness levels was one of the main aims of the project. Anthony explains that if someone took time off because of workplace stress, the cause was rarely documented on the sick note. While the steering group were aware of the overall sickness absence figures, they hoped that the indicator tool would give them a better idea of how much of absence was stress-related.

**Outcomes**

The most important outcome of implementing the HSE Management Standards was, according to Anthony, the acknowledgement that workplace stress was an issue and that the organisation was going to deal with it. Managers acknowledged that stress was not handled well before, but now the climate had changed. Because the experience of stress at work has become more acute, it is considered even more important to protect staff from its effects.

Often stress was seen as a personal failure rather than something that anyone can be subject to, given certain circumstances. Now the stigma about suffering from workplace stress has reduced at CWP, taking the focus from individuals and emphasising the organisation’s role in helping minimise stressors. While some managers were more sympathetic than others, the fact that there was organisation-wide support made staff feel more confident in talking about the issue. Anthony observed that, given that this is a mental health care trust, staff developed a sense that “if we can’t look after our own, who can we look after?”.

The new emphasis has brought various changes. For example, there has always been a training course managing stress available at CWP, but uptake was low. Now that the title of the course has been changed from: “How do you manage your stress?” to: “How to manage stress in the workplace”, the uptake has increased.

Another aim was to improve recruitment and retention and increase the number of staff returning to work after periods of stress-related, long-term sickness. CWP recently reviewed its Management of Attendance Policy. They used knowledge from the stress management process to highlight some of the triggers for absence. Now, if a member of staff is off sick regularly and stress is found to be a contributor, the staff member will be helped to recognise their particular stressors and given support to reduce their impact. Assessing workplace stress has helped managers to make early interventions rather than waiting for people to go off sick once the damage has been done.

The trust is now dealing with outstanding items in the individual local action plans, and monitoring stress-related sickness levels by team and by area so that issues can be pinpointed more quickly. All managers will have training on the revised Management of Attendance Policy, and staff side are involved in delivering this training.

**Links to related publications:**

- [www.hse.gov.uk/stress/casestudies/cheshirenhs.htm](http://www.hse.gov.uk/stress/casestudies/cheshirenhs.htm)

**County Durham and Darlington NHS Foundation Trust:**

**We can do something about stress**

**Background**

This case study is based on an interview with an RCN steward, Kath Fawcett, and extracts from the County Durham and Darlington NHS Foundation Trust case
study shown on the Health and Safety Executive’s website\(^1\). Deputy Ward Sister Kath Fawcett trained at Darlington Hospital in the 1960s and has worked there ever since. She has been an RCN steward since 1987, and was formerly both a steward and a health and safety rep.

There are about 6,000 employees in County Durham and Darlington NHS Foundation Trust, across four main hospital sites. In January 2005, their then occupational health physician signed up the trust to be one of the few health care organisations to adopt the HSE Management Standards. This work took place against a background of considerable organisational change, when there were approximately 700 redundancies at the trust.

Staff side supported the stress management project and the RCN and UNISON signed an agreement to participate in the work and help to gain employee involvement. Kath adds that this agreement was based on the expectation that there would be concrete action taken on the results of the assessment, even if that required some financial investment from the trust.

The trust set up a steering group, chaired by the director of estates and facilities, with members of the health and safety committee and staff side representatives including Kath, who was chair of the joint consultative committee. Before the work started, the steering group met several times to discuss the process with the HSE officer. While the unions were considered key players, in practice they found it very difficult to get time off to attend all of the meetings.

**Data gathering**

Managers knew from the staff survey that there were indications of workplace stress. The steering group now used the HSE indicator tool to gather detailed data. The questionnaire was attached to all employees’ pay slips and achieved a 30% response rate. The group also used sickness absence data and data from the occupational health department and counselling service. Sickness levels were not particularly high across the trust, but areas with higher levels seemed to correspond to the areas showing higher levels of stress according to the indicator tool.

The steering group then set up a series of focus groups. At first, these were not well attended. Kath felt that this was mainly due to managers not wanting to admit that there was a problem with workplace stress. There was also some difficulty in getting clinical staff to take time out to participate because of their workload, but measures were taken to improve attendance in areas where stress appeared to be high. In total, 120 staff attended the focus groups. The groups were made up from a range of different combinations of staff: groups of junior, middle and senior managers, some mixed groups, some site-specific. The peer groups – those that mixed staff who had common experiences and similar problems - were considered to be the most successful.

Every group considered the same initial question: “What is it like to work in this trust?” Discussion then covered the six HSE six key areas (demands, control, support, relationship, role and change) to uncover the issues for particular groups. The notes from all the focus groups were fed back to the steering group.

From the data gathering, the steering group discovered pockets of workplace stress in Durham and Darlington, particularly in pharmacy and general medicine. The steering group set up specially-facilitated discussion groups for staff in the problem areas, to find out more about the causes and to help staff to develop the action plans to solve them. Facilitators were taken from a range of backgrounds across the trust and given a helpful, two-day ACAS facilitation training course.

It was difficult to get general medicine staff away from the wards to tackle these issues. So the facilitators went onto the ward and arranged focus groups around the shift workflow, so that most people could get involved in the discussions at some point.

**Outcomes**

The results from the focus groups led the steering group to develop action plans for the whole trust, as well as specific plans for sub-groups. Some actions were given to named individuals to take forward. The trust has carried out extra work with specific departments where difficult issues were identified. The steering group used the stress indicator tool again to review the results of the action plans, and found

\(^1\) [http://www.hse.gov.uk/stress/casestudies/durhamnhs.htm](http://www.hse.gov.uk/stress/casestudies/durhamnhs.htm)
improvements in some areas but that there was still work to reduce stress further in others.

In pharmacy, problems were identified in communication both within the team and with other departments. Kath explains that the latter was partly due to the system where, if a staff member was waiting for a discharge prescription, they would phone the pharmacy to chase it up. These calls increased pharmacy staff workload and raised stress levels. As a result of the stress assessment, an online system was devised so that staff in other departments could see their progress in the queue for prescriptions on screen, reducing pressure on pharmacy staff to answer phone calls.

A specially facilitated group also helped the pharmacy team examine how they worked together. It was difficult for staff to confront their managers with their issues - and difficult for the managers to hear them. But the skill of the facilitators allowed an open and frank discussion and helped the team to devise ways of working which would improve things.

Staff were given an open invitation to suggest actions either for the whole trust or for particular areas. Realistic and achievable suggestions were taken up. For example, the coffee area was made separate from working areas so that staff could relax properly on their breaks. Another suggestion was for better training for line managers in the use of the various HR policies that were already in place. For example, managers were requested to be more flexible, on leave policies and flexible working for instance, rather than acting strictly 'by the book'.

The trust has now implemented a system where people experiencing workplace stress can self-refer to occupational health and/or the counselling service. However, people are sometimes reluctant to access these services without encouragement. So staff support officers, originally introduced to help deal with bullying and harassment, are now also involved in working on stress. These officers receive formal training in supporting staff who need help dealing with stress, and can direct individuals to occupational health or the counselling service. They are not usually staff side representatives, but will refer a member of staff to a staff side rep if they feel there is an appropriate issue or the need for formal action.

Managers were given training in identifying when a member of staff is suffering from stress and to recognise that the same level of pressure can have a different impact on different members of staff.

The most important outcome of the project, Kath feels, was that it raised awareness about workplace stress and made people realise that something can be done about it. She also said that it made the trust realise that people like to be appreciated and that such support can make a big difference to people’s working lives.

Learning points

- Prepare and resource properly. You need a team who can be mutually supportive and who understand the project, otherwise things can grind to a halt.
- Detailed planning is absolutely critical in a large organisation. Booking rooms, sending out invitations and so on dictated when the focus groups could run.
- A major problem was that there was not enough reflection time – things were very rushed.
- The exercise was undertaken at a very busy time. The usual staff side and management representatives ended up taking the bulk of the work, therefore, when it would have been desirable to involve a more diverse cross-section of staff.

NHS Direct: Addressing the causes of stress

Background

NHS Direct (NHSD) provides expert health advice and information 24 hours a day, 365 days a year. This case study is based on interviews with two RCN representatives based at two different NHS Direct call centres. Maria Bryson has been a nurse adviser for the last 10 years and a Safety representative for over 20 years. She now mainly acts in the steward’s role but is still interested in health and safety issues and raises them when appropriate. Douglas Gill has worked as a nurse adviser at NHSD for 10 years, has been an RCN steward for 15 and has now become a safety representative. Douglas is joint chair of the NHSD health and safety committee and was the lead RCN
representative on the stress steering group. Maria felt that some of the issues she read about in the HSE’s documents on stress were affecting staff at NHSD. For example, she was aware from the staff survey that there were high sickness absence rates and recruitment and retention problems which were significantly higher for frontline staff (nurses, health advisers, health information practitioners and first level managers). This prompted her to try to find out about the extent of workplace stress at NHSD and if possible to identify the root causes. Using the HSE’s stress indicator tool, Maria ran a trial to see what kind of responses she would get and sent the tool to the representatives’ network asking for a sample of frontline staff to complete it. Once she got 50 responses, she used the HSE’s analysis tool to present the findings.

From this initial piece of work, there were indications that NHSD frontline staff were indeed experiencing workplace stress, particularly in relation to control, relationships, role and change. She presented these findings at a National Joint Partnership Forum (NJPF) meeting. The first response from managers was negative, some resisting the idea that staff experienced any stress due to their work. However, Maria persisted and asked management to consider that stress might have been one of the underlying causes of the high turnover and absence rates.

Douglas adds that managers held the idea that workplace stress at NHSD was caused mainly by interaction with patients and there were already procedures in place including specifically targeted training to tackle this issue. The executive team was quite shocked to find that internal policies and procedures were causing stress, in particular the newly implemented rostering system, which they felt was merely an administrative function. However, the indicator tool’s findings supported the evidence from a number of exit interviews which showed that lack of control over when staff worked was the main reason for people leaving.

In Maria’s opinion, part of the cause of workplace stress is that nurses as a group tend to find it difficult to say ‘no’. Added to this, the NHS culture encourages the view that to be constantly busy is considered positive. NHSD had also become very target-driven over the past few years and the level of performance monitoring was contributing to a stressful working culture.

The Issues at NHSD

NHSD had also commissioned independent research into the well being of staff nationally, to see what was causing the recruitment and retention problems and the high sickness rates. This survey showed the main drivers of absence to be the impact of the rostering system and the lack of social interaction. The results were presented locally at the Regional Joint Partnership Forums (RJPF), highlighting hot topics for each region to deal with.

The survey showed particular stressors specific to the NHSD call centre environment. One of these was the lack of closure at the end of a shift. Maria explains that with no face-to-face interaction either with the patient or with your colleagues, you never get any visual reassurances as you would on a ward. You rarely find out if the advice you have given has had the desired outcome. The nurse advisers have no opportunity to discuss a patient during a ward-style handover, with only ten minutes or so at the end of their shift to look at their emails and get time sheets signed.

The staff survey showed that nurses at NHSD feel lonely at work, even though they are surrounded by people. The layout of many of the call centres separates managers, nurses and call handlers into different areas so they don’t get an opportunity to talk to each other.

Voice loss and laryngitis is also an issue. Maria explained that the policy at the moment is that if you can’t take calls, you can’t work – if you need to rest your voice, you are not allowed to come in and do other work such as emails or administration. So, rather than building up sick days, staff with voice loss tend to come in and take calls anyway, which can strain their throats and be very stressful.

Outcomes

These findings prompted Maria to suggest that the NJPR get the Health and Safety Committee to form a stress working group. A group was set up, including Douglas as the staff side representative, and it
developed a stress policy. The policy aims to help staff identify their own stressors and how they can avoid them or deal with them. Staff were asked for comments on the policy before the final wording was agreed in partnership between staff side and management. Each member of staff received an emailed copy. Douglas says that staff members like the policy because it is informal and takes a human approach, taking into account that anyone is vulnerable to stress whether its source is home or work.

The working group also developed action plans for the main causes of stress at NHSD, namely the rostering system, workload, monitoring and the working environment (too noisy or too hot or cold). For example, on rostering, there are now clear steps for a member of staff to take if they are unhappy with their working hours. The London area came up with a simple solution on the working environment: they created warmer and colder areas in the call room so that people could sit in the one they preferred. The working group has set up monthly meetings where the action plans will be regularly reviewed.

Feedback from further externally commissioned research, by IFF in 2008, has led management to make the service more patient- and staff-focused rather than target-led. For example, the research showed that patients appreciated it more when they felt they were having a "real conversation. So nurse advisers are now allowed to use their clinical knowledge more freely in dealing with patients, rather than following a script to the last word.

The separate pieces of research are coming together to create a sense of momentum to tackle the issues causing workplace stress. Continuing to work in partnership on this issue will no doubt improve the wellbeing of frontline staff, which in turn is expected to reduce the attendance and turnover problems. The stress working group will monitor absence and turnover data to see if the stress policy is having an impact. The next stage will be to link up the stress policy with other issues such as flexible working - these are interrelated, particularly when personal stresses affect performance at work.

Douglas advises any staff side rep who would like to pursue stress management to familiarise themselves with the issues before approaching managers, for example by reading the HSE website on stress and RCN guidance. He advises reps to "Stand up for yourself, don’t be afraid to have your say, but be able to back it up with the right evidence".

**NHS Highland: Using a systematic approach to tackle workplace stress**

**Background**

NHS Highland is the largest NHS Scotland health board (covering 41% of Scotland), and covers the most sparsely populated part of the UK, with a mountainous terrain, rugged coastline and populated islands. In 2005, NHS Highland made a commitment to deal with workplace stress, and appointed a fulltime stress prevention manager to co-ordinate this work, Stephen Hodges. This case study is based on an interview with Stephen and discussions with Diane Fraser, RCN representative and chair of the health and safety committee for NHS Highland.

Stephen worked as a staff nurse on an intensive therapy unit before he was seconded to undertake a study into the scale and nature of work-related stress in NHS Highland. Phase I of the study looked at the scope and nature of workplace stress, using a tool called Work Positive (which is similar to the HSE indicator tool) to survey the whole workforce. Despite the rural environment, the findings showed there was the same level of stress as in the rest of NHS Scotland. Phase II looked at the effectiveness of a computer-based training package in reducing individuals' perceptions of stress. The tool chosen was 'Under Pressure', produced by Robertson Cooper Ltd, and was very useful.

Around the same time, NHS Scotland's Partnership Information Network (PIN) produced a policy aimed at dealing positively with stress, and the HSE launched its Management Standards. Stephen was appointed health and safety adviser, which also encompassed a stress management role.

NHS Highland adapted the national stress policy for the Highlands, and integrated the HSE tool into the
policy. They rolled out a training programme on stress awareness for staff and to help support managers in dealing with workplace stress. Stephen also provided assistance to managers who were carrying out risk assessments using the HSE indicator tool. However, since risk assessments were not universally applied, Stephen realised that only those who were truly ‘signed up’ to managing stress were most likely to approach him.

HSE Inspection
An HSE inspection in 2007 looked at the management of stress and sickness absence at NHS Highland found evidence of good practice. But the HSE felt that there should be a more systematic rollout of the Management Standards. As a result, Stephen’s post was moved to the occupational health department and from 2008 became full time in managing stress. His work is in three strands, based on the HSE’s *Beacons of excellence in stress prevention*:

- the prevention of stress, including rolling out the HSE management standards across the whole of NHS Highland
- education and training, providing stress awareness courses, feeding into staff management training and the nursing/midwifery undergraduate courses at the University of Stirling
- supporting staff who are experiencing stress by running educational groups using cognitive behavioural therapy (CBT) to help people recover and return to work. This is part of a programme which also includes occupational health nurses providing guiding self-help, and one-to-one CBT with accredited therapists.

Stephen also sits on a stress steering group, which includes staff side representatives, and whose remit it is to join up these strands and ensure all parts of the organisation are aware of the work. The stress steering group reports into the health and safety committee. Stephen also gets together regularly with staff representatives and has carried out ‘train the trainer’ sessions on stress awareness. The reps can then carry out training events in their own localities. It is also useful because reps can raise the issue at forums that Stephen isn’t involved in, such as the area partnership forum, governance committees and the health and safety committee. The role of the staff side rep is invaluable in helping to spread the message of the importance of stress reduction and facilitate two-way communication.

HSE Management Standards
NHS Highland is currently systematically rolling out the stress Management Standards across the four Community Health Partnerships (CHPs) of NHS Highland, covering every ward in every NHS hospital. Stephen works with hospitals and workplaces to explain rationale for doing the work and provides the necessary information and resources.

Each workplace is then responsible for undertaking the risk assessment and sending the results to Occupational Health. Where there are staff side reps available, they can help to deliver the training and carry out the risk assessments. Stephen analyses these initial results and then guides the workplace through the process of focus groups and production of action plans.

The results for each ward or department are sent to the ward manager so that they can identify particular issues for their area and devise an action plan with their staff. All the ward results collectively build up a picture for a whole hospital, allowing the hospital manager to compare wards, find areas of good practice or any problem ‘hot spots’.

CHP managers receive all hospital results for comparison across their regions. Stephen also provides comparisons against the HSE benchmarks (drawn from real data from 200 organisations).

Stephen makes it clear during training that the management standards are goals to work towards, rather than a one-off event, and should become part of the ongoing safety management system. When the health and safety team audit a ward or department their checks include whether work on managing stress work is up to date. This project started in April 2008 and the aim is to finish all the initial risk assessments by the end of 2009.

Outcomes
Solutions from action plans that have made a difference so far include:
- improved communication during periods of change
introduction of regular staff meetings
dealing with problems or inconsistencies in handover
couraging staff to be more mutually supportive during busy periods
ensuring all staff have professional development plans and fair and equal access to training
getting more staff appointed to a team when there was evidence of excessive workloads
highlighting training needs.

The steering group is working on a corporate stress action plan. The steering group also oversees the process of stress risk assessment to make sure it runs smoothly and to time.

The HSE’s most recent inspection of NHS Highland showed good results. The organisation is pursuing the Healthy Working Lives initiative and working towards a number of awards under the initiative.

**Lessons learned**

Stephen stresses that it is important not to focus on the tool that you use, whether it be the HSE’s indicator tool or another – the tool merely facilitates a process of information gathering to identify problems. After that, the responsibility is with managers to talk to staff, identify the causes of stress and solve the problems together.

One of the key benefits of the HSE approach is that it is bottom up: the work starts in the ward, department or GP surgery and builds upwards. Although regular staff surveys are very useful to give a general overview of morale and motivation, they can’t pin point issues in a specific ward and in some cases can even mask problem areas.

Stephen’s view is that the focus groups are a much more important part of the process than any questionnaire in helping managers to communicate effectively with their teams to determine the actions needed to alleviate workplace stress.

The NHS Highland case shows the benefits of a dedicated manager to support implementation of the HSE standards. Stephen hopes that once all the initial risk assessments are complete, he can step back and allow managers to take this work forward themselves.

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2 for example, NHS Scotland Staff Survey, January 2009
References


Further Information

RCN Publications

RCN publications can be accessed at: www.rcn.org/publications


RCN Learning Zone


Health and Safety Executive information

HSE Web pages on Stress at: www.hse.gov.uk/stress
HSE Northern Ireland web pages on stress at: www.hseni.gov.uk/index/stress_management.htm

Other information


NHS Employers website: www.nhsemployers.org/HealthyWorkplaces/WorkplaceStress
International Stress Management Association: www.isma.org.uk
UK National Work-Stress Network: www.workstress.net
The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

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