

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PUBLIC HEALTH DRAFT GUIDELINE

Workplace policy and management practices to improve the health and wellbeing of employees

[Issue date: month/year]

What is this guideline about?

This guideline makes recommendations on improving the health and wellbeing of employees, with a particular focus on organisational culture and context, and the role of [line managers](#).

The aim is to:

- promote [leadership](#) that supports the health and wellbeing of employees
- help line managers to achieve this
- explore the positive and negative effect an organisation's culture can have on people's health and wellbeing
- provide a business case and economic modelling for strengthening the role of line managers in ensuring the health and wellbeing of employees.

The guideline is for employers, managers (including line managers) and employees. It will also be of interest to those working in occupational health, health and safety, trade unions and professional bodies. In addition, it may be of interest to other members of the public. (For further details, see [Who should take action?](#))

See [About this guideline](#) for details of how the guideline was developed and its current status.

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1 Draft recommendations

Recommendation 1 Create an organisation committed to workplace health

All employers should:

- Understand the strategic importance, value and benefits of a healthy workplace. Health and wellbeing should be an important agenda item for the top management of an organisation. Employers should encourage a consistent, positive approach to all employees' health and wellbeing.
- Familiarise themselves with the business case for ensuring employees' health and wellbeing.
- Demonstrate that all managers in the organisation, including directors and board members, are committed to the health and wellbeing of their workforce and act as good role models.
- Incorporate health and wellbeing in all corporate policies and communications. For example, by ensuring employees work reasonable hours and have regular breaks.
- Ensure that health and wellbeing is central to [talent management](#) processes for recruiting, developing and involving employees.
- Understand that a proactive and visible commitment to health and safety can improve the health and wellbeing of employees, that is, view health and safety as part of the culture of a caring and supportive employer – not just as a statutory requirement.

Recommendation 2 Ensure facilities, policies and procedures show a commitment to employee health and wellbeing

Employers should ensure:

- All facilities are clean, safe and of a good standard.
- Workplace policies and procedures are developed and implemented to reflect the principles of the [Health and Safety Executive's Management Standards for Work Related Stress](#). These cover 6 aspects of work and the

process for assessing and managing these identified risk factors, which include:

- demands (workload, work patterns and work environment)
 - control (how much say the employee has in the way they do their work)
 - support (from organisation, line manager and colleagues)
 - relationships (promoting positive working to avoid conflict and dealing with unacceptable behaviour)
 - role (if employees understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles)
 - change (how change is managed and communicated in the organisation).
- Workplace policies to improve workplace health and wellbeing are implemented and delivered with confidence. Make communication clear to ensure that employees have realistic expectations.

Recommendation 3 Ensure fairness and justice throughout the organisation

Employers (including managers) should:

- Understand that all levels of management have an obligation to ensure that proper procedures and legal obligations are complied with.
- Ensure all policies and procedures are fair and equitable, and any unfairness is addressed as a matter of priority. Line managers should know how to signpost employees to support if the employee feels that they are being treated unfairly.
- Ensure employees feel valued, trusted and included.
- Encourage employees to have a voice in the organisation, and actively seek their contribution in decision-making. Employees' contribution should be valued and acknowledged across the organisation and, if practical, their input should lead to action.

Recommendation 4 Provide leadership

Senior managers should:

- Provide consistent leadership from the top, ensuring the organisation as a whole takes a positive approach to employee health and wellbeing and that appropriate policies and procedures are implemented. This should be part of the everyday running of the organisation, as well as being included in performance reviews, goals and objectives.
- Provide support to ensure that effective workplace policies and interventions are implemented for line managers, so that they in turn can support the employees they manage.
- Ensure line managers are aware that health and wellbeing is a central part of their role, for example by including it in line managers' job descriptions and emphasising it during recruitment.
- Display the positive leadership behaviours they ask of their line managers, such as spending time with people at all levels in the organisation and talking with employees.

Recommendation 5 Empower line managers to enhance employee's health and wellbeing at work

Employers (including senior managers) should:

- Recognise and support the key role that line managers have as the primary contact between employees and the organisation.
- Acknowledge that line managers have an important role in protecting and improving the health and wellbeing of their employees.
- Make line managers aware of the importance of health and wellbeing within the organisation.
- Give line managers adequate time, training and resources to ensure they balance organisational performance with a concern for the health and wellbeing of their employees.

Recommendation 6 Develop a positive line management style

Line managers should:

- Adopt a 'transformational leadership' style of management. This includes:

- encouraging creativity, new ideas and exploring new ways of doing things and opportunities to learn ('intellectual stimulation')
- offering support and encouragement to each employee to build a supportive relationship; acting as a mentor or coach; being open and approachable to ensure that employees feel free to share ideas; recognising the contribution of each employee ('individualised consideration')
- having a clear vision that they can explain and make relevant to employees at all levels; ensuring employees share the same motivation to fulfil their goals ('inspirational motivation')
- becoming role models who are trusted and respected by employees. They should provide a sense of meaning and challenge and build a spirit of teamwork and commitment ('idealised influence').
- In addition to transformational leadership, use the following approaches:
 - consult regularly on daily procedures and problems
 - promote employee engagement and communication
 - recognise and praise good performance
 - work with employees to produce and agree employees' personal development plans
 - be proactive in identifying and addressing issues and concerns early, and take preventative action at the earliest opportunity.
- Show empathy and have an understanding of both internal and external causes of stress, such as excessive workload, financial worries, work-home conflict or family issues. Signpost employees to further support outside the workplace.
- Avoid negative behaviour such as detachment from colleagues and ignoring employees' suggestions. Ensure they monitor and manage their employees as a group ('group dynamics') and are always welcoming and accessible. Ensure they always consult employees before making decisions that will have an impact on them and try, where possible, to consider their suggestions.

Recommendation 7 Provide line managers with ongoing training

Employers should:

- Ensure line managers receive training in:
 - transformational leadership (see recommendation 6)
 - the importance of maintaining people’s health and wellbeing at work
 - the implications of organisational change and how to manage it
 - communication skills, including how to have difficult conversations with employees
 - developing people’s skills and resolving disputes
 - how to support employees by setting them relevant and realistic targets
 - how to recognise when someone may need support (for example, because of problems achieving a work–life balance, demands of home life or unfair treatment at work) and awareness of the services they could be signposted to.
- Ensure the above skills and behaviours are set out in any documents outlining the skills and knowledge line managers need and in their key performance indicators.
- Ensure line managers receive training to promote their awareness of mental health and wellbeing issues. This includes increasing their awareness of how they can have an impact on the psychological wellbeing of employees. It also includes equipping managers to identify when someone may have a mental health problem and ensuring they can give them advice on where to get further support.

Recommendation 8 Ensure the way jobs are designed and general work patterns have a positive effect on health and wellbeing

Line managers should:

- Where possible, be flexible about work scheduling, giving employees control and flexibility over their own time.

- Encourage employees to be involved in the design of their role to strike a balance between the work demanded of them and their sense of control over when and how it is completed, given the resources and support available.

Recommendation 9 Measure the impact of new activities and policies

Employers and managers should:

- Regularly monitor and evaluate the effect of new activities, policies or recommendations on employee health and wellbeing.
- Ensure managers regularly review their own progress in promoting workplace health and wellbeing and acknowledge any gaps in their skills and competencies. Organisations should support line managers in this activity.

Recommendation 10 Create a national database for workplace health and wellbeing data

National agencies, research organisations, human resource organisations or professional bodies should:

- Create a national database on workplace interventions to improve employees' health and wellbeing. This should include productivity and business outcomes, cost information and the general benefits of providing a healthy workplace.
- Encourage researchers on workplace health to contribute to this database.

2 Who should take action?

Introduction

The guideline is for all managers in all sectors (including directors and board members), employers and employees.

It will also be of interest to those working in:

- human resources, learning and development, organisational development and [talent management](#)
- occupational health
- trade unions
- professional bodies
- business organisations
- recruitment teams and organisations
- health and safety.

It will also be of interest to employees and other members of the public.

In addition, it may be of interest to professionals, commissioners and managers with public health as part of their remit working within the NHS, local authorities and the wider public, private, voluntary and community sectors.

Who should do what at a glance

Who should take action?	Recommendation
Line managers	1, 3, 4, 5, 6, 8, 9
Employers	1, 2, 3, 4, 5, 6, 7, 8, 9
Senior managers including directors and board members	1, 2, 3, 4, 5, 6, 7, 8, 9
Occupational health	1, 2, 3, 4, 5, 6, 7, 8, 9
Trade unions	1, 2, 3, 4, 5, 6, 7, 8, 9
Employee representatives	1, 2, 3, 4, 5, 6, 7, 8, 9
Business organisations	1, 2, 3, 4, 5, 6, 7, 8, 9
Human resource organisations	1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Recruitment teams or organisations	4, 5, 7, 9
Professional educators and trainers	4, 5, 6, 7, 9
Research organisations	10
Professional bodies	10
National agencies	10
Department for Work and Pensions (DWP), Department of Health (DH) and Public Health England (PHE)	1, 2, 3, 4, 5, 6, 8, 9

Who should take action in detail

Recommendation 1

Line managers, employers, senior managers including directors and board members, occupational health, trade unions, employee representatives, business organisations, human resource organisations and DWP, DH and PHE.

Recommendation 2

Employers, senior managers including directors and board members, occupational health, trade unions, employee representatives, business organisations, human resource organisations and DWP, DH and PHE.

Recommendation 3

Line managers, employers, senior managers including directors and board members, occupational health, trade unions, employee representatives, business organisations, human resource organisations and DWP, DH and PHE.

Recommendation 4

Line managers, employers, senior managers including directors and board members, occupational health, trade unions, employee representatives, business organisations, human resource organisations, recruitment teams or organisations, professional educators and trainers and DWP, DH and PHE.

Recommendation 5

Line managers, employers, senior managers including directors and board members, occupational health, trade unions, employee representatives, business organisations, human resource organisations, recruitment teams or organisations, professional educators and trainers and DWP, DH and PHE.

Recommendation 6

Line managers, employers, senior managers including directors and board members, occupational health, trade unions, employee representatives,

business organisations, human resource organisations, professional educators and trainers and DWP, DH and PHE.

Recommendation 7

Employers, senior managers including directors and board members, occupational health, trade unions, employee representatives, business organisations, human resource organisations, recruitment teams or organisations and professional educators and trainers.

Recommendation 8

Line managers, employers, senior managers including directors and board members, occupational health, trade unions, employee representatives, business organisations, human resource organisations and DWP, DH and PHE.

Recommendation 9

Line managers, employers, senior managers including directors and board members, occupational health, trade unions, employee representatives, business organisations, human resource organisations, recruitment teams or organisations, professional educators and trainers and DWP, DH and PHE.

Recommendation 10

National agencies, research organisations, human resource organisations or professional bodies.

3 Context

There is strong evidence to show that work is generally good for people's physical and mental health and wellbeing ([Is work good for your health and well-being?](#), Department for Work and Pensions 2006; [Annual report of the Chief Medical Officer surveillance volume, 2012](#), Department of Health 2014).

It meets important psychosocial needs in societies where employment is the norm and is central to someone's identity, social role and status ('Is work good for your health and well-being?'). Work can also reverse the ill-health effects of unemployment.

However, these benefits do depend on the type of work involved ([Good work and our times](#), Good Work Commission 2011).

During 2011/12, 1.1 million working people had a work-related illness. Half a million of these were new illnesses ([Annual statistics report for Great Britain 2012/13](#), Health and Safety Executive 2013). Work-related illness led to the loss of an estimated 27 million working days in 2011/12.¹ It cost society an estimated £13.4 billion in 2010/11 (excluding cancer) ('Annual statistics report for Great Britain 2012/13').

People's health can be damaged at work by:

- physical hazards
- physically demanding or dangerous tasks
- long or irregular working hours or shift work
- tasks that encourage a poor posture or repetitive injury
- tasks that mean someone is sedentary for prolonged periods of time.

Lack of control over the work (including a lack of opportunity to take part in decision-making), conflicts in workplace hierarchies, and covert or overt discrimination can also affect health.

All these factors are most prevalent among people who are in jobs that are low paid, unsafe and insecure ([Fair society, healthy lives](#), The Marmot review 2010). On the other hand, the Good Work Commission in 'Good work and our times', noted that 'employees and employers alike recognise that these days guaranteeing job security is unrealistic'. It also pointed out that employers have a role in ensuring people are equipped with transferable skills that will be an asset in the future.

The World Health Organization has highlighted the importance of ensuring the culture of an organisation promotes health and wellbeing ([Healthy workplaces:](#)

¹ All the data quoted by the Health and Safety Executive have been taken from the Labour Force Survey. These data refer to 2011/12 because no Labour Force Survey data for ill health are available for 2012/13.

[a model for action](#) 2010). A 'healthy' culture, for example, would include having fully implemented policies on:

- dignity and respect
- preventing harassment and bullying
- preventing gender discrimination
- tolerance for ethnic or religious diversity
- encouraging healthy behaviours.

Good line management has also been linked with good health, wellbeing and improved performance ([Working for a healthier tomorrow](#), Department for Work and Pensions 2008).

Poor-quality leadership, on the other hand, has been linked with stress, burnout and depression ([Mental capital and wellbeing: making the most of ourselves in the 21st century](#), Government Office for Science 2008). It can also affect how well employees relate to the organisation, their stress levels and the amount of time they spend on sick leave ([Preventing stress: promoting positive manager behaviour phase 4: How do organisations implement the findings in practice?](#), Chartered Institute of Personnel and Development 2011; Westerlund et al. 2010).

A Confederation of British Industry (CBI) report highlighted the importance of providing adequate training for line managers to help them support employees with a health condition to remain at work ([Getting better: workplace health as a business issue](#) 2014).

Evidence suggests that people attending work while they are sick ('presenteeism') is a more costly problem for employers than absenteeism ([Mental health at work: developing the business case. Policy paper 8](#), Sainsbury Centre for Mental Health 2007). This is partly because it is more likely to occur among higher-paid employees.

'Presenteeism' may be caused by either the culture of an organisation or the nature of the work – or both (people may come to work when they are unwell because they don't want to let their team members down). Almost three-

quarters of employers who responded to a CBI survey reported that presenteeism reduced staff productivity levels ([Healthy returns? Absence and workplace health survey 2011](#)). It leads to poorer longer-term health outcomes (Kivimäki et al. 2005; Donaldson-Feilder and Podro 2012).

4 Considerations

This section describes the factors and issues the Public Health Advisory Committee (PHAC) considered when developing the recommendations.

Please note: this section does **not** contain recommendations. (See [Recommendations](#).)

- 4.1 Self-employed people are not included in this guideline. However many self-employed people are also line managed, for example on a fixed-term contract or for a particular project. The guideline also applies to the line management of contract, temporary and agency employees.
- 4.2 The Committee acknowledged that the relationship between line management and employee wellbeing is complex and can vary by occupation, sector and a number of other factors.
- 4.3 The Committee acknowledged the different cultures and working practices between organisations. These can vary widely by organisation size, from large multinational organisations to [micro-organisations](#). These differences will affect how recommendations are implemented.
- 4.4 The evidence reviews showed that studies conducted in different countries often yielded similar results. The applicability of findings to the UK were taken into account.
- 4.5 All of the findings showed a positive association between all interventions and employee health and wellbeing. Causation could not be determined by the studies included in the qualitative reviews.

- 4.6 The consequences of implementing workplace health policies or interventions need careful consideration because they may have unexpected (and often undesirable) knock-on effects on other employees. The core principle of workplace health policies or interventions is to 'cause no harm'.
- 4.7 The Committee recognised that within most organisations promotion opportunities normally involve increased management responsibilities. However, some people with excellent technical skills do not have (or do not want to develop) the necessary 'people skills' to line manage. The Committee noted that these people may benefit from alternative promotion and development opportunities.
- 4.8 The Committee highlighted that a return to work from sickness does not necessarily indicate improved health and wellbeing of an employee. Committee members were aware of line managers being forced to implement aggressive return to work procedures. These may result in a sick colleague returning to work. Such procedures may encourage presenteeism to the detriment of the organisation.
- 4.9 Most of the studies identified in the evidence reviews report short-term outcomes. The Committee felt that a long-term focus is also needed when commissioning and planning further research. There is a need for more longitudinal studies to investigate sustainable effects.
- 4.10 The Committee suggested that further research studies need at least 3 measurement points:
- before the intervention takes place
 - after the intervention has finished, to measure immediate impact
 - a later point, such as 12–18 months from the start, to measure longer-term impact.

Economic evaluation

- 4.11 Many benefits of improving the health of employees through improved workplace practices are extremely hard to measure quantitatively. These benefits include a feeling of increased safety and satisfaction, greater loyalty, and improved societal reputation for employers, and are associated with increased productivity of workers. There is consistent evidence that relatively small investment in line manager training (and its effects on their attitudes and those of their employees) can lead to worthwhile improvements in worker satisfaction, which in turn are linked to gains in productivity for the organisation. From the modelling done for this topic, it is shown that these productivity increases will usually be at least as large as the benefits of lowering absenteeism, presenteeism and employee turnover. However, it may take some time to recoup the initial investment.
- 4.12 The Committee noted that organisations that suffer from cashflow problems (particularly in times of depressed economic activity) may need to focus on projects that give a rapid return on investment. However, the Committee observed that when economic conditions improve, organisations will be able to give more serious attention to instituting workforce interventions that are likely to gain substantial longer-term returns.
- 4.13 There is undoubtedly great variation from one organisation to the next in their ability to achieve productivity gains by these means. Organisations such as those offering seasonal work, which will naturally have very high rates of turnover, will gain less than organisations with more constant patterns of work flow and thus more stable workforces.

This section will be completed in the final document.

5 Recommendations for research

The Public Health Advisory Committee (PHAC) recommends that the following research questions should be addressed. It notes that ‘effectiveness’ in this context relates not only to the size of the effect, but also to cost effectiveness and duration of effect. It also takes into account any harmful or negative side effects.

All the research should aim to identify differences in effectiveness among groups, based on characteristics such as socioeconomic status, age, gender and ethnicity.

5.1 There is a need for research to examine the implementation of the recommendations made in this guideline. More UK intervention studies are needed with line managers in a range of organisations to answer the following questions:

- What is the effect of including positive management criteria (associated with employee health and wellbeing) in line manager selection?
- What is the effect of training line managers in positive management behaviours?
- What is the effect of changes to working practices (such as introducing more employee autonomy and control)?
- What is the effect of intervention length (such as training of line managers) and the gradual change in intervention effect? Such studies would help in economic modelling and in assessing the length of time over which the cost of interventions should be discounted in economic analyses.
- What is the role of occupational health, human resources and health and safety in supporting line managers in promoting workplace health and wellbeing?
- How might these functions work effectively, both together and separately, to improve health and wellbeing at work?

- 5.2 Research funding bodies such as the National Institute for Health Research should include clear outcome measures relating to workplace wellbeing, work retention, workplace absence, workplace performance and productivity, return to work and work retention in all the research they fund. This will ensure that all intervention research examines the effect on people's working lives.
- 5.3 There is a need to identify and use validated tools consistently to measure success, especially in measures of health and wellbeing, performance, productivity and in economic terms. Research studies should collect both subjective and objective measurable outcomes of wellbeing. This will help organisations to make a business case to invest in policies and measures to improve the health and wellbeing of their employees.
- 5.4 There is a need for better design and reporting of the outcomes used in studies, so researchers can identify 'active ingredients'. There is also a need for more accurate and detailed reporting of study methods to encourage transparency, ensure studies can be replicated and assess long-term impact.
- 5.5 Studies should report what does not work as well as what works. The suppression of negative results can also bias study effectiveness.

More detail identified during development of this guideline is provided in [Gaps in the evidence](#).

6 Related NICE guidance

Published

- [Promoting mental wellbeing at work](#). NICE public health guidance 22 (2009)

- [Managing long-term sickness and incapacity for work](#). NICE public health guidance 19 (2009)
- [Promoting physical activity in the workplace](#). NICE public health guidance 13 (2008)
- [Workplace interventions to promote smoking cessation](#). NICE public health guidance 5 (2007)
- [Behaviour change](#). NICE public health guidance 6 (2007)
- [Obesity](#). NICE clinical guideline 43 (2006)

Under development

- Workplace health: employees with chronic diseases and long-term conditions. NICE public health guideline. Publication date to be confirmed.
- Workplace health: older employees. NICE public health guideline. Publication date to be confirmed.

7 Glossary

Absenteeism

Absence from work that is attributed to sickness or to other reasons by the employee and accepted as such by the employer.

Leadership

The action of leading a group of people or an organisation, or the ability to do this. The ability of an organisation's management to make sound decisions and inspire others to perform well.

Line manager

A person with direct managerial responsibility for an employee.

Micro-organisation

An organisation employing fewer than 10 people.

Occupational health service

A service established either in-house or externally to:

- protect employees against health hazards from their work or working conditions
- support the physical and mental wellbeing of employees
- conduct medicals and monitor the health of both new and existing employees
- help organisations manage both short- and long-term sickness absence.

Participatory approach

Activities that allow people to play an active and influential part in decisions that affect their lives.

Presenteeism

Can describe being in work despite health problems. It also describes someone's attendance at work without performing all of their usual tasks (regardless of the reason). It describes a scenario in which employees do not function fully, leading to losses in productivity. Presenteeism can also make health problems worse.

Talent management

Talent management is the systematic attraction, identification, development, engagement and retention of employees who are of particular value to an organisation.

Transformational leadership

The leader creates a clear vision, encourages creative input from team members, treats people as individuals and acts as a positive role model.

8 References

Donaldson-Feilder E, Podro S (2012) The future of health and wellbeing in the workplace. ACAS future of workplace relations discussion paper series. London: Advisory, Conciliation and Arbitration Service

Kivimäki M, Head J, Ferrie JE et al. (2005) Working while ill as a risk factor for serious coronary events: the Whitehall II study. *American Journal of Public Health* 95: 98–102

Westerlund H, Nyberg A, Bernin P et al. (2010) Managerial leadership is associated with employee stress, health, and sickness absence independently of the demand-control-support model. *Work* 37: 71–9

9 Summary of the methods used to develop this guideline

Introduction

The reviews and economic modelling report include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the Public Health Advisory Committee (PHAC) meetings provide further detail about the Committee's interpretation of the evidence and development of the recommendations.

Guideline development

The stages involved in developing public health guidelines are outlined in the box below.

1. Draft scope released for consultation
2. Stakeholder comments used to revise the scope
3. Final scope and responses to comments published on website
4. Evidence reviews and economic modelling undertaken and submitted to PHAC
5. PHAC produces draft recommendations
6. Draft guideline (and evidence) released for consultation (and for fieldwork)

7. PHAC amends recommendations
8. Final guideline published on website
9. Responses to comments published on website

Key questions

The key questions were established as part of the [scope](#). They formed the starting point for the reviews of evidence and were used by the PHAC to help develop the recommendations. The overarching questions were:

Question 1: What is the role of the organisational culture and context in supporting line managers and, in turn, their employees? What is the role of organisational policy and processes?

Question 2: How can line managers promote the health and wellbeing of employees? Which interventions or policies are most effective and cost effective?

Question 3: Are there actions or activities by line managers that discourage or hinder the health and wellbeing of employees? How can line managers support and motivate employees?

Question 4: How can line managers best be equipped to identify employee health and wellbeing issues? How can line managers identify and support distressed employees?

Question 5: How can high-level management promote a positive line management style that is open and fair, that rewards and promotes positive behaviours and that promotes good working conditions and employee health and wellbeing?

Question 6: How can line managers best be supported and provided with good line management themselves?

Question 7: What are the barriers and facilitators to implementing interventions or policies to promote the role of line managers in improving employee health and wellbeing?

Question 8: Which types of support and training for line managers are effective and cost effective?

Question 9: What is the role and value of occupational health services in supporting line managers? Are these services effective and cost effective?

Question 10: What is the business case for strengthening the role of line managers in promoting the health and wellbeing of employees?

These questions were made more specific for each review.

Reviewing the evidence

Effectiveness reviews

Three [reviews of effectiveness](#) were conducted:

- Review 1: Workplace policy and management practices to improve the health of employees.
- Review 2: Workplace policy and management practices to improve the health of employees.
- Review 3: Workplace policy and management practices to improve the health of employees.

Identifying the evidence

Several databases were searched between October and November 2013 for effectiveness, qualitative and economic studies published from 2000 (reviews 1 and 2) and from 2009 (review 3).

The following additional searches were also carried out:

- a search of the websites of relevant organisations
- citation searches of material included in the reviews.

The following tasks were completed to identify additional evidence:

- a review of material submitted through the NICE call for evidence
- any known researchers and experts in the field not already contacted during the call for evidence were written to and asked for relevant material.

Selection criteria

Studies were included in the effectiveness reviews if they focused on:

- people aged over 16 in full- or part-time employment (paid or unpaid)
- employers in the public, private and 'not for profit' sectors with at least 1 employee and based in a developed or Organisation for Economic Co-operation and Development (OECD) country.

Reviews 1 and 2 included experimental and observational quantitative studies, and economic studies (cost-benefit and cost-effectiveness analyses).

Review 3 included qualitative studies.

Studies were excluded if they covered:

- self-employed or unemployed people, or sole traders
- statutory provision or interventions or support that employees found for themselves and that did not involve input from their employer
- specific interventions to promote physical activity, mental wellbeing and smoking cessation in the workplace, and to manage long-term sickness absence and a return to work.

Inclusion and exclusion criteria for each review varied and details can be found at [reviews 1, 2 and 3](#).

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the [Public Health Methods Manual](#) Each study was graded (++, +, -) to reflect the risk of potential bias arising from its design and execution.

Study quality

++ All or most of the checklist criteria have been fulfilled. Where they have not been fulfilled, the conclusions are very unlikely to alter.

+ Some of the checklist criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are unlikely to alter the conclusions.

– Few or no checklist criteria have been fulfilled. The conclusions of the study are likely or very likely to alter.

The evidence was also assessed for its applicability to the areas (populations, settings, interventions) covered by the scope of the guideline. Each evidence statement concludes with a statement of applicability (directly applicable, partially applicable, not applicable).

Summarising the evidence and making evidence statements

The review data were summarised in evidence tables (see the reviews in [Supporting evidence](#)).

The findings from the reviews and expert papers were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements were prepared by the external contractor (see [Supporting evidence](#)).

The statements reflect their judgement of the strength (quality, quantity and consistency) of evidence and its applicability to the populations and settings in the scope.

Cost effectiveness

There was a review of economic evaluations (carried out as part of the first and second effectiveness reviews) and an economic modelling exercise. See [Economic analysis of workplace policy and management practices to improve the health of employees](#)

Review of economic evaluations

The review of economic interventions was conducted as part of the effectiveness reviews 1 and 2. See [Identifying the evidence](#) and [Selection criteria](#) for details of the databases searches and the inclusion and exclusion criteria.

See [review 1 and review 2](#).

Economic modelling

It was not possible to develop a conventional economic model because of a lack of data, the enormous diversity of organisations and interventions, and the absence of a single, simple outcome.

Instead we created a 'ready reckoner' that organisations can populate with their own data to enable them to calculate a business case for action.

The 'ready reckoner' is available in [Modelling report: Economic analysis of workplace policy and management practices to improve the health of employees](#).

How the PHAC formulated the recommendations

At its meetings in February, March, May, June and July 2014, the Public Health Advisory Committee (PHAC) considered the evidence, expert papers and cost effectiveness to determine:

- whether there was sufficient evidence (in terms of strength and applicability) to form a judgement
- where relevant, whether (on balance) the evidence demonstrates that the intervention, programme or activity can be effective or is inconclusive
- where relevant, the typical size of effect
- whether the evidence is applicable to the target groups and context covered by the guideline.

The PHAC developed recommendations through informal consensus, based on the following criteria:

- Strength (type, quality, quantity and consistency) of the evidence.
- The applicability of the evidence to the populations/settings referred to in the scope.
- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of harms and benefits.
- Ease of implementation and any anticipated changes in practice.

Where evidence was lacking, the PHAC also considered whether a recommendation should be implemented only as part of a research programme.

Where possible, recommendations were linked to evidence statements (see [The evidence](#) for details). Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

10 The evidence

Introduction

The [evidence statements](#) from 3 reviews are provided by external contractors.

This section lists how the evidence statements and expert papers link to the recommendations and sets out a brief summary of findings from the economic analysis.

How the evidence and expert papers link to the recommendations

The evidence statements are short summaries of evidence, in a [review or report](#), (provided by an expert in the topic area). Each statement has a short code indicating which document the evidence has come from.

Evidence statement number 1.1 indicates that the linked statement is numbered 1 in review 1. **Evidence statement number 2.1** indicates that the linked statement is numbered 1 in review 2. EP1 indicates that expert paper 1 is linked to a recommendation.

Where a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by IDE (inference derived from the evidence).

Recommendation 1: evidence statement 1.1, 3.2d; EP1, EP4; IDE

Recommendation 2: EP2, EP4; IDE

Recommendation 3: evidence statements 1.1, 2.4, 3.1d, 3.3; EP4; IDE

Recommendation 4: evidence statements 3.1e, 3.2b, 3.2c; EP1, EP2, EP4, EP5; IDE

Recommendation 5: evidence statements 2.1a, 3.1a, 3.1d; EP4, EP5; IDE

Recommendation 6: evidence statements 2.4, 3.2a, 3.2c, 3.2f, 3.5; EP4; IDE

Recommendation 7: evidence statement 2.1, 3.1c; IDE

Recommendation 8: evidence statements 3.1c, 3.1d, 3.2c, 3.4; EP1, EP2, EP4, EP5; IDE

Recommendation 9: evidence statements EP1, EP3; IDE

Recommendation 10: IDE

Economic modelling

No cost effectiveness studies were found that could be used in the modelling report, despite an extensive literature search. So a 'ready reckoner' was developed for organisations to use instead.

The specific scenarios considered and the full results can be found in Modelling report: Economic analysis of workplace policy and management practices to improve the health of employees.

11 Gaps in the evidence

The Public Health Advisory Committee (PHAC) identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence. These gaps are set out below.

1. There were only 5 UK studies reported in the 3 evidence reviews undertaken for this guideline. There is therefore a need for more research in the UK. There is also a need for more economic and cost-effectiveness data.

(Source: evidence reviews 1, 2 and 3)

2. More evidence is needed from small- and medium-sized organisations.

(Source: evidence reviews 1, 2 and 3)

3. No studies were found on the line management of unpaid volunteers.

(Source: evidence reviews 1, 2 and 3)

4. More research is needed on the role of occupational health in supporting line managers in promoting workplace health and wellbeing.

(Source: evidence reviews 1, 2 and 3)

12 Membership of the Public Health Advisory Committee and the NICE project team

Public Health Advisory Committee E

NICE has set up several Public Health Advisory Committees (PHACs). These standing committees consider the evidence and develop public health guidelines. Membership is multidisciplinary, comprising academics, public health practitioners, topic experts and members of the public. They may come from the NHS, education, social care, environmental health, local government or the voluntary sector. The following are members of PHAC E:

Chair

Paul Lincoln

Chief Executive, UK Health Forum

Core members

Jane Royle

Consultant in Public Health, Cornwall Council

Jeremy Wight

Director of Public Health, NHS Sheffield

Ruth Hall

Independent Public Health Consultant, Cheshire

Matthew Taylor

Director, York Health Economics Consortium

Ralph Bagge

Community member

Topic members

Diana Kloss

Chair, Council for Work and Health

Elaine Harris

Healthy Workplace Manager, Somerset County Council

Ivan Robertson

Director, Robertson Cooper; Emeritus Professor University of Manchester;
Visiting Professor, University of Leeds

Mandy Wandle

Associate Director Public Health, The Fit for Work Team, Leicester

Mark Gabbay

Professor of General Practice, University of Liverpool; Academic Associate
GP, Brownlow Group Practice, Liverpool

D’Arcy Myers

Community topic member

Expert co-optees to PHAC

Maria Karanika-Murray

Senior Lecturer in Psychology, Nottingham Trent University

Expert testimony to PHAC

Paul Winter

Chief Executive, Ipswich Building Society

Jayne Hayward

Pulse Training Partnership; Federation of Small Businesses (Manchester and North Cheshire branch)

Jenifer Lord

JeniferLord.com; Federation of Small Businesses (Manchester and North Cheshire branch)

Richard Preece

Medical Director, Saga

Maria Karanika-Murray

Senior Lecturer in Psychology, Nottingham Trent University

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Health and Safety Officer, Prospect

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Editors

About this guideline

What does this guideline cover?

The Department of Health (DH) asked the National Institute for Health and Care Excellence (NICE) to produce this guideline on workplace policy and management practices to improve the health and wellbeing of employees (see the [scope](#)).

How was this guideline developed?

The recommendations are based on the best available evidence. They were developed by the Public Health Advisory Committee (PHAC).

Members of the PHAC are listed in [Membership of the Public Health Advisory Committee and the NICE project team](#).

For information on how NICE public health guidelines are developed, see the NICE public health guideline [process](#) and [methods](#) guides.

What evidence is the guideline based on?

The [evidence](#) that the PHAC considered included:

- Evidence reviews 1, 2 and 3: ‘Workplace policy and management practices to improve the health of employees’. All the reviews were carried out jointly by The Institute for Employment Studies, The Work Foundation and Lancaster University. The principal authors were: Jim Hillage, Jenny Holmes, Catherine Rickard and Rosa Marvell (Institute for Employment Studies), Tyna Taskila, Zofia Bajorek and Stephen Bevan (The Work Foundation) and Jenny Brine (Lancaster University).
- Economic modelling: ‘Modelling report: Economic analysis of workplace policy and management practices to improve the health of employees’ was carried out by the Work Foundation and the Institute for Employment Studies. The principal authors were: Charles Levy and Stephen Bevan (The Work Foundation) and Jim Hillage (Institute for Employment Studies).
- Expert papers:
 - Expert paper 1 ‘NICE workplace health expert testimony’ by Paul Winter, Chief Executive, Ipswich Building Society.
 - Expert paper 2 ‘People matter’ by Jayne Hayward, Pulse Training Partnership and Jenifer Lord, JeniferLord.com.
 - Expert paper 3 ‘NICE testimony: workplace practices to improve health’ by Richard Preece, Saga.
 - Expert paper 4 ‘Some additional evidence from work psychology’ by Maria Karanika-Murray, Nottingham Trent University.
 - Expert paper 5 ‘Workplace policy and management practices to improve employee health and wellbeing’ by Sarah Page, Prospect Union.

Note: the views expressed in the expert papers above are the views of the authors and not those of NICE.

In some cases the evidence was insufficient and the PHAC has made recommendations for future research. For the research recommendations and

gaps in research, see [Recommendations for research](#) and [Gaps in the evidence](#).

Status of this guideline

This is a draft guideline. The recommendations made in section 1 are provisional and may change after consultation with [stakeholders](#).

This document does not include all sections that will appear in the final guideline. The stages NICE will follow after consultation (including fieldwork) are summarised below.

- The Committee will meet again to consider the comments, reports and any additional evidence that has been submitted.
- After that meeting, the Committee will produce a second draft of the guideline.
- The draft guideline will be signed off by the NICE Guidance Executive.

The key dates are:

- Closing date for comments: 5 November 2014.
- Next PHAC meeting: 3 and 4 December 2014.

The guideline will complement NICE guidelines on: [promoting mental wellbeing at work \(PH22\)](#), [managing long-term sickness and incapacity for work \(PH19\)](#), [promoting physical activity in the workplace \(PH13\)](#) and [workplace interventions to promote smoking cessation \(PH5\)](#). (For further details, see [Related NICE guidance](#).)

The recommendations should be read in conjunction with existing NICE guidance unless explicitly stated otherwise. They should be implemented in light of duties set out in the [Equality Act 2010](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply

in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Implementation

NICE guidelines can help:

- Commissioners and providers of NHS services to meet the requirements of the [NHS outcomes framework 2013–14](#). This includes helping them to deliver against domain 1: preventing people from dying prematurely.
- Local health and wellbeing boards to meet the requirements of the [Health and Social Care Act \(2012\)](#) and the [Public health outcomes framework for England 2013–16](#).
- Local authorities, NHS services and local organisations determine how to improve health outcomes and reduce health inequalities during the joint strategic needs assessment process.

NICE will develop tools to help organisations put this guideline into practice. Details will be available on our website after the guideline has been issued.

Updating the recommendations

This section will be completed in the final document