National Institute for Health and Care Excellence

Final

Mental wellbeing at work

Evidence review F: Barriers and facilitators to the implementation and delivery of interventions to improve and protect mental wellbeing at work

NICE guideline NG212

Evidence reviews underpinning recommendations 1.1.1 to 1.1.7, 1.2.1 to 1.2.4, 1.9.1 to 1.9.3, 1.10.9 and research recommendations in the NICE guideline

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Final version

These evidence reviews were developed by the Public Health Internal Guideline development Team

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1.1 Review question

What are the barriers and facilitators to, and key aspects of (including systems and processes), the successful implementation or delivery of mental wellbeing interventions, programmes, policies, or strategies at work?

1.1.1 Introduction

Since NICE guideline PH22 Mental wellbeing at work was published in 2009, the nature of the workforce has changed in the UK. Increasing amounts of employees are on part-time, temporary, or zero-hours contracts. The variations between workplaces and differences in the nature of employment are important to consider when looking at approaches to improve and protect employee mental wellbeing.

Since 2009 there has been increasing recognition of mental wellbeing and how it is associated with the workplace and work outcomes. The Stevenson/Farmer review 'Thriving at work' estimates that 15% of UK workers have an existing mental health condition, and experiences in the workplace can affect mental wellbeing positively and negatively. Good employee mental wellbeing is positive for employees and their employers. Better mental wellbeing and job satisfaction are associated with increased workplace performance and productivity (Department for Business Innovation & Skills 2014). Poorer mental wellbeing however is associated with increased absenteeism and presenteeism and lost output costs the economy upwards of £74 billion annually. It is therefore important to implement interventions in the workplace to promote and improve mental wellbeing, and to prevent poor mental wellbeing amongst the workforces.

Many employers know the value of positive mental wellbeing but do not know how to promote it. Understanding what approaches are effective in preventing poor mental wellbeing, as well as promoting and improving mental wellbeing in the workplace are important, but of equal importance is understanding the barriers and facilitators to implementing and delivering mental wellbeing interventions, programmes, policies, or strategies at work.

1.1.2 Summary of the protocol

Population	**Inclusion:** All employees aged 16 years or older and their employers, managers, and those delivering interventions to them. **Eligible employees are in full or part time employment, including:** • on permanent, training, temporary or zero hours contracts • those who are self-employed. • volunteers

	Exclusion: • People who are not employed (as defined above) • Prisoners who engage in work activities • Inpatients in mental health institutions who engage in work activities. • Military personnel
Intervention	**Any workplace mental wellbeing intervention across 5 areas, including:** • Universal approaches for managers • Universal organisational level approaches • Universal individual level approaches • Targeted organisational level approaches. • Targeted individual level approaches. **This includes those interventions that aim to (one or more of):** • improve mental wellbeing. • promote positive mental wellbeing. • prevent poor mental wellbeing. • increase awareness or understanding of mental wellbeing. • increase recognition of employees who need support for mental wellbeing. • help managers understand, recognise, and respond to their employees' mental wellbeing. Interventions are eligible that are delivered in a workplace setting, or outside of a workplace where there is employer involvement in the intervention which may include the initiation, design, delivery, management, funding of, or signposting to, an intervention, including those delivered online or digitally).
Comparator	Not applicable

Outcomes	The review seeks to:
	• identify quantitative data on the proportion of respondents reporting the barrier, facilitator, or key aspect.
	• identify the views and experiences about the barriers, facilitators, and key aspects to implementing and delivering interventions. These may include attitudes, views and experiences regarding:
	  ○ the physical environment (including time)
	  ○ staffing
	  ○ size and type of organisation
	  ○ access to support services.
	  ○ Funding and policies

1.1.3 Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in Appendix A and the methods document. An example of the search strategy is provided in Appendix B.

Declarations of interest were recorded according to NICE's conflicts of interest policy.

1.1.4 Qualitative evidence

1.1.4.1 Included studies.

In total 17,925 references were identified through systematic guideline-wide searches. After priority screening 34 references were considered relevant based on title and abstract screening and were ordered. After the full text screening of these references, 9 (8 individual studies and 1 review) were eligible for inclusion in the systematic review and 25 were excluded.

The characteristics of the 9 included studies and a brief summary of the interventions are presented in Table 1: Summary of studies included in the qualitative. See Appendix C for PRISMA diagram and Appendix D for full evidence tables. The included studies all reported qualitative outcomes only. No included studies reported quantitative data about the proportions of people reporting each outcome.

1.1.4.2 Excluded studies.

25 studies did not meet the inclusion criteria and therefore excluded from the review. See Appendix F for full reasons of exclusion.

Table 1: Summary of studies included in the qualitative

Study	Setting	Informants	Intervention	Method	Themes in study
Carmichael, et al 2016	Workplace – construction and retail sector	Directors, chief executives, senior managers, owner-managers, and/or had oversight or a particular interest or experience in workplace health and wellbeing	Not specified – interviewees had a particular remit, interest or specialist knowledge of workplace health and wellbeing	Semi-structure interviews; Thematic analysis.	• Conceptions and value of workplace wellbeing • The business case. • Workplace health issues - priorities for interventions • Mental health and stress - important but causes differed between construction and retail. • Barriers to improving health and wellbeing - many in construction not many in retail. • Contracting and employment structure. • Working away from home, transient, and temporary employment • Long working hours and long travel-to-work distances • Tight deadlines, low-profit margins, and the macroeconomic climate • Predominantly male workforce and macho culture • Company attitudes and wider social norms • Targets and competitions • Lack of support from leaders and middle management
Hanna et al 2019	Workplace - construction industry (two large general construction firms and two medium	Stakeholders with health-related roles and responsibilities within the construction industry: Management and employees, and the sample roles and	Not specified – interviewees working in health and wellbeing related roles	Group and individual interviews; Thematic analysis using Braun and Clarke (2006)	• The construction industry as anti-health promoting. • Working equals earning • Competitive edge and client driven health agendas • Variance across the industry

Study	Setting	Informants	Intervention	Method	Themes in study
	sized scaffolding firms)	positions including site managers, site foreman, first aiders, health and safety officers, risk assessors, workforce development officers, company managers.			• Industry specific health issues
Mellor et al 2011	Workplace - public sector: health services, education, and local government.	100 visit proforma HSE records of inspectors' which included conversations with management, employees, and trade Unions. Semi-structured interviews with Health and Safety, and Occupational Health managers or advisors from health services and local government priority sectors.	Implementation of the Management Standards approach (MSA) (HSE 2007)	Analysis of a random sample of HSE investigator reports (n=100). Method of randomisation not specified. Semi-structured interviews Both analysed via 'Framework analysis' (Richie and Lewis, 2003)	**Challenges related to the organisational context in which the stress programme was due to be developed:** • Organisational change/restructure was a major interference to stress program progress (Proforma data [P]) • On-going organisation changes (Interview data [I]) • Target driven cultures (I) • Replacement of senior management (P; I) **Processes related to organisational members' perceptions and actions during implementation phases:** • Senior management support (P; I) • Employee participation (P, I) • Communication (P, I) • Organisational capability (P, I) **Considerations on the content and features of the approach itself:** • Content of the approach itself (P, I)
Mellor et al 2013a	Workplace - two healthcare trusts, one central government	Occupational health professionals, trade unions, health, and safety representatives,	Implementation of the Management Standards approach (MSA) (HSE 2007)	14 semi-structured interviews with 21 organizational	Findings are framed in the context of organizations implementation of the HSE Management Standard specifically the HSE

Study	Setting	Informants	Intervention	Method	Themes in study

	department and two private sector organizations	involved in the implementation of the Management Standards approach in their organization		members and documentary evidence from five organizations.
				
				Analysis via 'cross-case analysis' to the data using qualitative content analysis (Miles and Huberman, 1994).
					guidance on the 'five steps of risk assessment':
					Preparatory work and step 1: identify the stress risk factors.
					• Main drivers:
					  ○ compliance with health and safety law,
					  ○ reducing sickness absence,
					  ○ improving indicators,
					  ○ putting in place preventative measures
					  ○ adopting best practice
					• Senior management support
					• Establishing and embedding 'stress policy'
					• Permanent steering groups with mixed representation
					• Professional internal resources
					• Training of line managers
					
					Step 2: decide who might be harmed and how – gather data.
					• Time and cost
					• Survey fatigue
					• Benchmarking
					• Incorporating 'HSE management standards' into organizational policy
					
					Step 3: evaluate the risks – explore problems and develop solutions.
					• Worker involvement (Facilitator)

Study	Setting	Informants	Intervention	Method	Themes in study
					Step 4: record your findings – develop and implement action plan/s. • Manager 'unavailability' following risk assessments (Barrier) • Line manager commitment (Facilitator) • Line manager training on stress risk assessment (Facilitator) • A target driven culture and constant organizational changes (Barrier) **Step 5: monitor and review action plan/s and assess effectiveness.** • Support from senior management (Facilitator) • Additional HSE guidance (Facilitator)
Mellor et al 2013b	Workplace - public sector with established well-being strategy covering occupational safety and health, workplace health promotion, employee assistance programme.	Analysis of company records. Semi-structured interviews with strategy implementers: health and safety representatives, HR, occupational health providers; trade unions; line managers with supervisor and middle manager grades and different roles	Well-being strategy covering occupational safety and health (OSH), workplace health promotion (WHP); employee assistance programme (EAP);	Analysis of company records and documentation on various aspects of the well-being strategy. Semi-structured interviews with 20 stakeholders Analysis undertaken across both elements via 'framework analysis' (Richie and Lewis, 2003)	Findings presented using a literature-based 'conceptual-framework'. **Organizational enablers and challenges** • Integration of health, safety, and well-being strategy into business plans • Senior leadership commitment and support for Workplace Health Promotion • Involvement and coordination of stakeholders • Communication in Workplace Health Promotion • Striking a balance between a focus on occupational risks and lifestyles risks • Particular challenges in the line managers' role in well-being management • Need for an engaging leadership style.

Study	Setting	Informants	Intervention	Method	Themes in study

Quirk et al 2018	Workplace - NHS	NHS staff: four senior leaders, four heads of department and three health and wellbeing practitioners	Not specified - interviewees involved in development or implementing health and wellbeing in the NHS or working directly in health and wellbeing related roles	Semi-structured interviews
				
				Thematic analysis using Braun and Clarke (2006)
					Barriers to the implementation of Health and Wellbeing services in the NHS:
					• current state of the NHS and "times of austerity"
					  ○ Busy and pressurized environments caused by staff shortages.
					  ○ Financial barriers to implementation
					  ○ Perceptions of spending priorities - patients before staff
					
					Barriers to staff engagement with health and wellbeing services in the NHS:
					• Logistical barriers due to the nature of NHS work
					• Dependence on the existence of a receptive audience
					
					Facilitators of the implementation of health and wellbeing services in the NHS:
					• Government schemes and funding as incentives
					• Issues government schemes and funding
					• An organisational structure that supports staff HWB
					• An organizational culture that supports staff HWB
					
					Facilitators of successful delivery of HWB services in the NHS:
					• Coherent, strategic approach to implementation

Study	Setting	Informants	Intervention	Method	Themes in study
					• Communication and advertisement • Being creative and innovative with resources • Needs analysis and evaluation

Robinson et al 2014	Workplaces - small to medium enterprises, and larger enterprises.	Direct recipients of the project, including four workplace or business champions, as well as other employee training recipients, other managers, and a work-place union representative. Four project leads, and three other organizational stakeholders from commissioning primary care trust (PCT) bodies	Altogether Better Mental Health and Employment projects - a learning network and 16 community and workplace projects with an emphasis on physical activity, healthy eating and mental health and wellbeing.
			
			This study focused on mental health and employment seek to improve health and wellbeing in workplace settings, raising awareness of mental health issues through providing and targeting support, advice and training to employers and employees
				Secondary analysis of qualitative data (21 out of 28 semi-structured interview): Explores data from the evaluation of the Mental Health and Employment project strand which included semi-structured interviews with project participants	• Specificity to particular community and workplace environments
					  ○ Development of organizational plans and tools and delivering training.
					  ○ Developing roles to embed core activities into organizational environments.
					• The business/workplace champion role - as faciliatory
					• The business/workplace champion role - as a 'activator'
					• The business/workplace champion role – characteristics
					• Champions and the handover process
					  ○ Nurturing ownership - empowering employees to develop tools and practices to make changes.
					• Identifying and utilizing external support
					• Establishing the business case - evidencing the fit with the business case;

Scantlebury et al 2018	Systematic review
	Workplace – police, carer, criminal justice, prisons, and
		Non-mental health trained professionals	Mental health training:
			• Mental Health First Aid Training
				Focus groups, semi-structure interviews, survey (200 participants across 8 studies)	**Barriers to training:**
					• Training content
					  ○ Tailored
					• Delivery
					  ○ Length

Study	Setting	Informants	Intervention	Method	Themes in study
	unspecified settings		• Crisis Intervention Team (CIT) training • Mental Health Awareness for Prison Staff Program' • DVD/manual/ coaching skills training programme for carers of people with eating disorders		○ Method ○ Course instructions • Additional resources ○ Time ○ Appropriate • Organisational factors ○ Time and cost ○ Organisational culture ○ Poor implementation ○ Staff and manager buy-in **Facilitators to training:** • Training content. ○ Modules and specific content ○ Additional resources • Training delivery ○ Course trainers ○ Method, length, and frequency • Staff willingness to engage with training. ○ Staff recognition of the need to improve skill set. • Organisational factors ○ Importance and prioritisation ○ Consideration of workplace culture and practice ○ In house training **Perceived impact of training:** • Perceptions of mental health ○ Increased understanding, empathy and understanding of stigma.

Study	Setting	Informants	Intervention	Method	Themes in study

					• Response in situations involving mental health.
					  ○ Change in participant approach.
					  ○ Improved communication skills
					  ○ Reinforced existing skills.
					  ○ Increased confidence
					  ○ Improved symptom recognition
					• Impact on trainees
					  ○ Self-reflection
					  ○ Lack of measurable outcomes

Wyatt et al 2015	Workplace – NHS Trust (4 case studies)	Director, manager, healthy workplace champion/ representative, employee, permanent ward staff	Workplace health and well-being program	Open-ended/semi-structured interviews and feedback sessions.
				
				Thematic analysis
					• Visible high level support - management support and endorsement of participation (Facilitator)
					• Collective sense of ownership for the program
					  ○ staff input (what they want) at the start and during the program (Facilitator)
					  ○ Perceived lack of ownership when employees do not feel the program is driven by them (Barrier)
					  ○ Starting small and being responsive (Facilitator)
					• Effective communication of the program
					  ○ Regular updates through a variety of sources (Facilitator)
					  ○ Only using 1 or 2 methods of communication activities and events (Barrier)
					• Visibility of activities
					• Types of activities

Study	Setting	Informants	Intervention	Method	Themes in study
					○ Making participation fun and understanding what activities people would like to do (Facilitator) ○ Feeling like you have to participate/feeling preached at (Barrier) • Finding out what people want/providing opportunities. ○ Responding/not responding to employees (Facilitator/Barrier) • Enthusiastic champions ○ People involved being positive and encouraging participation (Facilitator) ○ "champions" and organizers moving away from the company (Barrier) • Positive relationships • Barriers to engagement ○ Physical barriers cost, time, age) to activity participation based on a personal choice. Facilitators and barriers to engaging in specific activities within the healthy workplace program: • Physical activity - Competitive challenges • Living close to/too far away from work to walk/cycle. • informal walking groups (facilitator) • Organizational support for healthy eating/seen as an organizational norm

Study	Setting	Informants	Intervention	Method	Themes in study
					to eat at the desk and not take a proper lunch break. • Stopping smoking • Psychological well-being

1.1.5 Summary of the qualitative findings

Table 2: Summary of the qualitative evidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
What contributed to intervention working					
Ensuring management and leadership buy-in	Quirk et al 2018; Wyatt et al 2015; Carmichael et al 2016; Mellor et al 2013a; Mellor et al 2013b; Robinson et al, 2014	Management, and non-management employees; health and wellbeing practitioners.	Visible involvement and endorsement of management and leadership for workplace health and wellbeing facilitated employee engagement into programmes, informed strategic approach and allowed strategic oversight, facilitating the integration, and embedding of health, and well-being strategy.	*I think if [managers] have an input on directing staff to the appropriate service and getting them interested, then it should work more effectively. But if they don't, then there's a breakdown.* (008, Workplace wellbeing practitioner) In construction, the importance of management in supporting a healthy workplace was articulated in relation to both setting priorities, strategic directions and buy-in by senior management *(CollectiveOrg2*:Construction – directors, chief executives, senior managers, owner-managers), particularly in relation to occupational health. *(InternatOrg*: directors, chief executives, senior managers, owner-managers *).* Gaining the commitment of directors and senior managers ensured that planning for OSH is an integral part of their business planning process (Mellor et al 2013b) Respondents referred to the importance of *"the Board being on board"* (001, Head of department: Human Resources or Occupational Health) with workplace HWB initiatives.	High confidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
				"It would be helpful to have an overall, an overarching strategy, I think that would be helpful. And we've not pulled it all together, there's lots of different initiatives but pulling it all together would be of benefit I think." (003 Senior leader).	
	Mellor et al 2011; Mellor et al 2013a	Management and non-management employees	Facilitated 'resource commitment and allocation'	*"vital for action plans to move forward"; "critical to the implementation of the strategy"; 'gave it clout'* (College principle) Facilitates Professional internal resources (occupation health, human resources, health, and safety team) to support managers (Mellor 2013a).	Moderate confidence
Establishing or having a strategy in place	Mellor 2013b; Quirk et al 2018; Robinson, 2014	Management and non-management employees; health and wellbeing practitioners.	Having a strategy communicated the approach to staff and encouraged senior manager engagement. It established a consistent common, prioritising and 'mainstreamed' the health and wellbeing agenda in the workplace.	Existing well-being policy helps communicate the approach to staff and encouraged senior managers to take part in the WHP initiative (Mellor 2013b) *"knowing what they're all working towards within a Trust"* (007, Head of department: Human Resources or Occupational Health) 'Mainstreaming' agenda they could take forward, e.g. through review of management attendance policy, action planning around 'reasonable adjustment', standards, staff packs and introducing routine low-cost stress awareness events and flexible training delivery from within the company (Robinson et al 2013)	Moderate confidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
Establishing the business case	Carmichael et al 2016; Mellor 2013a; Robinson, 2014;	Directors, chief executives, senior managers, owner-managers	Establishing the cost-effectiveness of proposed programs and clarifying program benefits in work metrics were outlined as key to facilitating action.	*looking after staff creates loyalty, thus a reduction in staff* turnover (FashionShop: Retail - directors, chief executives, senior managers, owner-managers) *looking after employees when they were unwell was cost effective* (Supermarket: Retail - – directors, chief executives, senior managers, owner-managers) *"a healthy work force is a more effective work force" and linked an "unhealthy work force" to a higher accident rate* (BuildTech&Tst: Construction - directors, chief executives, senior managers, owner-managers)	Moderate confidence
The role of training	Carmichael et al 2016; Mellor et al 2011, Mellor 2013a. Scantlebury et al 2018;	Management, and non-management employees; health and wellbeing practitioners.	New skills were required to improve practice in the management of mental wellbeing at work. An understanding of stress management was outlined as key to subsequent action planning.	*Perceived lack of management competency in conducting risk assessment* (Extracted from proforma data – Mellor et al 2011) Line manager training on stress risk assessment was vital to enhance their skills (Mellor et al 2013a) Training of line managers on stress management or leadership is key to subsequent action planning (Mellor et al 2013a) *It's about the managers being professional in their role and seeing the importance of good practice and good quality care; seeing this as an integral part of their role and promoting that at every turn. MCA [Mental Capacity Act] and DoLS [Department of Liberty Schemes] would be part of that"* (Gough et al 2012 in Scantlebury et al 2018).	High confidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
			Training needs to be timely, tailored, context specific; provide insight into laws, policy, and procedures; and provide practical skills to deal with real-life scenarios.	A more tailored approach that includes topic specific training for current institutional problems (e.g. drug epidemics) was suggested along with more emphasis on teaching laws, policies, and procedures specific for mental health. Staff wanted training to vary, reflecting the different (Anderson et al 2014 in Scantlebury et al 2018). Training should also include immediate tactical skills to deal with issues in the absence of mental health staff (Anderson et al 2014 in Scantlebury et al 2018) An integrated approach which linked the training to other issues and/or the wider context enabled trainees to apply the training. (Svensson et al 2015 in Scantlebury et al 2018). *"The problem is that I think homes find it difficult to release people for that training"* (Gough & Kerlin, 2012 in Scantlebury et al 2018)	High confidence
Needs assessment	Mellor, 2011; Mellor 2013a; Quirk et al 2018; Wyatt et al 2015	Management, and non-management employees receiving and implementing workplace health and wellbeing programs	Key process in informing a proposed workplace health and wellbeing strategy. Providing an opportunity for employee engagement, allowed the identification of employee need and facilitated strategic development.	*"One of the first things I did when I came into post was do some baseline data with some staff first just to kind of ascertain, you know, the health behaviours and status of staff and what they wanted and the type of things they think would help them lead a healthier lifestyle. And used that to inform the strategy, looked at our health profiles and compared them with local health profiles to see just exactly where some of our troubled areas are and also just generally find out what staff want."* (002, Head	Moderate confidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
				of department: Human Resources or Occupational Health) *"The healthy workplace, it's just providing opportunities for people. So I don't think it's about making people do anything. I think it's about providing choice."* (Wyatt et al 2015)	
Workplace capacity	Mellor, 2011; Quirk et al 2018; Robinson, 2014;	Management, and non-management employees; health and wellbeing practitioners.	Sufficient financial, technical, and human resources for example having a workplace champion or dedicated health and wellbeing staff, adequate line management competency were key facilitating factors in coordinated and embedded activities.	*"It works well where you've got a pro-active manager that is really committed to the process and wanting to see it through from beginning to end"* (Line manager – Mellor et al 2011) *"That's the biggest thing with this, with health and wellbeing and part of the CQUIN is around that line manager support, their training, their understanding as to why health and wellbeing is so really important, so that they can then cascade that down to their staff."* (002, Head of department: Human Resources or Occupational Health) "(Workplace champion) Liaises with an external lead to roll out an event. Facilitates general administrative arrangements. Makes specific organizational and room bookings. Coordinates enrolment" (Robinson et al 2013)	Moderate confidence
Access to and awareness of resources	Carmichael et al 2016; Mellor 2013a; Mellor 2013b; Quirk et al 2018;	Management, and non-management employees; health and wellbeing practitioners.	Initial resource investment in terms of time allow assessment and planning to take place. Government schemes and funding acted as an incentive for action on workplace health and wellbeing. Awareness pre-existing tools and examples of best-practice useful in initiating workplace health and wellbeing programs. Awareness of	"*In a cash-strapped service it is sadly the reality that you have to have some sort of financial motivation to do it. So, from that point of view both the CQUIN and the Healthy Workplace Initiative that offered us match funding to do things is very helpful".* (010, Head of department: Human Resources or Occupational Health)	Moderate confidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
	Robinson, 2014;		guidance and legislation was outlined as a lever for action	Initial investments of time for assessment and planning to promote reflection around the value of champions (Robinson et al 2013). *"Those stress risk assessments do tend to deliver something of the result that we were looking for in terms of managing the individuals stress, helping them to continue to function well or to improve their function while coping with whatever situation"* (Managers – Mellor et al 2013b)	
			The role of specialists with expertise in human resources, employment assistance and occupational health provided support and advice and ensure consistency in workplace health and wellbeing programs provided. Establishing links with and utilising external partners which study participants outlined as key to successful workplace health and wellbeing programs	*"It is important because I do find it difficult […] as a manager you dip into it now and again, we do have the support where we can go and get further advice to try and make sure things are consistent, (the EAP professionals) provide quite a vital service […], because […] they're experts in their field"* (Managers – Mellor et al 2013b). *"partnership working and relationship building is so crucially important and often when that's working well, you can pull in on some of that when you need to pull in on it"* (002, Head of department: Human Resources or Occupational Health). *"without their [external HWB organisation] direction we probably wouldn't have implemented it"* (008, Workplace wellbeing practitioner).	Moderate confidence
The role of communication	Mellor 2013a; Mellor 2013b;	Management, and non-management employees;	Having a focused and targeted communication strategy in place engaged senior staff and initiated action regarding health and wellbeing. Regular updates	*An all-round communication approach to awareness-raising including visible senior members' actions and multiple channels of communication helped organisations to*	Moderate confidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
	Quirk et al 2018; Wyatt et al 2015	health and wellbeing practitioners.	using a multi-pronged communication approach was key to raising awareness of workplace health and wellbeing programs and facilitating feedback after intervention initiation.	*combat this problem* (Extracted from proforma data – Mellor et al 2011). *"One of the things we have is a regular newsletter that goes out. So we are able to talk about what we are doing in there and make that again focus on the things that we've done, you know we are interested to get your input, your ideas, here's what we've got coming up in the future and there's a word -of-mouthpiece."* (Wyatt et al 2015) *"Interventions in our Trust that have worked well - flu is one that as an organisation, apart from last year, we've excelled at over the previous four years and a few people have said to me, why did you do so well? Because we went to them...We physically go out there. We know that staff struggle to even come down to the canteen and get a break, so when we're putting on displays and events, they just physically don't do it".* (002, Head of department: Human Resources or Occupational Health)	
The role of trade Union	Mellor, 2011; Mellor 2013b;	Management, and non-management employees; health and wellbeing practitioners. (public sector only)	Trade unions encouraged staff involvement and key in communicating what the workplace health and wellbeing programme was about to employees. The lack of trade union involvement was seen to reduce employee participation.	Encouraged staff involvement (in stress initiative) (Extracted from proforma data – Mellor et al 2011) A more significant role of the local trade unions is seen as key to engage more staff in Workplace Health Promotion (Mellor et al 2013b). Lack of Trade Union involvement was seen to reduce employee participation. (Extracted from proforma data – Mellor et al 2011)	Moderate confidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
				"[…] there seems to be a process going on to shift the responsibility to the individual and the department are reneging on its responsibilities by having no regard to how job design is being rolled out across the department. I mean I'd be very surprised if the people that made decisions on job design have had any regard to the well-being policy […]" (Trade Union Representative).	
Barriers					
Target driven culture	Carmichael et al 2016; Hanna, 2019; Mellor 2013b	Management, and non-management employees; health and wellbeing practitioners.	Target driven working culture was considered to impact the prioritisation of workplace health and wellbeing which impacted the ability to participate in training and workplace health programs.	*A target driven culture and constant organizational changes were barriers to line manager availability* (Health and Safety, and Occupational Health manager or advisor) *Target driven cultures can mean health and wellbeing is not priorities* (Health and Safety, and Occupational Health manager or advisor) *"There is an atmosphere at the moment of, there's a lot of targets that we have, a lot of monitoring that we give to people and sometimes there's a bit of an ethos of putting long hours in and we're trying to [...] you know, some managers, some of my senior officers are very much like this and then some are very keen on the work life balance, but at the same time there's pressure on people to work longer and longer hours [...] so there's a bit of ambiguity"* (Line manager).	High confidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
Lack of management and leadership buy-in	Carmichael et al 2016; Mellor, 2011; Mellor 2013a; Mellor 2013b; Quirk et al 2018; Scantlebury et al 2018;	Management, and non-management employees; health and wellbeing practitioners.	A perceived lack of support was linked to less health and well-being activity and intervention follow-ups. Support could be lack of 'manager availability' or 'understanding the value of health promotion in the workplace' or 'the value of training'.	*"The key was having him (director of corporate services) drive it (HWP) from a sort of high management, senior management level. I think if it had started from my level or another colleague it would never have gathered as much weight or speed."* (Wyatt et al 2015) Buy-in' from staff and managers were identified as additional barriers. A *`top-down approach'* was considered crucial by some participants, who emphasised the need for managers to buy-into and understand the training (Gough & Kerlin, 2012). *"[...] we know for instance that internally there's a great variability in the way managers embrace well-being, […] and so at a senior level, the buy-in to a holistic view of well-being is very strong, the challenge is filtering that through a complex management structure […] there can be a mismatch between the view of strategic management and the view of local operational managers [...]".*(Implementor)	Moderate confidence
			A lack of managers understanding of their role in establishing the workplace culture and understanding of the current legislative landscape, were considered barriers to implementation	*"it's the manager who locks or unlocks the culture in the workplace, so the manager blocks it, it won't filter past them, the manager embraces it, it will filter into everybody who works there […]* (implementor)	
Financial and resource availability	Carmichael et al 2016; Hanna, 2019; Quirk et al 2018	Management, and non-management employees; health and	The financial climate was considered to have led to the deprioritising of health and wellbeing programs impacting development and implementation. In construction tight deadlines and low profit margins and maintaining a competitive	"there's a lot of deadlines to meet, very demanding clients and yes, I wake up in the middle of the night thinking have I done this, have I done that, and it's […] it is very stressful" (SteelBuild: Construction - directors,	High confidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
		wellbeing practitioners.	edge was seen as restricting resource availability for workplace health and wellbeing programs. In the NHS austerity, the current financial deficit and funding shortages are outlined as constraining investment in and delivery of workplace health and wellbeing programs.	chief executives, senior managers, owner-managers). "we've just finished a job […] we have a contract for £480,000 […]. but our damages were £100,000 a week if we were late […] So you can imagine the stress" (SteelBuild: Construction - directors, chief executives, senior managers, owner-managers). *"on single digit profit figures"* (SpecEng: Construction - directors, chief executives, senior managers, owner-managers) *"the worst funding shortage in NHS history…as being the major barrier…we had fairly significant plans contained within the [health and wellbeing] strategy and then our financial situation in the Trust got considerably worse"* (004 Senior leader). *"*(funding) *breaks down the biggest barriers [to workplace HWB services]"* (006, Workplace wellbeing practitioner).	
Workplace factors	Carmichael et al 2016; Hanna, 2019; Mellor, 2011; Quirk et al 2018	Management, and non-management employees; health and wellbeing practitioners.	Workplace instability was outline as leading to delays, amendments and ending of workplace health and wellbeing programs.	'On-going organisational change' and restructure lead to delays, amendments and ending of programs (Health and Safety, and Occupational Health manager or advisor). The replacement of senior management positive and negative impact on wellbeing at work dependent on incumbents priorities (Extracted from proforma data – Mellor et al 2011).	High confidence
			The complexity of employment structure impacted employers ability to develop	*"It is such a transient market with labour, construction is, that is very difficult to say my long-term plan for this person is x, y, z*	High confidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
			adequate workplace health and wellbeing plans and for employees to attend them.	*because in a year or six months they might have moved on. It's very difficult"* (Participant 6: stakeholder with responsibility or focus on health and wellbeing). *"You've got people working different shift patterns* (NHS)*...Which is one of the reasons why I think some of our exercise classes are not working, because the people that have said they want them want them at eight o'clock at night or nine o'clock at night or six o'clock in the morning or seven o'clock in the morning when, you know, when they finish their shifts. And I think that's the problem is we've got such a diverse workforce".* (002, Head of department: Human Resources or Occupational Health)	
Individual staff barriers to engagement	Carmichael et al 2016; Mellor 2013b; Quirk et al 2018; Wyatt et al 2015;	Management, and non-management employees; health and wellbeing practitioners.	Staff resistance was outlined as a barrier to engagement in workplace health and wellbeing. Rationales for resistance included changes to traditional ways of working and a feeling that interventions were an intrusion into their non-working life; with a lack of sense of employee ownership and choice outlined as barriers. A lack of time, long-working hours, fatigue, and a lack of opportunities were barriers to engagement; with some concerns expressed that participating in programs could impact earning potential. Levels of workforce motivation and engagement were outlined as linked to the	In construction traditional ways of working, the way things had always been done, were identified as barrier to improving the health and wellbeing of workers (SteelBuild: Construction -directors, chief executives, senior managers, owner-managers). It could sometimes be demoralising trying to *"change hearts and minds of an industry […] that doesn't want to change its heart or mind"* (CollectiveOrg2: Construction -directors, chief executives, senior managers, owner-managers). Resistance from some staff to become involved in WHP as they perceive it as an intrusion into their personal lives: *"it is not*	High confidence

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
			success of workplace health and wellbeing interventions.	*linked to the work; I do that outside of work".* (Managers) Staff, *"have got to be motivated to do it"* (003, Senior leader) and that generally speaking, they *"don't have an interest in it"* (008, Workplace wellbeing practitioner). *"There are a lot of unhealthy people in the NHS and I think that it comes down to personal responsibility. And I think maybe if they knew what impact it was having on their health they may have taken more of a responsibility*. 009, Senior leader *"the demand [for workplace wellbeing services] continues to grow", but "people are knackered, and that doesn't always put you in the right frame of mind to want to take advantage of exercise or wellbeing"* (001, Head of department: Human Resources or Occupational Health). *"I think they (management) got it slightly wrong (at the start of the program) in that, 'Right this is how we're going to do it.' Yeah, possibly getting a bit more buy-in prior to saying that by saying, look, we'd like to do this, what do you think."* (Wyatt et al 2015) *" ...I just think they are not interested. They just want to come on, work and earn money...but the feel I get off people is they will always buy into stuff but it is about the work, that they need to earn their money"* (Participant 1: stakeholder with responsibility or focus on health and wellbeing).	

Review theme and subthemes	Studies contributing (Study theme)	Informants	Summary	Supporting statements	CERQual – confidence in the evidence
				"They don't wanna say they're ill cos they don't wanna take the time, they're not gonna get sick pay...they just can't afford to take time off" (Participant 10 - stakeholder with responsibility or focus on health and wellbeing) **"***I mean it's like if you smoke and they have a stop smoking service here but if you were forced to join it, then there would be, well, you wouldn't achieve anything."* (Wyatt et al 2015)	
Workplace barriers to engagement	Carmichael et al 2016; Mellor 2013b; Quirk et al 2018; Wyatt et al 2015;	Management, and non-management employees receiving; health and wellbeing practitioners.	Access to facilities was highlighted as a barrier to engagement in the workplace health and wellbeing programme by participants in one study due to multi-site nature of the workplace	*"With some of the exercise classes because we are over three different sites that's been met with a little bit of resistance. And although class numbers have been good, I think because people do shifts, they, it's not at a reasonable time or because we haven't been going to the [other] sites, people have taken offence to that. So we're having to work around it".* 008, Workplace wellbeing practitioner.	High confidence

1.1.6 The committee's discussion and interpretation of the evidence

1.1.6.1. The outcomes that matter most

The committee acknowledged the importance of both employee and employer themes outlined in the evidence but were surprised that the employee voice was not as 'strong' in the evidence presented. It was noted that data from employers were mainly from a 'senior level' and the committee outlined that they would have benefited from data from intermediate/lower-level managers. There was a general agreement with the qualitative themes regarding what contributed to interventions working (including ensuring management and leadership buy-in and the importance of establishing a mental wellbeing at work strategy; establishing the business case; the role of needs assessment; and the importance of workplace), barriers (including target driven culture; a lack of management and leadership buy-in, workplace and individual staff barriers to engagement) from the evidence presented and the committee noted a shift in responsibility to the individual from the organisation which some of the committee agreed was quite common in mental wellbeing at work initiatives. The committee acknowledged the evidence provided a reality check regarding the difficulties in implementing mental wellbeing interventions at work with some members surprised to see data outlining employee-side barriers to engagement but however they noted that the evidence did not represent all sectors, industries and populations.

Themes that were considered to contribute to an intervention working included: ensuring management and leadership buy-in, establishing or having a strategy in place, establishing the business case, the role of training, needs assessment, workplace capacity, access to and awareness of resources, the role of communication and the role of trade unions. Themes that were considered barriers included: target driven culture, lack of management and leadership buy-in, financial and resource availability, workplace factors, individual staff barriers to engagement and workplace barriers to engagement.

1.1.6.2 The quality of the evidence

Moderate to high confidence qualitative evidence was obtained from nine UK studies, where two were reporting on the implementation of the Management Standards approach (MSA), one was reporting on the implementation of a well-being strategy covering occupational safety and health (OSH), workplace health promotion (WHP); employee assistance programme (EAP), one was reporting on the implementation of the Altogether Better Mental Health and Employment projects focusing on mental health and employment elements, one was a systematic review reporting on mental health training, and one on a workplace health and wellbeing program in NHS trusts. Three studies focused on interviewing individuals involved in development or implementing health and wellbeing in the NHS, construction and/or retail or working directly in wellbeing health and wellbeing related roles or with specialist knowledge of workplace health and wellbeing. These studies identified barriers and facilitators to implementation of interventions, as well as the views of manager-owners, senior management, managers and employees. Some of the views expressed were from participants of the outlined interventions. Some of the studies provided data based on secondary analysis of qualitative data and underpinned primary qualitative data analysis with analysis of company records and investigator reports.

The methodologies used within studies were deemed appropriate but had some limitations and most of the evidence related to specific industries and sectors but the

PHAC considered that many of the themes could be extrapolated to other sectors. However, PHAC agreed that more evidence regarding the views of organisations about the benefits of mental wellbeing, the needs of small and medium sized enterprises in promoting mental wellbeing in the workplace, and the specific needs of employees from different groups for example those in low income groups were needed (see evidence review D – Universal individual-level approaches) and PHAC have made research recommendations in these areas. GRADE-CERQual profiling showed mostly moderate confidence in the evidence, with some evidence showing high certainty. Reasons for downgrading were primarily due to concerns with methodological limitations, as well as some concerns with coherence, adequacy and relevance.

The evidence is consistent with the committee's experience. However, the committee did outline that they had expected more data from employees regarding their experiences and intermediate/lower level managers, would have benefited from seeing more evidence from other sectors beyond NHS, construction and retail, and other populations. Some members highlighted moderate confidence evidence that providing a convincing business case to commissioners of mental wellbeing at work interventions may be a key enabler. Some members were mindful of moderate confidence evidence that employers want simple advice and that adopting a strategic approach might be the way to embed good workplace mental health. The evidence provided informed the development of all the recommendations outlined in this guideline.

1.1.6.3 Benefits and harms.

The committee discussed the evidence and noted that there appeared to be a shift of responsibility to the individual from organisations but did not identify any benefits and harms of this phenomenon. The committee were surprised that some barriers were expressed in the data from the employee side and discussed the high confidence findings regarding gender and engagement with certain interventions. For example, the concern that men are less likely to engage and discuss mental health issues and recognised that this should be taken into account when planning interventions and encouraging employees to come forward. However, the committee pointed out that there are mental health initiatives such as Men's Health Forum that are reducing barriers to men discussing mental health concerns. The committee discussed their concerns that in many industries, 'if you are not working you are not earning' will be a barrier to employee engagement with mental wellbeing interventions. The committee recognised that creating a supportive work environment [recs 1.2.1 to 1.2.4] and engaging with employees and representatives on how interventions are implemented [recs 1.9.1 to 1.9.3] will be important for addressing these issues.

High confidence in the findings of the review led to discussion on how to account for transient workforces and workforce stability in recommendations, and gender in the recommendation of particular interventions (for example yoga) and the barriers this may present for some employee's engagement. The committee highlighted that in their experience not having time to engage in mental wellbeing at work intervention is often cited as a barrier and were surprised at this and issues around 'taking people away from earning did not come out more strongly. The committee discussed themes related to barriers and facilitators at organisational level and how these tied in with the findings from the preceding effectiveness reviews with some members highlighting that providing a convincing business case to commissioners of mental wellbeing at work interventions may be a key enabler. The committee heard expert testimony on the need to engage with employers that are not actively considering employee wellbeing, and the committee noted a lack of evidence around the views of

organisations about the benefits of investing in mental wellbeing, and consequently drafted a research recommendation to address this. The committee also considered how local and regional authorities could use contracting and ethical procurement arrangements to encourage supply chain organisations to promote mental wellbeing among their employees (see Evidence review A: Universal organisational-level approaches) [rec 1.10.9]. Some members were mindful that employers want simple advice and that adopting a strategic approach might be the way to embed good workplace mental health [recs 1.1.1 to 1.1.7].

The committee discussed the high confidence evidence around the issue of time and engaging in interventions during work hours which was consistent with qualitative evidence in other reviews and acknowledged the complexity of the mental wellbeing interventions discussed and agreed that wider factors, including personal and wider individual factors, should also be considered, and that employers should engage with employees and representatives on how interventions are implemented [recs 1.9.1 to 1.9.3] (see individual universal approaches: Review D).

1.1.7 Recommendations supported by this evidence review.

This evidence review supports recommendations 1.1.1 – 1.1.7, 1.2.1 – 1.2.4, 1.9.1 – 1.9.3, 1.10.9, and the research recommendation on Supportive work environment, Training for managers and supervisors, Approaches for micro, small and medium enterprises, Organisational-level approaches for all organisations, Addressing study reporting, Identifying people at risk of poor mental wellbeing Needs of different employee groups, and Approaches for all employees. Other evidence supporting these recommendations can be found in the evidence reviews on evidence organisational universal level approaches: Reviews A; universal approaches for managers: Review B; targeted organisational level approaches: Review C; individual universal approaches: Review D; targeted individual level approaches: Review E.

1.1.8 References – included studies.

1.1.8.1 Qualitative

Carmichael, F., Fenton, S.-J.H., Pinilla-Roncancio, M.V. et al. (2016) Workplace health and wellbeing in construction and retail: Sector specific issues and barriers to resolving them. International Journal of Workplace Health Management 9(2): 251-268

Hanna, ES and Markham, Steven (2019) Constructing better health and wellbeing? Understanding structural constraints on promoting health and wellbeing in the UK construction industry. International Journal of Workplace Health Management 12(3): 146-159

Mellor, N., Mackay, C., Packham, C. et al. (2011) 'Management Standards' and work-related stress in Great Britain: Progress on their implementation. Safety Science 49(7): 1040-1046

Mellor, N., Smith, P., MacKay, C. et al. (2013) The "Management Standards" for stress in large organizations. International Journal of Workplace Health Management 6(1): 4-17

Mellor, N. and Webster, J. (2013) Enablers and challenges in implementing a comprehensive workplace health and well-being approach. International Journal of Workplace Health Management 6(2): 129-142

Quirk, Helen, Crank, Helen, Carter, Anouska et al. (2018) Barriers and facilitators to implementing workplace health and wellbeing services in the NHS from the perspective of senior leaders and wellbeing practitioners: a qualitative study. BMC public health 18(1): 1362

Robinson, Mark, Tilford, Sylvia, Branney, Peter et al. (2014) Championing mental health at work: emerging practice from innovative projects in the UK. Health promotion international 29(3): 583-95

Scantlebury, A., Parker, A., Booth, A. et al. (2018) Implementing mental health training programmes for non-mental health trained professionals: A qualitative synthesis. PLoS ONE 13(6): e0199746

Wyatt, Katrina M, Brand, Sarah, Ashby-Pepper, Julie et al. (2015) Understanding How Healthy Workplaces Are Created: Implications for Developing a National Health Service Healthy Workplace Program. International journal of health services : planning, administration, evaluation 45(1): 161-85

Appendices

Appendix A Review protocols

Review protocol for barriers and feasibility of interventions to the implementation and delivery of interventions to improve and protect mental wellbeing at work.

Field	Content
PROSPERO registration number	181918
Review title *(50 Words)*	A mixed methods review exploring barriers and facilitators to the implementation and delivery of interventions to improve and protect mental wellbeing at work
Review question (250 words)	What are the barriers and facilitators to, and key aspects of (including systems and processes), the successful implementation or delivery of mental wellbeing interventions, programmes, policies or strategies at work?
Objective	To identify the barriers and facilitators to the delivery and implementation of mental wellbeing interventions at work. To examine whether barriers to and facilitators of implementing interventions vary according to a range of factors including how the intervention is delivered and by whom, the study population, and the nature of the organisation.
Searches (300 words)	The following databases will be searched: • Cochrane Central Register of Controlled Trials (CENTRAL) • Cochrane Database of Systematic Reviews (CDSR) • Embase • MEDLINE • Psycinfo • Econlit • Epistemonikos • ASSIA • HealthEvidence.org Search strategies will be adapted to take account of the limitations of each database.

	Searches will be limited by: • Date: studies published from 2007 to present (though included studies from the previous NICE guideline, PH22, will also be considered for inclusion) • Language : English language • Setting: UK (using a validated search filter) Searches will also exclude the following publication types: • Editorials • news articles • Letters • Conference abstracts • "Notes". • Other non-research publications Other searches: Forwards and backwards citation searching will be carried out in Web of Science using any included studies or relevant systematic reviews as a starting point. The What Works Wellbeing and Department for Work and Pensions research reports websites will also be browsed for relevant evidence The searches will be re-run 6 weeks before final submission of the review and further studies retrieved for inclusion. The full search strategies for MEDLINE database will be published in the final review.
Condition or domain being studied (200 words)	Mental wellbeing in the workplace
Population (200 words)	Inclusion: All employees aged 16 years or older and their employers, managers, and those delivering interventions to them. Eligible employees are in full or part time employment, including: • on permanent, training, temporary or zero hours contracts • those who are self-employed.

	• volunteers Exclusion: • People who are not employed (as defined above) • Prisoners who engage in work activities • Inpatients in mental health institutions who engage in work activities. • Military personnel
Intervention (200 words)	Any workplace mental wellbeing intervention across 5 areas, including: • Universal approaches for managers • Universal organisational level approaches • Universal individual level approaches • Targeted organisational level approaches. • Targeted individual level approaches. This includes those interventions that aim to (one or more of): • improve mental wellbeing. • promote positive mental wellbeing. • prevent poor mental wellbeing. • increase awareness or understanding of mental wellbeing. • increase recognition of employees who need support for mental wellbeing. • help managers understand, recognise and respond to their employees' mental wellbeing. Interventions are eligible that are delivered in a workplace setting, or outside of a workplace where there is employer involvement in the intervention which may include the initiation, design, delivery, management, funding of, or signposting to, an intervention, including those delivered online or digitally).
Comparator (200 words)	Not applicable
Types of study to be included (150 words)	Inclusion: • Systematic reviews of surveys, mixed-method studies or qualitative studies (published in 2019 or 2020 to ensure currency) • Mixed-methods studies or qualitative studies • Surveys or other cross-sectional quantitative studies that report on barriers and facilitators to these interventions

Other exclusion criteria	• Papers published in languages other than English. • Studies not published in full (e.g. study protocols where no results are published, summary articles) • Studies published before 2007 will be excluded. • Non-UK-based studies will be excluded
Context (250 words)	Since NICE guideline PH22 Mental wellbeing at work was published in 2009, the nature of the workforce has changed in the UK. Increasing amounts of employees are on part-time, temporary or zero-hours contracts. The variations between workplaces and differences in the nature of employment are important to consider when looking at approaches to improve and protect employee mental wellbeing. Since 2009 there has been increasing recognition of mental wellbeing and how it is associated with the workplace and work outcomes. Experiences in the workplace can affect mental wellbeing positively and negatively. Good employee mental wellbeing is positive for employees and their employers. For example, better mental wellbeing and job satisfaction are associated with increased workplace performance and productivity. Poorer mental wellbeing however is associated with increased absenteeism and presenteeism and lost output costs the economy upwards of £74 billion annually. It is therefore important to implement interventions in the workplace to promote and improve mental wellbeing, and to prevent poor mental wellbeing amongst the workforces.
Primary outcomes (critical outcomes) (200 words)	The review will seek to • identify quantitative data on the proportion of respondents reporting the barrier, facilitator or key aspect. • identify the views and experiences about the barriers, facilitators, and key aspects to implementing and delivering interventions. These may include attitudes, views and experiences regarding: ◊ the physical environment (including time) ◊ staffing ◊ size and type of organisation ◊ access to support services.

	◊ Funding and policies
Timing	**Timing and measures:** Not applicable
Secondary outcomes (important outcomes) (200 words)	Not applicable
Data extraction (selection and coding) (300 words)	All references identified by the searches and from other sources will be uploaded into EPPI-R5 and de-duplicated. This review will use the EPPI-R5 priority screening functionality. At least 60%-70% of the identified abstracts will be screened. After this point, screening will only be terminated if a pre-specified threshold is met for a number of abstracts being screened without a single new include being identified. This threshold is set according to the expected proportion of includes in the review (with reviews with a lower proportion of includes needing a higher number of papers without an identified study to justify termination) and is always a minimum of 250. A random 10% sample of the studies remaining in the database when the threshold is met will be additionally screened, to check if a substantial number of relevant studies are not being correctly classified by the algorithm, with the full database being screened if concerns are identified. 10% of the abstracts will be reviewed by two reviewers, with any disagreements resolved by discussion or, if necessary, a third independent reviewer. The full text of potentially eligible studies will be retrieved and will be assessed in line with the criteria outlined above. A standardised EPPI-R5 template will be used when extracting data from studies (this is consistent with the Developing NICE guidelines: the manual section 6.4). Details of the intervention will be extracted using the TIDieR checklist in EPPI-R5. Outcome data will be extracted into EPPI-R5 as reported in the full text. Study investigators may be contacted for missing data where time and resources allow.
Risk of bias (quality) assessment (200 words)	Risk of bias will be assessed using the appropriate checklist as described in

	Developing NICE guidelines: the manual. For systematic reviews we will use the ROBIS tool. For mixed methods studies we will use the Mixed Methods Appraisal Tool (MMAT) For surveys we will use the CEBM checklist For qualitative studies we will use the CASP qualitative checklist
Strategy for data synthesis (300 words)	For quantitative data, the proportion or percentages of respondents reporting each barrier, facilitator or key aspect will be reported in GRADE tables. For qualitative data, the key themes from the studies will be categorised into themes across all studies using a thematic analysis. Supporting quotations and summaries of data will be included. Where appropriate, the quality or certainty across all available qualitative evidence will be evaluated for each outcome using the GRADE CERQual approach. For quantitative data (survey), where appropriate, the quality or certainty across all available evidence will be evaluated for each outcome using the GRADE approach. Where possible qualitative and quantitative findings will be presented in summary tables.

Analysis of sub-groups (250 words)	Where evidence allows, subgroup analyses will be conducted. The following factors will be explored in any subgroup analyses: • Gender • Age • Disability or other long-term physical or mental health condition status • Socioeconomic status • Occupational groups or roles at increased risk of poor mental wellbeing • Work sector (voluntary, public, private) • Organisation size (micro, small, medium, and large) • Type of employment contract (part-time, temporary, full-time, voluntary, training, zero hours contract) • Other groups for consideration listed in the EIA
Type of method of review	Intervention
Language	English
Country	England

Appendix B Literature search strategies

The search was developed in Medline and then translated into other databases. Searches were run and re-run in Applied Social Science Index and Abstracts (ASSIA), Cochrane Central Register of Controlled Trials (CENTRAL) / Cochrane Database or Systematic Reviews (CDSR), Econlit, Embase, Epistemonikos, HealthEvidence.org, MEDLINE ALL and PsycINFO. Citation searching was planned into the protocol for this question but not completed due to time limitations. References to studies retrieved for RQs 1-5 that were relevant to this review question could be copied over to this review, and vice-versa.

Medline search strategy

1 exp Occupational Stress/ (12503)
2 "Burnout, Professional"/ (11301)
3 Job Satisfaction/ (24412)
4 "job satisfaction".ti,ab. (8233)
5 (satisf* adj3 (work* or job*)).ti,ab. (11967)
6 work engagement/ (308)
7 (engage* adj3 (work* or job*)).ti,ab. (4724)
8 ((motivation or motivated) adj3 (work* or job*)).ti,ab. (2517)
9 or/1-8 (45552)
10 Absenteeism/ (8924)
11 absenteeism.ti,ab. (5551)
12 Presenteeism/ (267)
13 presenteeism.ti,ab. (1080)
14 Work Performance/ (746)
15 (work adj3 performance).ti,ab. (4923)
16 (job adj3 performance).ti,ab. (1851)
17 or/10-16 (18943)
18 wellbeing.ti,ab. (14461)
19 "well-being".ti,ab. (71710)
20 Mental Health/ (36294)
21 mental*.ti,ab. (340833)
22 Resilience, Psychological/ (5201)
23 Adaptation, Psychological/ (92523)
24 psych*.ti,ab. (790057)
25 or/18-24 (1129983)
26 17 and 25 (4009)
27 wellbeing.ti. (2695)
28 "well-being".ti. (12558)
29 exp *Stress, Psychological/ (81203)
30 stress.ti. (222961)
31 burnout.ti. (5834)
32 exp *Fatigue/ (15511)
33 fatigue*.ti. (25730)
34 tired*.ti. (586)
35 *Depression/ (69737)
36 (depression or depressed).ti. (107907)
37 *Anxiety/ (40311)
38 anxiety.ti. (48536)
39 *"Sleep Initiation and Maintenance Disorders"/ or *Sleep/ or *"Sleep Deprivation"/ (45097)
40 insomnia.ti. (6877)
41 sleep.ti. (87004)
42 productivity.ti. (9371)
43 exp *Efficiency/ (13456)
44 (confidence not "confidence interval*").ti. (5272)
45 *self-concept/ (24809)
46 *self-efficacy/ (7982)
47 "self esteem".ti. (4075)

48 (mental adj9 (literacy or knowledge or attitude* or awareness or communicat* or skill* or competen* or uptake or "take-up")).ti. (2924)
49 ("quality of life" or "quality adjusted life" or qaly* or qald* or qale* or qtime*).ti. (66944)
50 *Quality of Life/ or *Quality-Adjusted Life Years/ (87286)
51 or/27-50 (723033)
52 employment/ or employment, supported/ (46235)
53 (employee* or employment or employed).ti,ab,jw. (414308)
54 Workplace/ (21994)
55 (work or worker* or workload*).ti,ab,jw. (1104214)
56 (workplace* or worksite*).ti,ab,jw. (42033)
57 occupational.ti,ab,jw. (164036)
58 (job or jobs).ti,ab,jw. (59635)
59 (organi?ations or organi?ational or company or companies or corporation*).ti,ab,jw. (184902)
60 personnel.ti,ab,jw. (71181)
61 exp occupational groups/ (587964)
62 profession*.ti,jw. (89334)
63 (staff or staffing).ti,ab,jw. (158429)
64 (colleague* or coworker*).ti,ab,jw. (36665)
65 "Occupational Diseases"/ (82739)
66 Job Satisfaction/ (24412)
67 Occupational Health/ (32598)
68 Occupational Health Services/ (10476)
69 "Personnel Staffing and Scheduling"/ (16889)
70 "Organizational Culture"/ (17112)
71 or/52-70 (2438225)
72 51 and 71 (104584)
73 wellbeing.ti,ab. (14461)
74 "well-being".ti,ab. (71710)
75 exp Stress, Psychological/ (127376)
76 stress.ti,ab. (707069)
77 burnout.ti,ab. (10371)
78 exp Fatigue/ (29481)
79 fatigue*.ti,ab. (91133)
80 tired*.ti,ab. (5599)
81 Depression/ (114576)
82 (depression or depressed).ti,ab. (376534)
83 Anxiety/ (78121)
84 anxiety.ti,ab. (180528)
85 "Sleep Initiation and Maintenance Disorders"/ or Sleep/ or "Sleep Deprivation"/ (67809)
86 insomnia.ti,ab. (19736)
87 sleep.ti,ab. (157818)
88 productivity.ti,ab. (55647)
89 exp Efficiency/ (34702)
90 (confidence not "confidence interval*").ti,ab. (71834)
91 self concept/ (55605)
92 self efficacy/ (19503)
93 "self esteem".ti,ab. (20035)
94 (mental adj9 (literacy or knowledge or attitude* or awareness or communicat* or skill* or competen* or uptake or "take-up")).ti,ab. (12980)
95 ("quality of life" or "quality adjusted life" or qaly* or qald* or qale* or qtime*).ti,ab. (265564)
96 Quality of Life/ or Quality-Adjusted Life Years/ (196862)
97 or/73-96 (1946584)
98 *employment/ or *employment, supported/ (25702)
99 (employee* or employment or employed).ti,jw. (25514)
100 *Workplace/ (11020)
101 (work or worker* or workload*).ti,jw. (158976)
102 (workplace* or worksite*).ti,jw. (13211)
103 occupational.ti,jw. (104945)
104 (job or jobs).ti,jw. (15030)
105 (organi?ations or organi?ational or company or companies or corporation*).ti,jw. (28134)
106 personnel.ti,jw. (17378)

107 exp *occupational groups/ (427285)
108 profession*.ti,jw. (89334)
109 (staff or staffing).ti,jw. (30637)
110 (colleague* or coworker*).ti,jw. (2628)
111 *"Occupational Diseases"/ (68848)
112 *Job Satisfaction/ (11447)
113 *Occupational Health/ (23615)
114 *Occupational Health Services/ (7794)
115 *"Personnel Staffing and Scheduling"/ (9722)
116 *"Organizational Culture"/ (5404)
117 or/98-116 (842366)
118 97 and 117 (104865)
119 9 or 26 or 72 or 118 (188850)
120 limit 119 to english language (172067)
121 limit 120 to (comment or congress or consensus development conference or consensus development conference, nih or editorial or letter or news) (6391)
122 120 not 121 (165676)
123 Animals/ not (Humans/ and Animals/) (4634083)
124 122 not 123 (161233)
125 limit 124 to yr="2007 -Current" (104319)
126 exp United Kingdom/ (360158)
127 (national health service* or nhs*).ti,ab,in. (185325)
128 (english not ((published or publication* or translat* or written or language* or speak* or literature or citation*) adj5 english)).ti,ab. (93538)
129 (gb or "g.b." or britain* or (british* not "british columbia") or uk or "u.k." or united kingdom* or (england* not "new england") or northern ireland* or northern irish* or scotland* or scottish* or ((wales or "south wales") not "new south wales") or welsh*).ti,ab,jw,in. (2005030)
130 (bath or "bath's" or ((birmingham not alabama*) or ("birmingham's" not alabama*) or bradford or "bradford's" or brighton or "brighton's" or bristol or "bristol's" or carlisle* or "carlisle's" or (cambridge not (massachusetts* or boston* or harvard*)) or ("cambridge's" not (massachusetts* or boston* or harvard*)) or (canterbury not zealand*) or ("canterbury's" not zealand*) or chelmsford or "chelmsford's" or chester or "chester's" or chichester or "chichester's" or coventry or "coventry's" or derby or "derby's" or (durham not (carolina* or nc)) or ("durham's" not (carolina* or nc)) or ely or "ely's" or exeter or "exeter's" or gloucester or "gloucester's" or hereford or "hereford's" or hull or "hull's" or lancaster or "lancaster's" or leeds* or leicester or "leicester's" or (lincoln not nebraska*) or ("lincoln's" not nebraska*) or (liverpool not (new south wales* or nsw)) or ("liverpool's" not (new south wales* or nsw)) or ((london not (ontario* or ont or toronto*)) or ("london's" not (ontario* or ont or toronto*)) or manchester or "manchester's" or (newcastle not (new south wales* or nsw)) or ("newcastle's" not (new south wales* or nsw)) or norwich or "norwich's" or nottingham or "nottingham's" or oxford or "oxford's" or peterborough or "peterborough's" or plymouth or "plymouth's" or portsmouth or "portsmouth's" or preston or "preston's" or ripon or "ripon's" or salford or "salford's" or salisbury or "salisbury's" or sheffield or "sheffield's" or southampton or "southampton's" or st albans or stoke or "stoke's" or sunderland or "sunderland's" or truro or "truro's" or wakefield or "wakefield's" or wells or westminster or "westminster's" or winchester or "winchester's" or wolverhampton or "wolverhampton's" or (worcester not (massachusetts* or boston* or harvard*)) or ("worcester's" not (massachusetts* or boston* or harvard*)) or (york not ("new york*" or ny or ontario* or ont or toronto*)) or ("york's" not ("new york*" or ny or ontario* or ont or toronto*))))).ti,ab,in. (1354315)
131 (bangor or "bangor's" or cardiff or "cardiff's" or newport or "newport's" or st asaph or "st asaph's" or st davids or swansea or "swansea's").ti,ab,in. (52985)
132 (aberdeen or "aberdeen's" or dundee or "dundee's" or edinburgh or "edinburgh's" or glasgow or "glasgow's" or inverness or (perth not australia*) or ("perth's" not australia*) or stirling or "stirling's").ti,ab,in. (201691)
133 (armagh or "armagh's" or belfast or "belfast's" or lisburn or "lisburn's" or londonderry or "londonderry's" or derry or "derry's" or newry or "newry's").ti,ab,in. (24931)
134 or/126-133 (2580349)
135 (exp africa/ or exp americas/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp australia/ or exp oceania/) not (exp United Kingdom/ or europe/) (2801631)
136 134 not 135 (2437621)
137 125 and 136 (13102)
138 intervention*.ti,ab. (947113)
139 training.ti,ab. (388545)

140 exp Inservice Training/mt, og [Methods, Organization & Administration] (10030)
141 program*.ti,ab. (842000)
142 (policy or policies).ti,ab. (238280)
143 policy/ (2463)
144 (strategy or strategies).ti,ab. (1011982)
145 evaluation studies.pt. (247878)
146 or/138-145 (3088242)
147 implement*.ti,ab. (465929)
148 implementation science/ (273)
149 deliver*.ti,ab. (623478)
150 accept*.ti,ab. (438120)
151 (change* adj3 behav*).ti,ab. (58106)
152 barrier*.ti,ab. (280087)
153 facilitat*.ti,ab. (508987)
154 obstacle*.ti,ab. (45795)
155 determinant*.ti,ab. (227875)
156 obstruct*.ti,ab. (267598)
157 adopt*.ti,ab. (237105)
158 support*.ti,ab. (1485663)
159 help*.ti,ab. (775853)
160 hinder*.ti,ab. (53590)
161 deter*.ti,ab. (3568508)
162 imped*.ti,ab. (86751)
163 (cooperat* or "co-operat*").ti,ab. (144215)
164 Cooperative Behavior/ (42699)
165 oppos*.ti,ab. (207753)
166 or/147-165 (7558157)
167 137 and 146 and 166 (4484)

Re-run searches

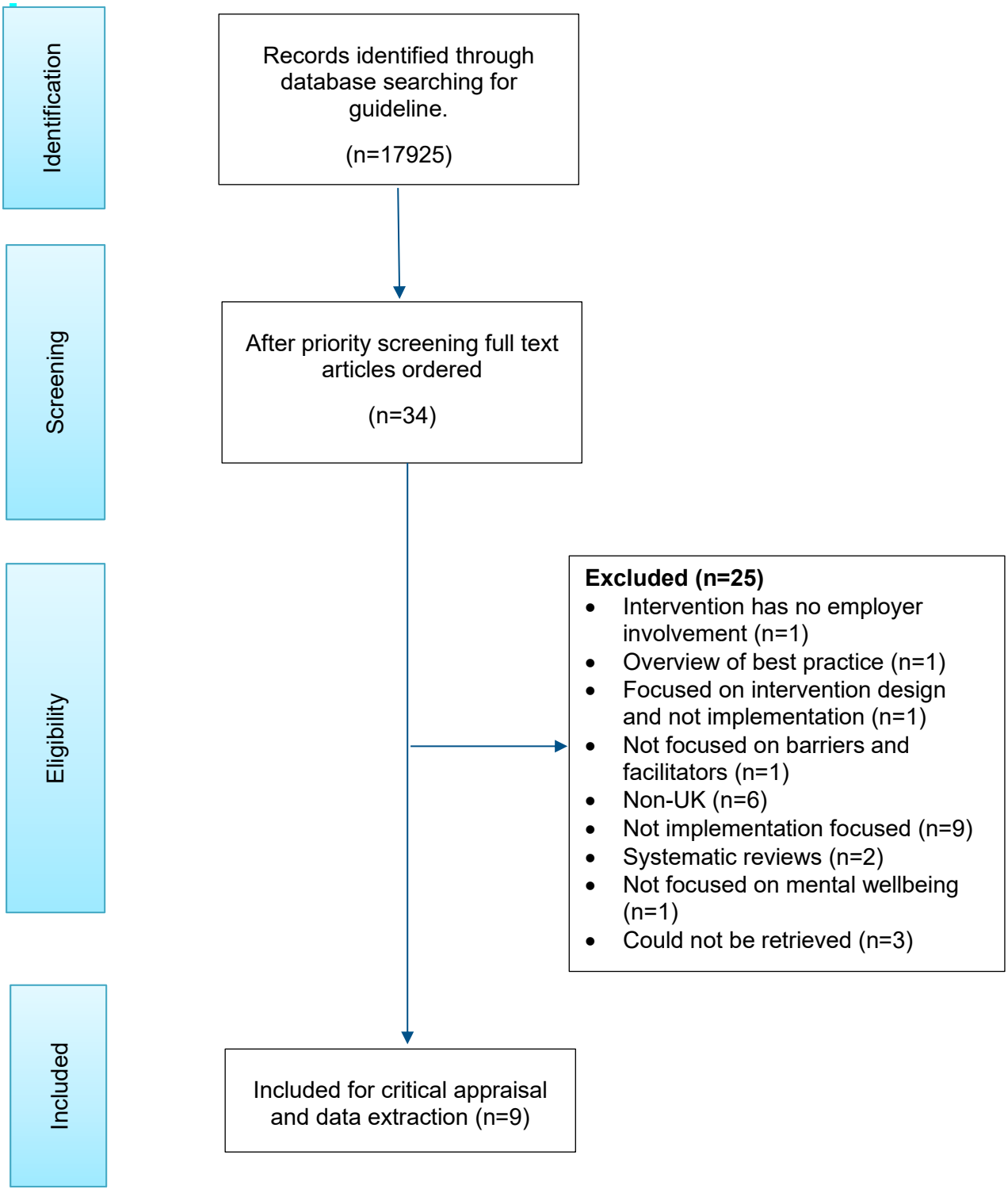
1 exp Occupational Stress/ (14643)
2 "Burnout, Professional"/ (12701)
3 Job Satisfaction/ (25474)
4 "job satisfaction".ti,ab. (9047)
5 (satisf* adj3 (work* or job*)).ti,ab. (13119)
6 work engagement/ (484)
7 (engage* adj3 (work* or job*)).ti,ab. (5384)
8 ((motivation or motivated) adj3 (work* or job*)).ti,ab. (2798)
9 or/1-8 (49853)
10 Absenteeism/ (9211)
11 absenteeism.ti,ab. (6036)
12 Presenteeism/ (360)
13 presenteeism.ti,ab. (1275)
14 Work Performance/ (938)
15 (work adj3 performance).ti,ab. (5543)
16 (job adj3 performance).ti,ab. (2022)
17 or/10-16 (20497)
18 wellbeing.ti,ab. (17783)
19 "well-being".ti,ab. (81488)
20 Mental Health/ or Psychology, Positive/ (41373)
21 mental*.ti,ab. (373842)
22 Resilience, Psychological/ (6388)
23 Adaptation, Psychological/ (96129)
24 psych*.ti,ab. (847486)
25 or/18-24 (1217426)
26 17 and 25 (4374)
27 wellbeing.ti. (3302)
28 "well-being".ti. (14448)
29 *Psychology, Positive/ or exp *Stress, Psychological/ (87007)
30 stress.ti. (242593)
31 burnout.ti. (7053)

32 exp *Fatigue/ (16507)
33 fatigue*.ti. (27779)
34 tired*.ti. (626)
35 *Depression/ (75699)
36 (depression or depressed).ti. (115869)
37 *Anxiety/ (43695)
38 anxiety.ti. (53580)
39 *"Sleep Initiation and Maintenance Disorders"/ or *Sleep/ or *"Sleep Deprivation"/ (48084)
40 insomnia.ti. (7695)
41 sleep.ti. (94399)
42 productivity.ti. (10196)
43 exp *Efficiency/ (13882)
44 (confidence not "confidence interval*").ti. (5907)
45 *self concept/ (25909)
46 *self efficacy/ (8695)
47 "self esteem".ti. (4380)
48 (mental adj9 (literacy or knowledge or attitude* or awareness or communicat* or skill* or competen* or uptake or "take-up")).ti. (3238)
49 ("quality of life" or "quality adjusted life" or qaly* or qald* or qale* or qtime*).ti. (73138)
50 *Quality of Life/ or *Quality-Adjusted Life Years/ (94867)
51 or/27-50 (783289)
52 employment/ or employment, supported/ (47882)
53 (employee* or employment or employed).ti,ab,jw. (451161)
54 Workplace/ (23912)
55 (work or worker* or workload*).ti,ab,jw. (1217298)
56 (workplace* or worksite*).ti,ab,jw. (46116)
57 occupational.ti,ab,jw. (172171)
58 (job or jobs).ti,ab,jw. (64306)
59 (organi?ations or organi?ational or company or companies or corporation*).ti,ab,jw. (201460)
60 personnel.ti,ab,jw. (76331)
61 exp occupational groups/ (621535)
62 profession*.ti,jw. (94676)
63 (staff or staffing).ti,ab,jw. (172056)
64 (colleague* or coworker*).ti,ab,jw. (39477)
65 "Occupational Diseases"/ (84002)
66 Job Satisfaction/ (25474)
67 Occupational Health/ (34277)
68 Occupational Health Services/ (10605)
69 "Personnel Staffing and Scheduling"/ (17385)
70 "Organizational Culture"/ (17828)
71 or/52-70 (2636906)
72 51 and 71 (115543)
73 wellbeing.ti,ab. (17783)
74 "well-being".ti,ab. (81488)
75 Psychology, Positive/ or exp Stress, Psychological/ (135312)
76 stress.ti,ab. (774559)
77 burnout.ti,ab. (12664)
78 exp Fatigue/ (31275)
79 fatigue*.ti,ab. (99876)
80 tired*.ti,ab. (6004)
81 Depression/ (123679)
82 (depression or depressed).ti,ab. (404434)
83 Anxiety/ (84521)
84 anxiety.ti,ab. (201143)
85 "Sleep Initiation and Maintenance Disorders"/ or Sleep/ or "Sleep Deprivation"/ (72091)
86 insomnia.ti,ab. (21993)
87 sleep.ti,ab. (172120)
88 productivity.ti,ab. (62274)
89 exp Efficiency/ (35645)
90 (confidence not "confidence interval*").ti,ab. (79292)
91 self concept/ (57571)

92 self efficacy/ (21025)
93 "self esteem".ti,ab. (21461)
94 (mental adj9 (literacy or knowledge or attitude* or awareness or communicat* or skill* or competen* or uptake or "take-up")).ti,ab. (14594)
95 ("quality of life" or "quality adjusted life" or qaly* or qald* or qale* or qtime*).ti,ab. (295356)
96 Quality of Life/ or Quality-Adjusted Life Years/ (213990)
97 or/73-96 (2114419)
98 *employment/ or *employment, supported/ (26669)
99 (employee* or employment or employed).ti,jw. (26850)
100 *Workplace/ (12076)
101 (work or worker* or workload*).ti,jw. (169142)
102 (workplace* or worksite*).ti,jw. (14262)
103 occupational.ti,jw. (108640)
104 (job or jobs).ti,jw. (15967)
105 (organi?ations or organi?ational or company or companies or corporation*).ti,jw. (29676)
106 personnel.ti,jw. (17956)
107 exp *occupational groups/ (451700)
108 profession*.ti,jw. (94676)
109 (staff or staffing).ti,jw. (32119)
110 (colleague* or coworker*).ti,jw. (2787)
111 *"Occupational Diseases"/ (69898)
112 *Job Satisfaction/ (11955)
113 *Occupational Health/ (24626)
114 *Occupational Health Services/ (7892)
115 *"Personnel Staffing and Scheduling"/ (9980)
116 *"Organizational Culture"/ (5734)
117 or/98-116 (885954)
118 97 and 117 (115212)
119 9 or 26 or 72 or 118 (207061)
120 limit 119 to english language (189846)
121 limit 120 to (comment or congress or consensus development conference or consensus development conference, nih or editorial or letter or news) (7063)
122 120 not 121 (182783)
123 Animals/ not (Humans/ and Animals/) (4748807)
124 122 not 123 (177994)
125 limit 124 to yr="2007 -Current" (121076)
126 exp United Kingdom/ (370166)
127 (national health service* or nhs*).ti,ab,in. (213273)
128 (english not ((published or publication* or translat* or written or language* or speak* or literature or citation*) adj5 english)).ti,ab. (97011)
129 (gb or "g.b." or britain* or (british* not "british columbia") or uk or "u.k." or united kingdom* or (england* not "new england") or northern ireland* or northern irish* or scotland* or scottish* or ((wales or "south wales") not "new south wales") or welsh*).ti,ab,jw,in. (2150770)
130 (bath or "bath's" or ((birmingham not alabama*) or ("birmingham's" not alabama*) or bradford or "bradford's" or brighton or "brighton's" or bristol or "bristol's" or carlisle* or "carlisle's" or (cambridge not (massachusetts* or boston* or harvard*)) or ("cambridge's" not (massachusetts* or boston* or harvard*)) or (canterbury not zealand*) or ("canterbury's" not zealand*) or chelmsford or "chelmsford's" or chester or "chester's" or chichester or "chichester's" or coventry or "coventry's" or derby or "derby's" or (durham not (carolina* or nc)) or ("durham's" not (carolina* or nc)) or ely or "ely's" or exeter or "exeter's" or gloucester or "gloucester's" or hereford or "hereford's" or hull or "hull's" or lancaster or "lancaster's" or leeds* or leicester or "leicester's" or (lincoln not nebraska*) or ("lincoln's" not nebraska*) or (liverpool not (new south wales* or nsw)) or ("liverpool's" not (new south wales* or nsw)) or ((london not (ontario* or ont or toronto*)) or ("london's" not (ontario* or ont or toronto*)) or manchester or "manchester's" or (newcastle not (new south wales* or nsw)) or ("newcastle's" not (new south wales* or nsw)) or norwich or "norwich's" or nottingham or "nottingham's" or oxford or "oxford's" or peterborough or "peterborough's" or plymouth or "plymouth's" or portsmouth or "portsmouth's" or preston or "preston's" or ripon or "ripon's" or salford or "salford's" or salisbury or "salisbury's" or sheffield or "sheffield's" or southampton or "southampton's" or st albans or stoke or "stoke's" or sunderland or "sunderland's" or truro or "truro's" or wakefield or "wakefield's" or wells or westminster or "westminster's" or winchester or "winchester's" or wolverhampton or "wolverhampton's" or (worcester not (massachusetts* or boston* or harvard*)) or ("worcester's" not (massachusetts* or

boston* or harvard*)) or (york not ("new york*" or ny or ontario* or ont or toronto*)) or ("york's" not ("new york*" or ny or ontario* or ont or toronto*))))).ti,ab,in. (1482545)
131 (bangor or "bangor's" or cardiff or "cardiff's" or newport or "newport's" or st asaph or "st asaph's" or st davids or swansea or "swansea's").ti,ab,in. (58849)
132 (aberdeen or "aberdeen's" or dundee or "dundee's" or edinburgh or "edinburgh's" or glasgow or "glasgow's" or inverness or (perth not australia*) or ("perth's" not australia*) or stirling or "stirling's").ti,ab,in. (219891)
133 (armagh or "armagh's" or belfast or "belfast's" or lisburn or "lisburn's" or londonderry or "londonderry's" or derry or "derry's" or newry or "newry's").ti,ab,in. (27830)
134 or/126-133 (2756522)
135 (exp africa/ or exp americas/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp australia/ or exp oceania/) not (exp United Kingdom/ or europe/) (2952350)
136 134 not 135 (2600632)
137 125 and 136 (15127)
138 intervention*.ti,ab. (1053766)
139 training.ti,ab. (429558)
140 exp Inservice Training/mt, og [Methods, Organization & Administration] (10311)
141 program*.ti,ab. (909062)
142 (policy or policies).ti,ab. (265520)
143 policy/ (3013)
144 (strategy or strategies).ti,ab. (1139204)
145 evaluation studies.pt. (26)
146 or/138-145 (3186550)
147 implement*.ti,ab. (530175)
148 implementation science/ (585)
149 deliver*.ti,ab. (683118)
150 accept*.ti,ab. (471571)
151 (change* adj3 behav*).ti,ab. (63939)
152 barrier*.ti,ab. (312341)
153 facilitat*.ti,ab. (560608)
154 obstacle*.ti,ab. (50802)
155 determinant*.ti,ab. (243392)
156 obstruct*.ti,ab. (284185)
157 adopt*.ti,ab. (264965)
158 support*.ti,ab. (1616326)
159 help*.ti,ab. (857400)
160 hinder*.ti,ab. (61791)
161 deter*.ti,ab. (3786094)
162 imped*.ti,ab. (95685)
163 (cooperat* or "co-operat*").ti,ab. (153116)
164 Cooperative Behavior/ (44166)
165 oppos*.ti,ab. (221532)
166 or/147-165 (8137924)
167 137 and 146 and 166 (5254)
168 ("20200124" or "20200125" or "20200126" or "20200127" or "20200128" or "20200129" or 2020013* or 202002* or 202003* or 202004* or 202005* or 202006* or 202007* or 202008* or 202009* or 20201* or 2021*).ed,dt. (2223370)
169 167 and 168 (1092)

Appendix C Qualitative evidence study selection



Appendix D Qualitative evidence

D.1 Carmichael 2016

Bibliographic Reference Carmichael, F.; Fenton, S.-J.H.; Pinilla-Roncancio, M.V.; Sing, M.; Sadhra, S.; Workplace health and wellbeing in construction and retail: Sector specific issues and barriers to resolving them; International Journal of Workplace Health Management; 2016; vol. 9 (no. 2); 251-268

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes *(The study seeks to explore the nature of the health and wellbeing issues faced within the construction and retail sectors and the difficulties faced in addressing these issues. Outlines that those in employment spend most time in the workplace. A happier and healthier workplace is an ethical responsibility but impacts productivity and reduces costs associated with injury and illness; and has wider societal impacts. Evidence-base flags construction and retail sectors experience significant employee negative psychological wellbeing, links to poor health outcomes (musculoskeletal, disability, chronic disease, mortality).)*
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes *(In-depth, semi-structured interviews with a sample of experts in the construction sector (and a small sample of experts in the retail sector in order to provide a point of comparison) with the aim of exploring health and wellbeing issues, the factors underlying these issues and the obstacles to improving the health and wellbeing of the workforce.)*
Research Design	Was the research design appropriate to address the aims of the research?	Yes *(In-depth, semi-structured interviews with a purposively sampled group was not justified per se but is appropriate given the aims and objectives of the study. The authors outline what they seek to explore and outline a protocol of the considerations when undertaken the research and applying the method.)*

Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes *(A purposively sampled group of ten experts, seven from firms in the construction sector and three from retail businesses. Interviewees were either directors, chief executives, senior managers, owner-managers, and/or had oversight or a particular interest or experience in workplace health and wellbeing; The recruitment utilized business links associated with the wider portfolio of work in occupational health and workplace wellbeing in which this study was situated. The interviews were conducted with either company directors or owners or with managers or employees nominated because they had a particular remit, interest or specialist knowledge of workplace health and wellbeing.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(Interviews conducted by the research team in the participant's place of work or by telephone/Skype using a pre-constructed interview schedule. Data was collected via semi-structure interviews, used open questions adopting a narrative approach focused on the participants' experience of work. Interviews transcribed verbatim and any identifiable data relating directly to the interviewees was anonymized. Specific justification for the data-collection method not outlined but is appropriate given the aim and objectives of the study. The interview schedule incorporated some flexibility in order to respond to answers and the different sectors, work roles and experiences of the participants. No evidence of modifications or changes to methods.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes *(This study recruited utilizing links with business associated with a wider portfolio of work in occupational health and wellbeing. Interviewers did not impose any prior definitions of workplace wellbeing or give clues as to causality as the primary interest of the study was "how the participants, as industry experts, conceived these issues, their causes and how they could be resolved"; the starting point of each interview was a question about the participants' own conception of workplace wellbeing and its importance in the context of their business to allow participants conceptualization of wellbeing in general and ideas about workplace wellbeing to be voiced and defined which has implications for the design and evaluation of workplace initiatives)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Existing links utilized for recruitment but no mention of consent. All individual and company names, locations and any identifying details have been changed. The interviewees role within the company have been anonymized.)*

Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Interviews transcripts analysed thematically to explore the significance of the individual experiences using a staged process based on grounded theory. Transcripts coded systematically identifying themes and patterns across the data. Transcripts were read by the lead researcher and open codes allocated to individual concepts, similar codes collated together into a smaller 'conceptual categories'; themes identified in relation to the coded extracts and the entire dataset. Trustworthiness of analysis established by co-researcher review of all transcripts and the thematic structure and cross-checked to ensure congruence. The findings are discussed in detail as aggregates of the individual narratives.)*
Findings	Is there a clear statement of findings?	Yes *(Findings were explicit with credibility/trustworthiness validated via co-researches analysis of codes, themes, and transcripts.* **1) Conceptions and value of workplace wellbeing** *1.1) Construction: 'workplace wellbeing' predominantly rationalized 'eudemonically' (encompassing purpose and meaning; implies a strong link between wellbeing and physical and mental health as a personal resources) focusing on health and safety e.g. 'general health' or 'quality of working environment' - diet, hygiene and workplace relations were also outlined in this context.* *1.1.1) Construction: safety major concern, mental wellbeing secondary or conditional on safety "everyone should go home at the end of the day in the same condition they came in the beginning of the day" (SteelBuild).* *1.1.2) Construction: Management/Leadership key to supporting a healthy workplace in relation to setting priorities, strategic directions and buy-in by senior management (CollectiveOrg2); and occupational health (InternatOrg).* *1.1.3) Construction/Retail: employers have a supporting role but individuals should assume personal responsibility for their own health and wellbeing (CollectiveOrg1, Supermarket);*

		multiple causes of ill health, including stress, that people bring stresses into the workplace that impact their performance (Build&Support). *1.1.4) Retail: more holistic perspective encompassing work satisfaction. Workplace wellbeing was about "taking care of the people who use us and the people who we employ" and "it's very important that they [staff] are happy at work" (manager: FashionShop). Important to create "an environment where people are happy to be in work" (manager: Supermarket)* **1.3) The business case** *1.3.1) Links between workplace wellbeing, the success of a business, and the business case for workplace wellbeing initiatives, were recognised by most of the participants - particularly retail representatives (FashionShop: looking after staff creates loyalty, thus a reduction in staff turnover; Supermarket: looking after employees when they were unwell was cost effective; BuildTech&Tst: "a healthy work force is a more effective work force" and linked an "unhealthy work force" to a higher accident rate)* *1.3.2) Construction: aging workforce so investing in health could enable people to work for longer and "have a more fulfilled life" (CollectiveOrg1)* *1.3.3) Costs of failing to comply with the health and safety framework outlined as an important incentive for workplace health and wellbeing initiatives.* *1.3.4) Workplace wellbeing initiatives should not be made in terms of short-term financial returns - reputation and resilience were also important (InternatOrg).* **2) Workplace health issues - priorities for interventions** *2.1) Physical health - issues vary by industry. Construction: lots of exposure to risk, traditional ways of working can exacerbate issues, some risks have been addressed but others have not with some conditions (Cancer: from substances [silica]; skin [working outdoors]) not featuring in health strategies*

		2.2) Relative Danger, risk and safety in construction (safety over health/wellbeing)- Because of the danger, concerns with safety trumped concerns with mental wellbeing and health "much as I want you to not be stressed at work, I'd probably be more concerned if you were decapitated" (SpecEng - director); In this context health and safety rules and regulations tended to be viewed positively (SteelBuild); The concerns of office workers tended to be trivialised in relation to these kinds of risks: "Well you know people don't die in an office normally and I've had four people die working for me over the last 10 years" (SpecEng). **2.3) Mental health and stress - important but causes differed between construction and Retail.** *2.3.1) Of those asked in Retail subverting competitive pressure was seen to positively impact staff health and wellbeing.* *2.3.2) Of those asked in Construction: Issues linked to workplace stress were important but hidden/not given attention.* *2.3.2.1) Masculinity of construction, men reluctant to admit stress and ask for help (CollectiveOrg2)* *2.3.2.2) Lack of collective understanding of causes and effects of stress and stigma (InternatOrg); 'Wimpish' (CollectiveOrg1)* *2.3.2.3) Fewer initiatives to discuss mental health issues compared to safety and physical health (SpecEng)* *2.3.2.4) Work patterns and structures (long hours, travel times, tight deadlines) common causes of stress in construction (CollectiveOrg1).* *2.3.2.5) "litigious contractual nature of contract and construct" (SpecEng); pressures of managing wider risks for the public in constructions (roofs, rail, and tunnels).*

		2.3.2.6) Attitudes/behavior of line managers and concerns about bullying in the workplace (BuildTech&Tst). **3) Barriers to improving health and wellbeing - many in construction not many in retail** *3.1) Traditional work practices, older workers, and unwillingness to change.* *3.1.1) The way things have always been done were identified as a barrier to improving health and wellbeing (SteelBuild)* *3.1.2) Older workers (20 years+ service) more likely to have accidents "they just get complacent, get a bit laxy" (BuildTech&Tst)* *3.1.3) Demoralizing trying to "change hearts and minds of an industry [...] that doesn't want to change (CollectiveOrg2)* **3.2) Contracting and employment structure.** *3.2.1) Complexity of employment mix (direct/contractors) on 'a job' makes it difficult to implement, manage, monitor, and evaluate health and wellbeing policies - sub-contracting can be a barrier to implementing health and wellbeing initiatives - "makes it particularly challenging to keep track of individuals in the workforce, to achieve consistency with group-based initiatives and sustain longer term interventions" (CollectiveOrg2)* *3.2.2) Larger, major construction clients can provide facilities and put in plans to address wellbeing (CollectiveOrg1) but implementation (e.g. health checks) could be passed down the supply chain making monitoring compliance difficult.* **3.3) Working away from home, transient, and temporary employment.**

		3.3.1) Diminish wellbeing initiatives effectiveness - "it's more difficult in terms of a health surveillance programme, wellbeing initiative, to engage with people on longer term" (InternatOrg). *3.3.2) Perceived cost-effectiveness of intervention due to transient nature of the workforce (Collective Org1); a suggestion that employment legislation encourages more 'transients' and weaker links between employees and employer (Collective Org1)* *3.3.3) Working away/on-site can lead to health and well-being issues - poor living conditions, absence of social support networks, primary care support.* *3.3.4) Attending Primary care and other appointments difficult if being paid hourly - costly to take leave.* *3.3.5) Financial insecurity caused due to short-term contracts/temporary work can lead to travel abroad to seek long term work - support from companies (large) can alleviate some of these issues.* *3.3.6) Migrant workforce - workers and workforce issues due to language differences and communication breakdowns (CollectiveOrg2)* **3.4) Long working hours and long travel-to-work distances** *3.4.1) "long working days can obviously lead to fatigue and this this would have knock on effects on performance at work and accident rates" (BuildTech&Tst)* *3.4.2) Lack of opportunity to engage in Physical activity or consume good diets; One organization looking into gym membership as an employee benefit (Build&Support); however "...when health and wellbeing schemes are introduced people need to be allowed time to take advantage" (InternatOrg)* **3.5) Tight deadlines, low-profit margins, and the macroeconomic climate**

		3.5.1) Financial pressure: Low margins and large penalties for missing deadlines; scrutiny of costs which puts pressure on health and wellbeing initiatives which are seen as less important (CollectiveOrg2) *3.5.2) Tight deadlines cascade down the levels and can lead to bullying "I want that piece of work done, I don't care how you get it done, just do it" (CollectiveOrg2).* *3.5.3) volatility of the construction industry in response to exogenous macroeconomic forces can also weaken incentives for long-term investment in wellbeing program unless a strong business case can be made.* **3.6) Predominantly male workforce and macho culture** *3.6.1) "the biggest challenge, honestly is […] is culture. Yes. Attitude, behavior, and culture […] it's a very macho culture, you know, you can't stand the heat get out of the kitchen" (CollectiveOrg2).* *Men don't want to talk about mental health; Retail (more female environment) "if there's something […] they'll usually just take me on one side and say can I have a chat with you, I've got a problem, this is happening, or that's happening, and I say to them, how can we help, how can we support you?" (FashionShop).* *3.6.2) Cater for the male character in approach - self-explanatory and be referred to themselves; "we don't like going to the doctors, so we do give health checks at work" (SteelBuild).* *3.6.3) Macho male environment creates stress through: stressful interactions and sense of pride from overworking, modelling/influence on younger employees.* **3.7) Company attitudes and wider social norms**

		3.7.1) Issues are sector wide but company level culture was the key to tackling health and safety but there has to be a will to address these issues. *3.7.2) International comparison led one interviewee to suggest UK had an ingrained culture of resistance to taking responsibility for health and wellbeing in the workplace and this needs to change to facilitate 'campaigns that, or interventions that work' (CollectiveOrg2)* **3.8) Targets and competitions** *3.8.1) Impose pressure.* *3.8.2) Encourage under-reporting and falsification: Potential for accidents at work to be under-reported due to participation in a target driven competition to complete "a million man hours without an accident" (SteelBuild).* *3.8.3) Potential risks of competition (cross-company comparisons): a need for independent benchmarks and accreditation to generate a more collectively responsible culture (Build&Support).* **3.9) Lack of support from leaders and middle management** *3.9.1) Barriers: Middle-management insecurities and lack of understanding of the complexities of workplace health and the related legislation (CollectiveOrg2); A focus on safety "quite a big obstacle with regards to health as well, workplace health" (CollectiveOrg2).* *3.9.2) A need for health audit in addition to a safety focus.* *3.9.3) Role and buy-in from leadership for health and wellbeing initiatives key "I think it very much helps that the senior leadership are visible in getting involved in the activities and that there's management support" (InternatOrg). But this was not always in place: "a lot of the*

		time, the leadership is very financially driven and it's all about figures and costings" (BuildTech&Tst) **4) Current and future issues** *4.1) Progress made but a lack of professional health and wellbeing expertise to support the industry. A feeling that mental health "we've still got a very long way to go" (InternatOrg)* *4.2) Fear of industry Blacklisting; an acceptance of people's right to refuse to work in unsafe conditions or with those working in unsafe way and an acceptance of whistleblowers more generally as recognition of the importance of health and wellbeing.* *4.3) Regulation and legislation: Changes in current legislation represent what some companies have been doing (SteelBuild); "the HSE needs to kind of really push out a standard there to push the other employers […] more legislative requirement because I think a lot of companies will try and get away from it because they know that they can"(BuildTech&Tst).* *4.4) Formal, industry wide, information and resource structure in place to deal with the transient workforce thought to be helpful (InternatOrg). Existing legislation had "plateaued" - new more "behavioral", less prescriptive direction would be more effective in changing the way people thought about health and safety and encouraging them to question traditional practices (SteelBuild).* *4.5) Tick-boxing: Minimum in order to comply with government recommendations, legislation or client audit process - "companies are only doing it because the client insists there's a KPI auditing process and you must comply" (BuildTech&Tst)".* *4.6) Financial environment and short-termism: Health and wellbeing programs a day or a week - a more long-term approach required (CollectiveOrg1); Retail have a different employment mix and can provide longer term options 'occupational health nurse'.* *4.7) Lack of specialist knowledge and information (Construction/Retail)*

		4.8) Catching-up with issues rather than preventing issues (CollectiveOrg1))
Research value	How valuable is the research?	The research has some value *(In construction there are some persistent workplace wellbeing issues that are obstacles to improving workplace health, safety, and wellbeing; these are quite specific to the type of work undertaken, working arrangements and the work culture. Findings are not generalizable due to limited sample size but provide insight. Identified the need for more evidence especially covering the longer term and that this feed into policy decisions. Development of methods to evaluate workplace interventions)*
Overall risk of bias and relevance	Overall risk of bias	Low
	Relevance	Relevant

D.2 Hanna 2019

Bibliographic Reference Hanna, ES; Markham, Steven; Constructing better health and wellbeing? Understanding structural constraints on promoting health and wellbeing in the UK construction industry; International Journal of Workplace Health Management; 2019; vol. 12 (no. 3); 146-159

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes *(Explores the views of stakeholders with health-related roles and responsibilities within the construction industry to examine their views of the landscape of the construction industry and its relationship to the health and wellbeing of the workforce.)*
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes *(A case study approach is used to explore what the key health and wellbeing issues are seen to be within the construction industry by those who are working in health and wellbeing related roles. The paper provides a qualitative evidence base around health and wellbeing within the construction industry, building on*

		knowledge around the health and wellbeing of construction workers and providing new insights into the broader structural features that may create challenges or opportunities for building better health and wellbeing within the industry.)
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell *(Reference to mixed methods approach: Qualitative semi-structured interviews which were conducted with key stakeholders from four case studies drawn from across the UK construction industry; This qualitative data formed part of a wider project into the health and wellbeing of the construction industry; Lack of justification for the approach specified)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes *(The cases were recruited through industry networks and groups and through key contacts provided by the project steering group. The case studies included two large general construction firms (one which conducts house building and the other large commercial building projects) and two medium sized scaffolding firms. The firms were all located within England, one large firm was a national company, the other worked across the North of England and the two medium firms were based in Yorkshire and Herefordshire, respectively. Participants were an equal mix of those in management and those who were employees, and the sample represented different roles and positions of responsibility within the firms, including site managers, site foreman, first aiders, health and safety officers, risk assessors, workforce development officers, company managers. Some participants in management roles had previously worked on site in a trade, so were able to see both sides of the management/workforce picture. There was a broad range of experience and most had worked in construction for over 10 years.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(19 recordings with 21 people from the four case studies conducted; Group interviews (decision not justified); Interviews ranged in length from 15 to 70 minutes; digital recordings transcribed verbatim. Interviews were conducted face to face where possible, most conducted on construction sites where the participants were located, or in their company offices, although three were conducted by telephone due to the preference of participants. Interview question agreed with 'steering group';)*

Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell – details not specified
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The research gained ethical approval from university ethics committee (ref: 24492) and all included quotations anonymized and presented in the format of Participant and a number.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(All interviews conducted by the lead author, who also led the analysis. The interview data was analyzed thematically using Braun and Clarke (2006) by the lead author, with theme checking and discussion with the authors before agreement of the following two themes: The construction industry as anti-health promoting and Understanding industry specific health issues. Sub-themes presented with verbatim quotes.)*
Findings	Is there a clear statement of findings?	Yes *(The interview data was analyzed thematically by the lead author, with theme checking and discussion with the authors before agreement; 2 overarching themes with 7 sub themes:* **1) The construction industry as anti-health promoting** 1.1) BARRIER: The type of workforce in the industry - *transient and layered nature of the sector makes it difficult to have a long term plan: "It is such a transient market with labour, construction is, that is very difficult to say my long-term plan for this person is x, y, z because in a year or six months they might have moved on. It's very difficult" (Participant 6)* 1.1.1) BARRIER: directly employed and sub-contractor, and workforce layers cause confusion regarding who has responsibility for health and well-being especially when an employee is employed by one firm but sub-contracting on other projects; difficulties in creating transparency across and between workforce

		layers*: "I know a subcontract company that had a problem with someone on drugs. And they kept it to themselves. Thy couldn't tell the principal contractor, but they confronted the guy. They did everything that was right...But as a contractor, you'd say, we'd say, 'he's not coming to our job" (Participant 8)* *1.1.2) BARRIER: The construction industry is perceived to be 'fixed' and "just how it was".* 1.2) Working equals earning: 1.2.1) BARRIER: Workforce mix - Having high levels of sub-contractors, self-employed and transients in the workforce were considered by interviewees to mean that working was a priority and not health promotion and improvement *" ...I just think they are not interested. They just want to come on, work and earn money...but the feel I get off people is they will always buy into stuff but it is about the work, that they need to earn their money" (Participant 1)* 1.2.2) BARRIER: The restrictive nature of the "working equals earning equation" was damaging for health as employees were reluctant to take time off and this could compound health problems where 'carrying-on' is seen as the norm and self-management of injuries was part of the solution *"They don't wanna say they're ill cos they don't wanna take the time, they're not gonna get sick pay...they just can't afford to take time off" (Participant 10)"...they have this pressure that is they have any time off, then you know, its gonna affect their home life, so they'll just soldier on through...they'll probably drink more to ease the pain and it's like an ever-decreasing circle of poor health (Participant 5)* 1.2.3) FACILITATOR: Direct employment considered an advantage for 'health work' due to entitlements such as sick pay and benefits - so they could take care of their health compared to those who could not access these benefits*"...We have a lot of our own guys who are on the books, so they get sick pay. They get looked after...But a lot of people are sub-contracted. Then they get nothing if they're ill." (Participant 7)*

		1.3) The competitive edge and client driven health agendas - competition for work (tendering) and margins to maintain competitive edge restricts resource/opportunities for enabling health promotion. *"We are here to make money" (Participant 19)* *"You have to do one thing to get to the next thing done...and then you've got an afternoon away talking about eating five a day fruit and veg people are like bloody hell; I've got other things to do" (Participant 16)* 1.3.1) BARRIER: Limited sharing of best practice *"...I am sure other companies are doing the same sort of thing but we don't get to hear the details" (Participant 19)* 1.3.2) FACILITATOR: Clients as motivators for health agendas: 1.3.2.1) FACILITATOR: The demands of larger clients were seen as a rationale for an emerging focus on health and wellbeing within some companies. *;"I've noticed that health has taken a bigger role within this...I think it's a lot driven by our clients and legislation as well is putting more emphasis on companies to take more responsibility regarding the health of their employees...over the last four years we're more aware of health assessments, pre-employment health assessments is what we've introduced...and then we do drug and alcohol testing on a regular basis...a lot of it I must admit is client drive because of the type of work, the type of sites we go on - we work for [rail company] so you can imagine their procedures are quite strict" (Participant 12)* 1.3.2.2) FACILITATOR: Clients want to know the workforce on the project were fit for purpose and the focus on health and wellbeing was seen as risk management rather than health promotion.

		"We are finding that health surveillance is important. We in our company do medicals because we are classed as critical workings because we are working at heights...it is customer driven, so a lot of our customers demand us to have their certification" (Participant 6) 1.3.2.3) FACILITATOR/BARRIER: Client demand (top down driver) seen as part of the tendering/competitive process but also a bureaucratic exercise rather than driven by health/workforce improvement: *"It's their responsibility. It seems like a lot of things that we do, it's just box ticking, outside covering. I think it's more of a box ticking exercise, and it covers companies probably just for insurance purposes...I think it's more about that than actual health and wellbeing" (Participant 13)* **1.4) Variance across the industry** 1.4.1) larger companies perceived as higher quality and focused on health and wellbeing; Smaller/lower quality firms were seen to underperform in terms of basic requisite health and safety, so health and wellbeing is even lower on their agenda. 1.4.2) Smaller companies were considered to be less heavily monitored (type of clients and work) client agendas around health and wellbeing were seen as less applicable to smaller companies. *"...we are not talking about the small to medium building companies out there. They are way off, absolutely miles away" (Participant 6)* 1.4.3) Size of contracts seen as a barrier and facilitator to engaging in health and wellbeing.

		"I mean this is a £15 million project and it's a lot easier...these jobs are a lot easier to promote things like this [health and wellbeing], whereas if you've got a small job where everything is tight..." (Participant 7) **2) Industry specific health issues** 2.1) Differences between layers of industry*: managers versus employees - those working in construction are not all undertaking manual site-based work so the promotion of health and wellbeing needs to speak to the variety of needs across the industry.* 2.1.1) Barrier and facilitator: Health and wellbeing issues differ based on role - desk-based versus on-site and these changed. *"So [my work is] probably different to what of the other guys do in and around site..."(Participant 10)* *"I mean since I stopped working on the spanners, my eyesight has gone terrible sitting in front of a computer. I am now wearing glasses. There are drawbacks in everything." (Participant 6)* 2.1.2) Barrier and facilitator: The variety of roles in the industry mean that a one size fits all approach to health and wellbeing is unlikely to succeed. *"A guy digging a hole all day might need steak and kidney pie...and he'll be as skinny as a rake. Whereas the manager, who's not so skinny might need the salad..." (Participant 8)* *"I think that's the problem with IT as well and it doesn't go off. I think management have an issue, but I think the lads generally can, they can leave on a Friday and then that's it. Shut off' (Participant 7)*

		2.2) The foreshortening of working life in construction - on-site manual work takes a physical toll on the work force with interviewees outlining musculoskeletal issues as a reason for leaving the industry. *"I don't see how people can work till the retirement age in this industry, doin the physical jobs" (Participant 13)* 2.2.1) Some roles (scaffolding or dry lining) resulted in shortening of working life. *"There is a lot of bodily strain, there are not many scaffolders that retire as a scaffolder. They don't make it" (participant 4)* 2.3) Construction as stressful - stress was seen as the major mental health issue across the workforce, especially management. *"Managers are the most likely people...but the workforce as well, they [managers] are the most likely people to say if there is anybody on the site that is stressed ad mentally upset..."(Participant 1)* 2.3.1) Pressured nature of construction and volume of work were seen as causes of workplace stress - which varied with the type and nature of the job. *"Yeah, stress - like I'm not too bad at the minute, cos it's not busy. When it is busy, it's horrible y'know." (Participant 3)* *"...it depends what job you're on, the last job I was on...there was like fifteen weeks to do in about four weeks, we were working around the clock...but yeah, you see a lot of stress" (Participant 9)* 2.3.2) Stress across levels and job types but pressure could be self-induced.

		"I was always very aware of you know, you are always under pressure to finish a job...sometimes you put yourself under the pressure because you want to get on, you want to be the best" (Participants 4))
Research value	How valuable is the research?	The research is valuable *(Health and wellbeing in the construction industry is shaped and constrained by structural issues this is framed in the realities of 'industry as a whole'. Discussions outlines the lack of nationality and cultural background of workers as theme. Reference is made to cost of ill health and poor wellbeing (estimated at £100 billion/year) and that a focus on this makes prudent financial sense although cost-benefit analysis has not been undertaken but benefits for employees and employers have been outlined; however financial bottom line in a competitive industry is a key barrier/facilitator to any action. Health and wellbeing need to be approached in alignment with priorities, make-up, needs and wants of the industry. Stress is an issue that reflects many sectors. Client agendas are a key driver in health and wellbeing focus but the case needs to make for all: employers (large and small) and employees. Working longevity and skills retention where there are skill shortages are key points for endorsement of health and wellbeing promotion. Cultural change and a focus on wider determinants of health are key. Safety as an issue in construction is used as an example of how health and wellbeing is being treated and is now progressing. Issues regarding smaller employers is identified as a barrier to change.)*
Overall risk of bias and relevance	Overall risk of bias	Low
	Relevance	Highly relevant *(UK based; Construction industry specific but application to other sectors.)*

D.3 Mellor 2011

Bibliographic Reference	Mellor, N.; Mackay, C.; Packham, C.; Jones, R.; Palferman, D.; Webster, S.; Kelly, P.; 'Management Standards' and work-related stress in Great Britain: Progress on their implementation; Safety Science; 2011; vol. 49 (no. 7); 1040-1046

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes *(Identify what constituted barriers to progress in the implementation of the Management Standards approach (MSA) (HSE 2007) for preventing and reducing work-related stress nationally. MSA seeks to encourage employers and employees to work together to identify psychosocial risks and adopt solutions to minimize these risks.)*
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes *(Process evaluation that has two elements:1) Analysis of a stratified random sample of 100 visit proforma (i.e. every fifth out of 500) from public sector (three sectors: health services, education, and local government) organizations across eight regions of HSE records of inspectors' visits (2007–2009; >60 specially trained inspectors in work-related stress policy were involved in recording these 100 visits). Includes information on progress made through documentary evidence (e.g. policies, meeting reports, etc.), and conversation with a range of organizational members (e.g. management, employees, trade Unions, etc.) depending on their involvement in the stress program and their availability at the time of the visit. 2) Over 60. retrospective semi-structured research interviews with ten organisations (health services; local government priority sectors) to obtain accounts of organisations' experience of the implementation stages.)*
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell *(The rationale underpinning the decision to use an analysis of HSE inspector reports and semi-structure interviews is not outlined. The rationale seems clear given the aims and objectives but not discussed within the papers method.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes *(The recruitment strategy is twofold covering the two data streams:* *1) A stratified random sample of 100 visit proforma (i.e. every fifth out of 500) from public sector organizations across eight regions and three sectors. The sample represented mostly large size organizations. The justification for the recruitment approach is understandable given the aim/objective of the study but not fully rationalized.* *2) Retrospective semi-structured research interviews conducted within ten organizations from health services and local government priority sectors. The aim was to obtain direct and*

		free accounts of organizations' experience of the implementation stages. The recruitment strategy was purposive and informed by inspectors' knowledge, in order to include 'typical' cases which were at least at the action plan stage to be able to provide insights into the research topic)
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(The data collected does address the research issue outlined. There is a lack of justification for some aspects. 1) Researchers were given access to HSE investigator reports of which a random sample was taken (method of randomization is unclear). Where the analysis was undertaken is not specified but assume it was a desk-based exercise. Data is collected via a standardized HSE proforma ad subsequently analyzed.* *2) Semi-structured interviews undertaken with a HSE inspector informed purposive sample. Interviewees were Health and Safety, and Occupational Health managers or advisors. Location of interviews unclear. All interviews recorded and transcribed verbatim. No evidence of modification and data saturation is not discussed)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell *(The researcher/participant and data relationship has been considered as possible limitations of the study findings but not explicitly outlined in the methodology.* *1) Proforma analysis are inspector interpretation on organisations responses and not all are qualified with verbatim quotes (Analysis therefore are third order). As there are over 60 contributors to these proformas this is thought to reduce any potential bias; and the thematic analysis undertaken in this study attempts group themes across the data corpus* *2) The study does not outline how researchers considered their own role, potential biases and influences might impact their undertaking the semi-structured interviews or analysis)*
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell *(No reference to permissions, informed consent, or ethical clearance. This might be due to this being categorised as a 'process evaluation' and that all participants are/were members engaged with HSE)*
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(Proforma and interview data analyzed via a 'Framework analysis (Richie and Lewis, 2003; another name for thematic analysis). Which has been justified due to its focus on the nature*

		of issues encountered rather than the number of occurrences, and it allowing the accommodation of the types of data collected (non-research based enquiry (inspection visits) and from a small sample of qualitative research interviews. Data was coded and categorized into themes. Recurrent themes across cases (proforma or interview) as well specific within-case themes were identified and interpreted within the context of organizations making progress (or lack thereof) in implementing the Management Standards. Direct quotes are not provided but a summary of themes is outlined with exploration of potentially contradictory items outlined. The role of the researcher and their impact on data collection and analysis is not specified; A 'concept-driven code' was applied to findings based on past research - it is unclear why this has been done)
Findings	Is there a clear statement of findings?	Can't tell *The findings are outlined but attribution to data and the process of attribution is unclear. This may be due to journal word limits etc but the move from data to theme to finding is not clearly established; There are minimal qualify quotes/data with a lack of justification as to why this is the case.* *Three overarching themes (1, 2, 3) used to frame findings based on previous research:* **1) challenges related to the organisational context in which the stress programme was due to be developed.** Barrier: **1.1) Proforma data (P): Organisational change/restructure was a major interference to stress program progress.** 1.1.1) Led to delays/amendments/ending of program. 1.1.2) The changes themselves were a source of stress. 1.1.3) Focus of intervention on those at risk of change/stress

		1.2) On-going organisation changes (I) **1.3) Target driven cultures (I)** *"on-going changes within the organisation and a target driven culture* *"There's competing pressures to keep it alive on the agenda . . .and a target driven culture, patients, waiting times. . . and other pressures for key performance indicators that sometimes it's just that keeping this as a key priority can be difficult".* **Barrier and facilitator:** **1.4) Replacement of senior management** 1.4.1) Positive/negative impact dependent on incumbents priorities **2) Processes related to organisational members' perceptions and actions during implementation phases.** **2.1) Senior management support** Facilitators: 2.1.1) Strong senior management and HR visible support (P, I) The importance of senior management support giving priority and sufficient resources to the program for it to move forward: *"vital for action plans to move forward"; "critical to the implementation of the strategy".* *2.1.2)* Board member or senior manager members part of the stress steering group (I)*'gave it clout'* when implementing action plans. Barriers:

		2.1.3) Weak support from senior management support (P, I) 2.1.4) Belief that stress issues cannot be solved (P) **2.2) Employee participation** Facilitators: 2.2.1) Employee involvement in survey completion and in suggestions for improvement (P, I) 2.2.2) Trade Union consultation (P) Trade Unions were instrumental in some workplaces, with regard to employee involvement, in encouraging staff to take part in the stress initiative. However, when Trade Unions had not been sufficiently consulted, employee participation was lower, as was the survey response rate *(Study narrative not a direct quote)* Barriers: 2.2.3) Lack of TU involvement led to lower employee participation (P) **2.3) Communications (Facilitator)** 2.3.1) Regular updates (P) 2.3.2) Multi-pronged communication approach (presentations, emails, etc.) (P) An all-round communication approach to awareness-raising including visible senior members' actions and multiple channels of communication helped organisations to combat this problem. Interview results similarly acknowledge that regular feedback to staff was seen as key especially after interventions were put in place. One explanation given for this was that

		"staff would not think it is a one off process" and that actions were followed up (Study narrative not direct quote). **2.4) Organizational capability** Facilitators 2.4.1) Sufficient resources (financial, technical, and human) (P) 2.4.2) Line management competency and support (P, I) 2.4.3) Specialist expertise (P, I)Active and competent stress steering group (I) *"It works well where you've got a pro-active manager that is really committed to the process and wanting to see it through from beginning to end.* *"When managers who are under a lot of stress themselves. . .get good support from their own managers – when they're supported within their business unit".* Barriers 2.4.4) Perceived lack of management competency in conducting risk assessment (P) 2.4.5) Insufficient resources (P) 2.4.6) Managers unavailability slows down action plan delivery (I) **3) Considerations on the content and features of the approach itself.** **3.1) Content of the approach itself** Facilitators:

		3.1.1) Strategy to target departments or groups at risk: efficient and less time consuming approach (I) 3.1.2) HSE Indicator Tool eased the assessment of stress (I) 3.1.3) Focus groups valued by staff (I) "focus groups were also mentioned as being positive in the sense that they had the potential to ‘‘boost morale’’ as ‘‘staff felt valued and thought that the organisation was listening to them’’. Barriers: 3.1.4) HSE Indicator Tool not suited for some work environments (P) 3.1.5) Risk assessment seen as resource intensive (I, P) 3.1.6) External consultancies’ help needed for focus group facilitation (P) 3.1.7) Gap in HSE guidance on how to conduct an evaluation of interventions (I)
Research value	How valuable is the research?	The research is valuable *(The context and content are relevant; The aim and object speak to a key theme of the barriers and facilitators to implementing workplace strategy; HSE are a leading policy maker in this area which is key and the policy they outline is in use.)*
Overall risk of bias and relevance	Overall risk of bias	Moderate *(Research design requires greater clarity and rationale for decisions made. Issues regarding the consideration of researchers influence on researcher were not clarified. Issues regarding ethics and informed consent were not specified in the context of the process evaluation nature of the study; Rationale underpinning aspects of the data-analysis required clarification. The findings provided associated data for some elements but not all without rationale as to why this was the case.)*
	Relevance	Highly relevant *(UK policy implementation; UK settings, Mental wellbeing and work is the clear focus)*

D.4 Mellor 2013a

Bibliographic Reference Mellor, N.; Smith, P.; MacKay, C.; Palferman, D.; The "Management Standards" for stress in large organizations; International Journal of Workplace Health Management; 2013; vol. 6 (no. 1); 4-17

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes *(Examine how HSE management standards are translated into organizational practice. Specifically, identify how employers have implemented the Management Standards in large organizations, the organizations for which the national stress policy guidance was originally developed. It seeks to inform the extent to which current stress guidance is useful for employers and identify potential refinements. The rationale underpinning the research is that gaining an understanding of the key activities, and of the enabling or hindering processes occurring at each of the five steps of the risk assessment method, will provide insights as to what constitute the strengths and weaknesses of such an approach for stress prevention and reduction. The Management Standards refer to good management practice with regard to six main psychosocial risks in the workplace: job demands, control, support from management and peers, relationships at work, clarity of role and organizational change.)*
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes *(The research seeks to identify organizational practice in two public and three private sector organizations through a case study method which is recommended when attempting to uncover how a phenomenon, over which there is little or no control, is produced and when the impact of context is important.)*
Research Design	Was the research design appropriate to address the aims of the research?	Yes *(Case study method seeks to uncover how a phenomenon, over which there is little or no control, is produced and when the impact of context is important. Discussion in the study is minimal regarding justification but is appropriate given the aims and objectives.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes *(Qualitative data collected (between 2009 and 2010) used 14 semi-structured interviews with 21 organizational members and documentary evidence from five organizations comprising two healthcare trusts, one central government department and two private sector organizations. A purposive sample was used in order to include "typical" cases, i.e. large public and private sector organizations from different sector and locations. Organizations*

		identified through professional networks, with five selected on the basis that they had fully implemented the Management Standards approach for longer than a year, had a reasonable number of activities undertaken within the period and could provide documentary evidence of their activities. The intention was to gather the views of the implementers to understand how the HSE guidance was interpreted and followed. The respondents were occupational health professionals, trade unions, health, and safety representatives, all at the forefront of the implementation of the Management Standards approach in their organization.)
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(Semi-structure interviews, open-ended questions asked about the activities carried out during the risk assessment, their successes and challenges aiming to uncover the enabling and inhibiting factors to implementation. Where possible, stress policies, minutes of steering group meetings, action plans for interventions and outcome data were collected as further evidence of activities undertaken within organizations. Two implementers per case study (except only one in one case) were interviewed. In one case study, the views of trade unions and managers could also be sought.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell *(The study does not refer to the consideration of the role of the researcher, their potential biases or ability to influence data collection or in the formulation of research questions. The study outlines that purposive sampling was undertaken utilizing 'professional networks' but this has not been clarified.)*
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell *(The study does not refer to ethical clearance, consent, or processes to safeguard anonymity.)*
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(Study refers to qualitative data analysis relying on full transcripts of the interviews when these could be tape-recorded. Indicating that this was not always the case. The study applied a 'cross-case analysis' to the data using qualitative content analysis (Miles and Huberman, 1994), and outlines the steps undertaken (familiarization with and summery of transcripts/documentary evidence; analytical framework development based on the HSE guidance on implementation [what should be done and what was done by organization, how was it justified was it reported as effective or not and highlighting similarities and differences across cases]. The justification for this approach has not been outlined.)*

Findings	Is there a clear statement of findings?	*Can't tell* Findings are framed in the context of organizations implementation of the HSE Management Standard specifically the HSE guidance on the 'five steps of risk assessment' - which at the outset assumes senior management commitment to support the approach and worker involvement to implement needs-based intervention. There is a lack of qualifying data for the statements made and it is unclear what underpins them or how they have been derived. **1) Preparatory work and step 1: identify the stress risk factors** 1.1) Main driver was compliance with health and safety law, reducing sickness absence, improving other human resources or occupational health indicators, putting in place preventative measures to address root cause of the stress issues and adopting best practice - *no direct quote outlined.* 1.2) Key enabler: senior management support 1.2.1) Allowed "strategy to move forward' (resources allocation, chairing the stress strategy steering group or being exemplar in managing their own stress) - no direct quote outlined. 1.2.2) Persuading senior management to: accept stress as an important business issue; implement a well-being corporate strategy - no direct quote outlined. 1.3) Establishing and embedding 'stress policy' (preventative and remedial action, detailed, manager guidance or risk assessment and focus groups) into corporate plans, internal systems and procedures demonstrated 'stress' as a priority - no direct quote outlined. 1.4) Permanent steering groups with mixed representation stakeholders to co-ordinate initiatives and address risk assessment process - no direct quote outlined.

		1.5) Professional internal resources (occupation health, human resources, health, and safety team) to support managers - without support less activities and no follow-ups - no direct quote outlined. 1.6) Training of line managers on stress management or leadership key to subsequent action planning. **2) Step 2: decide who might be harmed and how – gather data** 2.1) Time and cost a factor in data collection - no direct quote outlined. 2.2.) Survey fatigue - no direct quote outlined. 2.3) respondent utilized HSE tools and benchmarked against HSE or organizational average - no direct quote outlined. 2.4) Incorporating 'HSE management standards' into organizational policy allowed causes (work/non-work) to be discerned - no direct quote outlined. **3) Step 3: evaluate the risks – explore problems and develop solutions** 3.1) Worker involvement (focus groups or discussion group) post workplace survey results (gather data - I assume) important in: 3.1.1) obtaining local and practical solutions. 3.1.2) motivating employees in contributing to the approach. 3.1.3) a time-consuming exercise. **4) Step 4: record your findings – develop and implement action plan/s**

		4.1) Manager 'unavailability' following risk assessments outlined as a 'significant barriers' to effective implementation. 4.2) Line manager commitment in the process was outlined as key to ensure that action plans were in place. 4.3) Line manager training on stress risk assessment was vital to enhance their skills but ensuring that all line managers received this training was challenging due to their unavailability. 4.4) A target driven culture and constant organizational changes were barriers to line manager availability. **5) Step 5: monitor and review action plan/s and assess effectiveness** 5.1) support from senior management was said to be “vital for action plans to move forward” or “critical to the implementation of the strategy”. 5.2) Additional HSE guidance was needed on how to proceed for more rigorous evaluation.)
Research value	How valuable is the research?	The research has some value *(The context and policies under discussion are all key to mental wellbeing at work and are specific to the UK. The findings are quite specific but could be looked at more broadly regarding how policy and strategy are considered; but are limited.)*
Overall risk of bias and relevance	Overall risk of bias	High *(There is a lack of clarity regarding the rationale underpinning the methodological approach and data analysis. The findings are presented as author narrative with limited outline of what data/evidence underpins the findings or the rationale underpinning the approach adopted. There is no reference to the lack of ethical consideration, consent, or procedures to insure anonymity. There is a lack of detail outlining the consideration the researcher undertook to reduce their influence on data collection, construction of interview proforma and other processes to facilitate the research.)*
	Relevance	Relevant

D.5 Mellor 2013b

Bibliographic Reference Mellor, N.; Webster, J.; Enablers and challenges in implementing a comprehensive workplace health and well-being approach; International Journal of Workplace Health Management; 2013; vol. 6 (no. 2); 129-142

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes *(Examines how the complexity of integrating various health management systems was achieved in a large organization that adopted a comprehensive definition of workplace health. The study seeks to identify key enablers and challenges in the implementation of a comprehensive approach to the management of employee well-being - with a particular focus on line managers' role in such an initiative)*
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes *(Using a case study approach, the study seeks to understand the complexity of integrating various health management systems was achieved in a large organization and identify key enablers and challenges in the implementation of a comprehensive approach to the management of employee well-being.)*
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell *(The justification for adopting a 'case study approach' is not clearly justified. The rationale and considerations in adopting this approach are not discussed from a methodological perspectives (limitations, alternative approaches considered etc). A large UK public sector organization was chosen as a case study because it had developed an extensive well-being strategy covering occupational safety and health (OSH), workplace health promotion (WHP); employee assistance programme (EAP); and had been in place for several years.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(Its clear why the 'large UK public sector organization' was chosen as the case study (developed an extensive well-being strategy in place for several years; current context in which this organization operated at the time of this study was described as challenging with significant reduction in staff and increased workload and the introduction of new work*

		processes to increase operational efficiency). What is less clear is who else had been considered and the decisions underpinning the decisions to go with one organization over others; the specifics of the recruitment strategy itself are unclear. Semi-structured interviewee participants were selected purposively based on how well they were informed and involved in the design of the comprehensive strategy put in place.)
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell *(The rationale underpinning the approach to data collection is unclear and not discussed; Rationale underpinning 20 participants for interview is not outlined; No indication of methods modification; Triangulation across the two data sources is outlined in terms of analytical process but not as a justification for data collection methods. Data collection was from two sources: 1) Analysis of company records and documentation on various aspects of the well-being strategy (company wellbeing and stress policy; well-being strategic plan; award application; web-based detailed documents on well-being advice for staff; well-being board briefing, measurement and accountability of well-being within government departments; HR competency framework; public presentations given by the health and safety manager, occupational health provider yearly statistical reports detailing the occupational health services usage from 2005 to 2009; company summary statistics on absenteeism rate, staff turnover, staff opinion surveys; internal report on 11 focus groups to identify "the engaging manager" within the organization having an influence on employee well-being.2) Semi-structured interviews with 20 stakeholders (strategy implementers: health and safety representatives, HR, occupational health providers [n=8]; trade unions [n=5]; line managers with supervisor and middle manager grades and different roles [n=7]) to uncover the successes and challenges of the strategy from various perspectives. An overview of which participants were asking which questions is outlined:1) Well-being strategy implementers: explain their role in the strategy, activities carried out, enablers and obstacles encountered. 2) Managers: views on the health and well-being services (WHP and EAP) offered within the organization; role in the WHP implementation and the management of stress at group and individual levels; training required to help improve staff wellbeing. Additional data (staff opinion surveys, EAP statistical reports over the last five years, absenteeism and turnover data, policies, and other strategy-related internal reports) was used to inform the case study.)*

Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell *(The study does not refer to the potential impact of the researcher in the process of formulation of the research question, data collection and analysis, or recruitment. No reference is made to the setting for data collection.)*
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell *(Processes regarding ethics, consent and anonymity are not discussed)*
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(Triangulation is outlined as one of the processes undertaken in the analysis of the data but the rationale for adopting this approach is unclear in the context of the study. The data (which is assumed to mean both analysis of records and semi-structured interviews) was analyzed using 'framework analysis' (Richie and Lewis, 2003) - a form of thematic analysis - the stages of which are outlined in brief (familiarization with the interviews' transcripts and summarizing participant's account for each question into an analytical framework from which elements and dimensions reflecting the range of experiences and views of participants are drawn out). A subsequent step involving regrouped into emergent themes, highlighting common and topical views and issues was undertaken. The justification for the approach adopted is unclear.)*
Findings	Is there a clear statement of findings?	Yes *Findings are unpacked using a literature-based 'conceptual-framework' - no further details are provided.* **1) Organizational enablers and challenges** **1.1) Integration of health, safety, and well-being strategy into business plans*:*** 1.1.1) Implementers: gaining the commitment of directors and senior managers ensured that planning for OSH is an integral part of their business planning process. *No direct quotes* 1.1.2) Implementers: Existing well-being policy helps communicate the approach to staff and encouraged senior managers to take part in the WHP initiative. *No direct quotes*

		1.1.3) Implementers: Reducing duplication - combining existing activities (workplace health promotion) with existing services (Employee assistance program), ensuring service providers communicated - but no evidence of these things occurring in practice *No direct quotes.* **1.2) Senior leadership commitment and support for Workplace Health Promotion -** *Unclear if this was a barrier or facilitator?* **1.3) Involvement and coordination of stakeholders.** 1.3.1) Site sponsors encouraging WHP events attendance were perceived as helpful in alleviating staff resistance. 1.3.3) Trade union: A more significant role of the local trade unions is seen as key to engage more staff in Workplace Health Promotion. **1.4) Communication in Workplace Health Promotion.** *1.4.1)* Implementers: a more focused and targeted communication strategy was needed to get all senior and middle managers as well as staff involved in WHP. *1.4.2)* Implementers: challenging to communicate messages within a large and complex organizational structure with multiple individual businesses, regions, districts, and sites. *"Units can often act autonomously and this presents a challenge particularly in terms of consistency of message and implementation".* 1.4.3) Implementers: Communicating results of staff health assessments to managers may engage managers and encourage focus on high risk offices and develop action plans. **1.5) Striking a balance between a focus on occupational risks and lifestyles risks.**

		1.5.1) Managers: resistance from some staff to become involved in WHP as they perceive it as an intrusion into their personal lives. Staff comments: *"it is not linked to the work; I do that outside of work".* 1.5.2) Trade unions: important to communicate clearly what WHP is about. **1.6) Particular challenges in the line managers' role in well-being management** 1.6.1) Need for a better understanding from managers of the value of health promotion. Implementers: *"[...] we know for instance that internally there's a great variability in the way managers embrace well-being, […] and so at a senior level, the buy-in to a holistic view of well-being is very strong, the challenge is filtering that through a complex management structure […] there can be a mismatch between the view of strategic management and the view of local operational managers [...]".* 1.6.1.1) Variable WHP attendance in this programme that would require a better understanding of the managers' role within WHP. 1.6.1.1.1) Implementers: some managers did not appreciate the importance of their role in the WHP: *"it's the manager who locks or unlocks the culture in the workplace, so the manager blocks it, it won't filter past them, the manager embraces it, it will filter into everybody who works there […] we've seen some real examples of an individual manager who can actually block a well-being approach for 25, 30, 40 people because that individual manager won't have anything on their site about it […]".* 1.6.2) Need for a culture change. 1.6.2.1) Managers: difficulty of rostering front-line staff to allow them time away from their desk to participate in the WHP. *1.6.2.2)* Line managers/middle managers are thought to be target driven and can be reluctant to release staff for WHP or do not perceive well-being as the priority. *"There is an atmosphere at the moment of, there's a lot of targets that we have, a lot of monitoring that we give to people and sometimes there's a bit of an ethos of putting long hours in and*

		we're trying to [...] you know, some managers, some of my senior officers are very much like this and then some are very keen on the work life balance, but at the same time there's pressure on people to work longer and longer hours [...] so there's a bit of ambiguity". 1.6.3) Need for tailored team-level psychosocial factors assessment and interventions. 1.6.4) Need for clarity and further training on individual stress assessment. 1.6.4.1) The individual risk assessment for stress is recognized as a valuable tool by managers and the trade unions *"Those stress risk assessments do tend to deliver something of the result that we were looking for in terms of managing the individuals stress, helping them to continue to function well or to improve their function while coping with whatever situation".* 1.6.4.2) Managers: more clarification about the procedure was needed as well as training on what constitutes stress and how to be mindful of what should be said to employees to avoid counselling. *"So my recollections of the training, bit too mechanical, not enough focus on what sorts of things are actually sensible and acceptable solutions".* 1.6.4.3) Managers: Current training needs included: how to identify and help people suffering from stress before they go off sick; and how to conduct difficult conversations, as this would help in discussions with individuals about their capability, expectations, and discipline matters. 1.6.5) Need for specialist help in the management of ill-health. 1.6.5.1) Absence of management policy that details responsibilities for managers and employees and specific training for managers. 1.6.5.2) Managers value the advice they obtain from their HR business partner, EAP and OHP when they encounter difficulty with the return to work procedure - HR business partners were seen as ensuring consistency in the way support provided; EAP services source of help for themselves in their role as managers and for staff; OHP advice and

		support when dealing with unfamiliar disabilities: *"It is important because I do find it difficult [y] as a manager you dip into it now and again, we do have the support where we can go and get further advice to try and make sure things are consistent, (the EAP professionals) provide quite a vital service [y], because [y] they're experts in their field".* **1.7) Need for an engaging leadership style.** To identify what makes engaging leadership behaviours, a series of 11 focus groups was conducted with staff in 2009. *Findings of focus group: instil a positive team climate, give recognition, enable, and develop staff)*
Research value	How valuable is the research?	The research has some value *(UK context that deals with the implementation of workplace policies that are currently in use. The findings require further interpretation to be of value and are derived from one case study thus limiting potential generalizability. Views expressed were mainly from implementers.)*
Overall risk of bias and relevance	Overall risk of bias	High *(There was a lack of justification for the approach adopted in terms of sampling, method of data collection, methodological approach, and data analysis. The findings were presented without consistent use of direct quotes and it was difficult to understand how triangulation was applied and where. The process of thematic analysis lacks detail and discussion.)*
	Relevance	Relevant *(The study has relevance but has significant limitations)*

D.6 Quirk 2018

Bibliographic Reference	Quirk, Helen; Crank, Helen; Carter, Anouska; Leahy, Hanna; Copeland, Robert J; Barriers and facilitators to implementing workplace health and wellbeing services in the NHS from the perspective of senior leaders and wellbeing practitioners: a qualitative study.; BMC public health; 2018; vol. 18 (no. 1); 1362

Section	Question	Answer

Aims of the research	Was there a clear statement of the aims of the research?	Yes *(Explore the perceptions of NHS senior leaders and health and wellbeing practitioners regarding barriers and facilitators to implementing workplace health and wellbeing services for staff in the NHS.)*
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes *(Semi-structured interviews were conducted with NHS staff, consisting of four senior leaders, four heads of department and three health and wellbeing practitioners in one region of the UK; and sought to examine the experiences and views of senior leaders and practitioners and explores to what extent the ambitions of the NHS Five Year Forward View and the staff HWB Commissioning for Quality and Innovation (CQUIN) payment framework have been impactful; and explores senior leaders' and workplace wellbeing practitioners' perceptions of 1) Barriers to implementing workplace HWB services in the NHS 2) Facilitators to implementing workplace HWB services in the NHS 3) The ideal implementation of workplace HWB services in the NHS)*
Research Design	Was the research design appropriate to address the aims of the research?	No *(Authors have not justified fully the decision to adopt a qualitative approach (although it is appropriate) or the rationale underpinning the method of data collection (semi-structured interview with senior leaders and workplace wellbeing practitioners across the NHS in one region of the UK) but these are appropriate. Authors go on to outline the potential value of this research in the context of the current need and existing evidence base; and that considering the potential value, the current research explores the experience of initiating and delivering workplace HWB services in local NHS Trusts, focusing on the barriers and facilitators to effective implementation and the impact of on-going policy initiatives (5YFV; CQUIN))*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(Senior leaders and workplace wellbeing practitioners were recruited via purposeful sampling procedure - justification is not fully outlined but is clear that those selected would be able to address the aims and objectives. Individuals working in appropriate roles within the NHS were highlighted and contacted directly by the project team through local network contacts. The number of participants interviewed was based on the number needed to achieve theoretical data saturation. With each interview conducted, the research team judged whether the data emerging was new and satisfying the research purpose. The*

		researchers deemed no new data to emerge at the eleventh and twelfth interview, at which point recruitment ceased.)
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(A mutually convenient interview time and method (telephone or face-to-face) was arranged. Written consent was received prior to the interview. The location of face-to-face interviews has not been specified. An interview schedule was employed across participants to ensure consistency across interviews which was adapted for practitioners to cover implementation of workplace HWB services. Interviews were recorded using a digital sound recording device and transcribed verbatim with 1/12 interviews not transcribed due to a technical issue. The researchers deemed no new data to emerge at the eleventh and twelfth interview, at which point recruitment ceased.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell *(Interviewers trained in interview techniques. One experienced researcher with a background in workplace wellbeing in the NHS. One is a principal researcher with a background in the development, management, and delivery of workplace wellbeing program.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The research was reviewed and approved by Sheffield Hallam University local research ethics committee. Interested individuals were provided with an information sheet and consent form. Verbal consent was confirmed before the interview. Thirteen people expressed an interest to participate. Written consent was received from 12.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Interview data were analyzed using Braun and Clarke's (2006) six-stage process of thematic analysis. NVivo 11 was used to organize codes and themes. Data analysis began with an inductive approach. Deductive codes relating to specific areas of interest were then looked for in the data. Data analysis was led by one research and supported by another with one interviewer verify the identification and refinement of themes. Verbatim quotes with occupation type in parentheses have been used to represent each theme and subtheme.)*
Findings	Is there a clear statement of findings?	Yes *(Four overarching themes (two barriers; two facilitators):*

		Barriers Theme **1) Barriers to the implementation of HWB services in the NHS** - current state of the NHS and *"times of austerity"* perceived as having a negative impact on Trust's ability to effectively implement staff HWB services (Overarching theme) **Sub themes:** **1.1) Busy and pressurized environments caused by staff shortages.** 1.1.1) Negative impact on staff Health and Wellbeing: *"the workplace is under huge pressure and that isn't going to go away because of the difficulties of attracting and retaining staff" (005, SL).* 1.1.2) A workforce that needs HWB services is not necessarily a workforce that will be receptive to such services: *"the demand [for workplace wellbeing services] continues to grow", but "people are knackered, and that doesn't always put you in the right frame of mind to want to take advantage of exercise or wellbeing" (001, HR).* 1.1.3) Those people responsible for the implementation of Health and wellbeing services are also under pressure and i*ts* perceived as having a negative consequences on their ability to deliver effective and resourceful services: *"Everybody who is delivering those services is running to a standstill and we don't necessarily have the time to step back and say actually, could we do this in a better way, could we actually deliver this by doing things differently maybe even free up some resources to do things". (010, HR)* **1.2) Financial barriers to implementation of HWB services** 1.2.1) Respondents referred to financial constraints and how lack of financial resource compromises the ability to invest in HWB services: *"the worst funding shortage in NHS history…as being the major barrier…we had fairly significant plans contained within the [health and wellbeing] strategy and then our financial situation in the Trust got considerably worse"(004, SL).*

		1.2.2) The financial deficit is a major barrier: having funding, *"breaks down the biggest barriers [to workplace HWB services]" (006, P) and enables health and wellbeing teams to invest in the necessary resources and equipment to deliver a successful service.* **1.3) Perceptions of spending priorities - patients before staff** 1.3.1) A perception that the money available in the NHS should be prioritised for patient care rather than staff HWB. 1.3.1.1) the NHS is traditionally viewed as a service that cares for and invests in services for patients, not its staff. *1.3.1.2)* Compared to a private organisation, the NHS as a public body would be criticised by the media and general public for prioritising staff health and wellbeing initiatives over patient care: *"In the private sector, health and wellbeing can be supported, because at the end of the day it's being paid for out of shareholders' money; in the NHS I think there is awareness that because we're a public sector employer we are actually spending taxpayers' money." 010, HR* **2) Barriers to staff engagement with health and wellbeing services in the NHS** **Sub themes** **2.1) Logistical barriers due to the nature of NHS work** 2.1.1) The fundamental characteristics of the NHS work environment made staff engagement with workplace health and wellbeing services difficult. 2.1.2) The main logistical barrier believed to be the time constraints associated with shift work: Long and/or variable shifts limited staff engagement time and produced a demand for services 24/7. *"You've got people working different shift patterns...Which is one of the reasons why I think some of our exercise classes are not working, because the people that have said they want them want them at eight o'clock at night or nine o'clock at night or six*

		o'clock in the morning or seven o'clock in the morning when, you know, when they finish their shifts. And I think that's the problem is we've got such a diverse workforce". 002, HR 2.1.3) Logistical issues made access to health and wellbeing services difficult e.g. Trusts situated across multiple sites, some staff members did not have direct access to on-site health and wellbeing facilities and services. Access to facilities impeded by the limited space available on site: *"With some of the exercise classes because we are over three different sites that's been met with a little bit of resistance. And although class numbers have been good, I think because people do shifts, they, it's not at a reasonable time or because we haven't been going to the [other] sites, people have taken offence to that. So we're having to work around it. 008, P"* 2.2) **Dependence on the existence of a receptive audience** 2.2.1) Individual-level motivation in the workforce. Some respondents held the belief that staff members should be held personally responsible for their own health: *Staff, "have got to be motivated to do it" (003, SL) and that generally speaking, they "don't have an interest in it" (008, P).* 2.2.2) The success of health and wellbeing services was believed to be dependent on individuals understanding the importance of Health and wellbeing, taking personal responsibility and being receptive to workplace HWB services: *"There are a lot of unhealthy people in the NHS and I think that it comes down to personal responsibility. And I think maybe if they knew what impact it was having on their health they may have taken more of a responsibility. 009, SL* **Facilitators Theme** 3). Facilitators of the implementation of health and wellbeing services in the NHS Sub themes 3.1) Government schemes and funding as incentives

		3.1.1) All respondents were aware of government schemes and funding initiatives (Five Year Forward view, commissioning for quality and innovation (CQUIN) and local funding awards). Most respondents were ambivalent about whether government schemes and initiatives were an incentive to initiate change in workplace health and wellbeing services in the NHS. Such incentives were considered to have mixed, positive, negative or no impact on the Trust's HWB agenda. Respondents perceived government schemes and funding to be a catalyst for change because they: 3.1.1.1) Raise awareness about the importance of HWB at the Executive Board level: *Respondents believed that government schemes such as CQUIN raise awareness about the importance of staff HWB and as a result, workplace HWB services are prioritised at the Executive Board level: In October, our bombshell hit. And if I'm being honest it totally wiped the health and wellbeing item off the agenda. It wasn't top of the priority list. It was on mine, but I wouldn't say it was at, at Board level or, or managers' level and I think particularly the CQUIN has brought it back to the table, because there's a penalty now if we don't achieve what we've been asked to achieve. 002, HR* 3.1.1.2) Are a powerful incentive: *In a cash-strapped service it is sadly the reality that you have to have some sort of financial motivation to do it. So, from that point of view both the CQUIN and the Healthy Workplace Initiative that offered us match funding to do things is very helpful. 010, HR* *3.1.1.3)* Encourage consistency across organizations: *It's enabled the NHS to move forward together adopting similar approaches in certain areas that are covered by the CQUIN which then means that wherever you go in the NHS you're getting a similar sort of approach, so you're getting a bit of reinforcement. 004, SL* *3.1.1.4)* A structured approach was also considered beneficial: *We're signed up to a [name of award] Award. So that is looking at five different areas soaround substance use and misuse, healthy weight, mental health, and wellbeing, protecting health, so things like cancer, domestic abuse, those kind of things and then health and safety. So that award gives us a real structured approach to how we try and take things forward… We achieved bronze last summer and we've just submitted our silver. So that gives us a real structured*

		focus...this is obviously much more holistic and in depth assessment rather than just the NHS Health Check. 002, HR Respondents had some issues government schemes and funding: *3.1.1.5)* Government schemes frequently lacked support from adequate funding or resources - *some believed that they did not have the resource capacity to succeed: I think [CQUIN] helped in the sense of raising awareness, of course it's not been backed by huge resource, so it's one thing to sort of say that it's important but it's another thing to actually back that and support it properly. 009, SL* *3.1.1.6)* schemes and funding did not change or add to already established services: *I don't think it's particularly changed the mindset, but I think because we're doing quite a lot anyway... the CQUIN is about, what are you going to do in the future, as opposed to acknowledging what you have done already-... so there's nothing really that's prompted us [to change]. 001, HR* *3.2)* An organisational structure that supports staff HWB - support was required at all levels of the organisation; from the Executive Board to the front-line HWB practitioners*:* 3.2.1) To have a supportive Executive Board - top-down support essential for the successful initiation of workplace health and wellbeing strategy initiatives in the NHS. Respondents referred to the importance of *"the Board being on board" (001, HR) with workplace HWB initiatives.* At the Executive Board level, HWB had to be considered a priority. 3.2.2) To have managerial engagement - managers need to value workplace HWB and be supportive of their staff attending and engaging with HWB services, so that they can communicate the value of HWB to their staff: *I think if [managers] have an input on directing staff to the appropriate service and getting them interested, then it should work more effectively. But if they don't, then there's a breakdown. 008, P* *3.2.3)* To have dedicated HWB staff roles with the relevant skills and expertise - clearly outlined HWB job role with well-defined expectations, being a protected role with post

		holder having relevant skills and expertise: *"That's the biggest thing with this, with health and wellbeing and part of the CQUIN is around that line manager support, their training, their understanding as to why health and wellbeing is so really important, so that they can then cascade that down to their staff." 002, HR* *3.3)* An organizational culture that supports staff HWB - taking a preventative approach to workplace HWB requires a change in the whole NHS organizational culture. Change would involve *"trying to change that culture to make people understand the importance of staff health and wellbeing" (007, HR) - reference to price changes in canteen and smoke free workplaces.* 4) Facilitators of successful delivery of HWB services in the NHS - four identified facilitators to successful delivery of workplace HWB services in the NHS: 4.1) Coherent, strategic approach to implementation - was synonymous with the prioritization of HWB and staff HWB. Strategy was in place in some trusts but understanding and awareness inconsistent. 4.1.1) Common goal: *"knowing what they're all working towards within a Trust" (007, HR); but there is scope for improvement.* 4.1.2) Opportunistic: where strategy was not clear approaches were opportunistic: *"It would be helpful to have an overall, an overarching strategy, I think that would be helpful. And we've not pulled it all together, there's lots of different initiatives but pulling it all together would be of benefit I think." 003, SL.* 4.1.3) Whole systems approach or All-encompassing system: smooth referral scheme, referring staff to services offered by the Trust or by the local community: *"Because we were part of the healthy living service, we were able to directly refer people in to the healthy living service, so we were able to refer people straight into the stop smoking service, the healthy living service …So that made a big difference I think, as a practitioner, having the ability to refer people and give them that support straightaway as well" 006, P*

		4.2) Communication and advertisement 4.2.1) physically going out to the workforce and having presence on the ground with messages: *"Interventions in our Trust that have worked well - flu is one that as an organisation, apart from last year, we've excelled at over the previous four years and a few people have said to me, why did you do so well? Because we went to them...We physically go out there. We know that staff struggle to even come down to the canteen and get a break, so when we're putting on displays and events, they just physically don't do it". 002, HR* 4.2.2) Word-of-mouth techniques for communications and advertisement, as opposed to email communication were believed to be a successful method for making staff aware of the HWB services available. 4.3) Being creative and innovative with resources: 4.3.1) Fostering and using external partner relations - respondents with successful HWB implementation described how they had fostered good relationships with external partners such as workplace wellbeing organizations, local councils, local gyms, and businesses: *"partnership working and relationship building is so crucially important and often when that's working well, you can pull in on some of that when you need to pull in on it" (002,HR).* 4.3.2) Sharing knowledge and expertise with external partners was perceived as a catalyst for change: *"without their [external HWB organisation] direction we probably wouldn't have implemented it" (008, P).* 4.4) Needs analysis and evaluation: *4.4.1)* Informs strategy - *"One of the first things I did when I came into post was do some baseline data with some staff first just to kind of ascertain, you know, the health behaviours and status of staff and what they wanted and the type of things they think would help them lead a healthier lifestyle. And used that to inform the strategy, looked at our health profiles*

		and compared them with local health profiles to see just exactly where some of our troubled areas are and also just generally find out what staff want." 002, HR. 4.4.2) Identifies strategies to engage those not engaging. 4.4.3) robust evaluation of HWB services - demonstrate positive outcomes, share successes with employees and the Executive Board support; funding applications, give credibility to the HWB service and to improve the service for the future: *"[Evaluation] is about demonstrating that we do care about our staff. Our strapline is we care and I think it's important, particularly within NHS where often we struggle to recruit staff, particularly our nurses and doctors, if one of the unique selling points is going to be that we do care about our staff and we can demonstrate that and we get some recognition for doing that then, you know, that's really quite important." P002, HR)*
Research value	How valuable is the research?	The research is valuable *(Findings can be used to extrapolate practical implications for the implementation of HWB services in the future. The methodological rigour supports the credibility of the research; results reflect the viewpoint of HWB practitioners and senior leaders in one area of the UK and might not be representative of all NHS Trusts. Further research should explore viewpoint of line managers, the study may have recruited HWB practitioners or senior leaders with a particular interest in workplace HWB, however a broad range of experience and insights were achieved and data saturation was reached.)*
Overall risk of bias and relevance	Overall risk of bias	Moderate *(Lack of clarity regarding rationale for research method and approach; The selection of participants was clearly justified - it appears pragmatic but this is not outlined; The researchers do not clarify or discuss their potential impact on the research itself.)*
	Relevance	Highly relevant *(Limited in terms of potential generalizability but is UK and NHS specific)*

D.7 Robinson 2014

Bibliographic Reference Robinson, Mark; Tilford, Sylvia; Branney, Peter; Kinsella, Karina; Championing mental health at work: emerging practice from innovative projects in the UK.; Health promotion international; 2014; vol. 29 (no. 3); 583-95

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes *(It examines the potential of a role-based intervention component, engaging workplace-based 'business champions' to drive forward organizational change with the aim of producing a culture that promotes mental health and wellbeing within the specific settings of businesses of different sizes [small to medium enterprises (SMEs) with up to 250 employees, and also larger enterprises].The intervention 'Altogether Better Mental Health and Employment projects' was commissioned as part of the evaluation of the 5-year Altogether Better (ATB). It seeks to empower people to improve individuals and their families health. The program is regional (Yorkshire and Humber) and consists of a learning network and 16 community and workplace projects with an emphasis on physical activity, healthy eating and mental health and wellbeing. This paper focus on mental health and employment seek to improve health and wellbeing in workplace settings, raising awareness of mental health issues through providing and targeting support, advice and training to employers and employees.)*
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes *(Secondary analysis of qualitative data: Explores data from the evaluation of the Mental Health and Employment project strand which included semi-structured interviews with project participants)*
Research Design	Was the research design appropriate to address the aims of the research?	No *(It is unclear if this is a secondary analysis of the semi-structured interviews that comprised the intervention's evaluation or if this is something else. No information outlined regarding appropriateness or justification of research design. Authors outline that 'the evaluation' adopted a qualitative approach, to understand the context, delivery, and outcomes of the Altogether Better projects.)*

Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(The recruitment strategy for the evaluation which this paper reports on are not specified. 21 out of 28 semi-structured interview were used as they focused on 3 out of 4 interventions which focused on the primary aim of the paper which was to understand the Business Champion model. Projects located in towns in West Yorkshire, (Wakefield, Rotherham, and Doncaster), focusing in particular on employers within neighbourhoods with the highest risk of poor health. 21 interviews were conducted: Fourteen work-place interviews were conducted with direct recipients of the project, including four workplace or business champions, as well as other employee training recipients, other managers, and a work-place union representative. Four project leads, and three other organizational stakeholders from commissioning primary care trust (PCT) bodies were also interviewed. Project leads were the first to be interviewed and invited to suggest other key respondents. Individuals were sampled from this list based on how their background and role would contribute to the 'project evaluation', ensuring diversity by organizational sector, and inclusion of champions and recipients. Potential participants were excluded if their businesses had so far had little involvement with the project, and if employees were neither champions, managers nor training recipients.)*
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell *(Setting for data collection not justified but is probably based on what the evaluation focused on, the interest on the 'business champion model' and convenience. Data was collected via semi-structured interviews but no justification outlined as to why this approach was taken; data collected (recorded) were transcribed evaluation team members read and familiarized themselves with the transcripts; a coding framework was developed from thematic areas of interest within the data itself, refined and agreed among the evaluation team, and applied to the transcripts using the NVivo software to extract major themes. Data saturation not discussed and unclear if there were any modifications to methods.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell *(The data was collected as part of a wider project evaluation of which this paper reports on an element of. The role of the researcher who undertook the primary research is the primary author of this paper. The role of the researcher and their influence on the primary evaluation and on this papers, findings are not outlined.)*

Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethics approval for the Evaluation was granted through Leeds Metropolitan University research Ethics Committee. Interview participants received in advance an information sheet to explain the purpose of the evaluation and were free to withdraw from the evaluation at any time. All interviews were digitally recorded post-consent with anonymity assured)*
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(Data collection is not described in detail within this paper but is cross-referred to another publication for further details (Robinson et al 2010). Data collected (recorded) were transcribed evaluation team members read and familiarized themselves with the transcripts; a coding framework was developed from thematic areas of interest within the data itself, refined and agreed among the evaluation team, and applied to the transcripts using the NVivo software to extract major themes. Data saturation not discussed and unclear if there were any modifications to methods. The reported findings are drawn from an analysis of participants' responses to interview schedules which included a topic focus on project settings and activities, participant roles, organizational plans and change processes.)*
Findings	Is there a clear statement of findings?	Yes - The application to the RQ6 is tenuous and requires interpretation - Were linked studies included? 1) Specificity to particular community and workplace environments 1.1) Core elements: development of organizational plans and tools and delivering training. 1.2) Developing roles to embed core activities into organizational environments. 2.1) The business/workplace champion role - as faciliatory 2.1.1) Built into the 'project' planning with company director to provide internal leadership for initiatives. 2.1.2) (Their) impact depended on setting, existing role, skills, and motivation.

		2.1.3) Role outlined as: Liaises with an external lead to roll out an event. Facilitates general administrative arrangements. Makes specific organizational and room bookings. Coordinates enrolment. 2.2) The business/workplace champion role - as a 'activator' 2.2.1) Role outlined as: Coordinates different strands of the project within an organization. Embeds the project within an organization. Raises the awareness of staff. Encourages empowering actions within an organization (changing work procedures, facilitating employee control, decision-making around wellbeing). Forges and strengthens networks and partnerships. 2.3) The business/workplace champion role - characteristics 2.3.1) 'enthusiasm and commitment' - key for motivating others across an organization to engender culture change. "I'd want them to be genuine about it and show an enthusiasm for it to get the knowledge that they need, so they've got a bit of confidence". 2.3.2) communication skills and attributes of flexibility, trustworthiness, and open-mindedness - ability to listen to employees' concerns and feelings, and respect confidences "open mindedness, I have to remain approachable, honest and yet give them the understanding that any conversations we do have are between me and the individual". 2.3.3) Knowledgeable and facilitate access to knowledge of others. 2.3.4) formalization of role can provide leverage but hinder credibility (dilution of role) and facilitate inaction in target population. 2.3.5) Expectations against organizational drivers and constraints "open mindedness, I have to remain approachable, honest and yet give them the understanding that any conversations we do have are between me and the individual."

		3) Champions and the handover process 3.1) Nurturing ownership - empowering employees to develop tools and practices to make changes. 3.1.1) Protected time and resource. 3.1.2) Appropriate workplace training 3.1.3) evaluation - identifying what worked best. 4) Identifying and utilizing external support - 'Champions' alone cannot initiate change; requires models for capacity building and embedding practice 5) Establishing the business case - evidencing the fit with the business case. 5.1) Barriers to implementation were overcome through: 5.1.1) Initial investments of time for assessment and planning to promote reflection around the value of champions. 5.1.2) 'mainstreaming' agenda they could take forward, e.g. through review of management attendance policy, action planning around 'reasonable adjustment', standards, staff packs and introducing routine low-cost stress awareness events and flexible training delivery from within the company.)
Research value	How valuable is the research?	The research has some value *(The findings are placed in the context of the wider evidence base (a systematic review was part of the study) and policy but the specific qualitative elements are not always clear in the discussion section; findings lacked direct quotes and understanding elements in the context of what worked well, barriers and facilitators to mental wellbeing at work were difficult to pick out.)*

Overall risk of bias and relevance	Overall risk of bias	High *(The study cross refers to other ;inked publications for specific details regarding methodology and rationale; Qualitative findings lacked direct quotes to qualify them; This is a secondary qualitative analysis of the qualitative elements of a service evaluation and much of the details to provide depth of understand was absence within this paper.)*
	Relevance	Relevant *(UK based but the findings are quite specific and applying them to the wider context of mental wellbeing at work requires some interpretation.)*

D.8 Scantlebury 2018

Bibliographic Reference Scantlebury, A.; Parker, A.; Booth, A.; McDaid, C.; Mitchell, N.; Implementing mental health training programmes for non-mental health trained professionals: A qualitative synthesis; PLoS ONE; 2018; vol. 13 (no. 6); e0199746

Study

Barriers and facilitators (N = 8)

Systematic review that sought to identify and explore qualitative evidence on views and experiences of non-mental health professionals receiving mental health training and the barriers and facilitators to training delivery and implementation; A total of 10282 identified of which 8 studies included.

Study Characteristics

Study design	Systematic review
Study details	Dates searched. 1995 to 2016 Databases searched.

	Criminal Justice Abstracts (CJA); MEDLINE; Embase; PsycINFO; ASSIA; CENTRAL; SSCI; ERIC; Campbell Library; Social Care Online and EPOC Sources of funding This review was undertaken as part of Connect, the Co-production of policing evidence, research, and training: focus mental health project (http://connectebp.org/). Funded by the Higher Education Funding Council for England (HEFCE) and the Home Office through the College of Policing. Award number J05. The funder had no role in study design, data collection and analysis,
Inclusion criteria	200 participants considered across 8 included studies. Qualitative studies (focus groups, semi-structure interviews, survey): 8
Exclusion criteria	Adapted SPIDER protocol. Exclusion criteria outlined: 1) Mental health trained professionals 2) Mental health awareness training delivered as part of a basic training package to newly appointed Police staff 3) Training which did not primarily aim to improve knowledge or change behaviour and/or attitudes towards mental health. For example, training that sought to improve how individuals interact with an elderly population, which may include dementia training was not included. Not specified - but inclusion criteria outlined "Interviews, focus groups, open-ended surveys and observational studies. Audits and evaluations of mental health training for mental health charities and English and Welsh Police forces".
Intervention(s)	8 studies: Svensson et al 2015: Sweden; To explore participant's experiences of Mental Health First Aid Training (MHFAT) Tully et al 2015: USA; To examine officer perceptions of `preparedness' following Crisis Intervention Team (CIT) training.

	Walsh et al (2009): UK; To report on the development and pilot delivery of the `Mental Health Awareness for Prison Staff Program'. Anderson et al (2014): USA; To help individuals working within the criminal justice system to develop the tools needed to interact with prisoners with mental health issues. Rani et al (2012): UK; To evaluate a newly developed inter-professional training course on dual diagnosis. McGriff et al (2010): USA; Identify the knowledge, attitudes, and applied skills/experiences in managing mental health crisis situations in a busy airport. To elicit suggestions for improvements to the Crisis Intervention Team (CIT) program for police officers at airports. Macdonald et al (2011): UK; To evaluate the effects of a DVD/manual/coaching skills training programme for carers of people with eating disorders. Gough et al (2012): UK; To explore the issues around implementation of skills learnt, application of knowledge and maintenance of these new skills/knowledge from the perspective of key stakeholders with managerial responsibility following training on the Mental Capacity Act (MCA).
Outcome(s)	
Number of studies included in the systematic review	n=8
Studies from the systematic review that are not relevant for use in the current review	Not applicable; All studies are of relevance and have not been disaggregated
Additional comments	

Barriers to training	1) **Training content.** 1.1) Training needs to be tailored to the needs of the trainees, their work context, and the people they come into contact with, to ensure its usefulness and future application in practice. 1.1.1) Training lacked focus in terms of the requirements of the trainee [Anderson et al 2014], or that it is treated as a standalone training and so fails to consider the wider context or other relevant aspects of practice [Gough et al 2012]. 1.1.2) An integrated approach which linked the training to other issues and/or the wider context enabled trainees to apply the training. This did mean some repetition of training aspects it was considered valuable in ensuring that those with prior experience could recap and refresh their skills [Svensson et al 2015]. *'It doesn't help to see things in isolation. A lot of stuff is thrown at managers, such as 'we're going to focus on Mental Capacity, now dementia, then something else'. Things are not necessarily joined up so people end up talking very passionately about stroke, for e.g. and are unable to make the connection with Mental Capacity or safeguarding'* (Gough et al, 2012). 2) **Training delivery** 2.1) Length of training: different preferences around the length of training - whole days dedicated to the training were regarded as `too intense', and gave insufficient scope to process the information and reflect on the training whilst others preferred condensed delivery over two days [27] 2.2) Method of delivery: Conventional methods of training delivery regarded as too abstract to encourage trainees to apply the knowledge in practice [29]. To address this, targeted approaches which made a direct association to the workplace or practice context were deemed important, as were real-life scenarios, which were seen to be better for facilitating implementation of the training within the workplace [29]. 2.3) Course instructors: Perceived to not provide sufficient guidance and to not be able to provide answers to the situations being managed by trainees [30]. Experienced and knowledgeable instructors were regarded as crucial for ensuring the credibility of training and its impact [27]. *'One mistake was that the ones holding the course didn't have more experiences of mental ill health than I did. They were candid about it, but insecure . . .maybe they were not so experienced, they couldn't answer follow-up questions. In future*

	courses, there should be more experienced instructors, both for their own sakes and for ours.' (Svensson, Hansson, Stjermswalk, 2015). 3) **Additional resources.** 3.1) The time required for trainees to familiarise themselves with additional course materials was a barrier. *"I suppose my main problem was actually finding the time when I could actually watch them and read the book without getting too distracted"* (Macdonald et al.,2010). 3.2) Importance of appropriate training materials/resources: Issues around use of DVDs (duration; poor quality; use of inaccessible language; not being specifically targeted at the trainees; and being difficult to use [30]. *'I suppose my main problem was actually finding the time when I could actually watch them and read the book without getting too distracted.'* (Macdonald et al., 2010). 4) **Organisational factors -** to attending the training and implementing training in practice 4.1) time and cost - associated with staff attending training was an issue, particularly for those with fewer numbers of staff and smaller budgets [29]. *'The problem is that I think homes find it difficult to release people for that training'* (Gough & Kerlin, 2012) 4.2) organisational culture: 4.2.1) Employers' competing priorities impacted on attendance at training events and meant that employees were not automatically permitted to attend training [29]. *"It's one thing reading it in the book and going 'right OK, OK this sounds pretty simple' and then you might sit down and do it and its gonna take you like two hours to have this conversation because it's such a tricky one"* (Macdonald et al., 2010). 4.3) Poor implementation was attributed to lack of time, workload, caring responsibilities or not recognising the need for change [25, 29].

	4.4) `buy-in' from staff and managers were identified as additional barriers. A `top-down approach' was considered crucial by some participants, who emphasised the need for managers to buy-into and understand the training (Gough & Kerlin, 2012).
Facilitators to training	Facilitators to training delivery and implementation. 1) **Training content**. 1.1) modules and specific content: 1.1.1) Based on needs, presented in a processable format (protocol-based training; explanations of mental health disorders and the purpose of treatments). 1.1.2) combined with other training to foster focus. 1.1.3) Tailored approach focused on current workforce specific issues and teaching on laws, policy, and procedure; Training should include immediate tactical skills to deal with issues in the absence of mental health staff. 1.2) Additional resources: 1.2.1) DVD and Manuals acceptable to most but not all: relevant examples and scenarios; language; realistic; involvement of key stakeholders such as service users and members of the relevant staff group in the development and delivery of the training was perceived to be a key facilitator in promoting acceptance. *"Seeing the program from the patients' point of view, "It was an eye-opener"* (Rani et al 2011). 1.2.2) Resources included: course manuals, workbooks, checklists, crib-sheets, DVDs, videos, and e-learning and were perceived to provide flexible, practical, useful, and acceptable additions to the training content. *'The manual can be used as a reference book if there's anything one reflects upon. It's educational and easy to use'*. (Svensson et al 2015)

	1.2.3) Materials featuring real-life people with mental health problems and role-play facilitated self-identification and implementation. 2) **Training delivery** 2.1) Course trainers (also known as instructors or facilitators): experienced, skilled, and knowledgeable; knowledge of the context, culture and terminology of participants' workplace, an ability to answer participants' questions and provide specific contextual examples and guidelines: '*He (the instructor) was very good; he gave me guidelines, so I knew how I should work. I could call the psychiatric services in that case*.' (Svensson et al 2015) 2.2) Method, length and frequency of training need to be considered and varied across studies (bite-sized vs over days courses); refreshers; adaptable range of methods; real-life examples: *'We have to start looking at more alternative and blended approaches. I think we have to stop looking at that old fashioned way of looking at the face to face (training) delivery getting everyone looking into a central point'* (Gough et al 2012). 3) **Staff willingness to engage with training** 3.1) staff recognising the need to improve their own practice in managing people with mental health problems through developing new skills [31]. Staff understanding of the reasons behind the training was important in facilitating legitimisation of changed practice [32]. 4) **Organisational factors** - culture, incentives for training, the training environment, time and cost and organisational `buy-in' identified as facilitating training and implementation.  4.1) Emphasis on importance and prioritization: Managerial and staff `buy in' to training, alongside a `top-down' approach (training as a core part of employees' role); making training mandatory and offering incentives e.g. increased annual leave, alternative work rotas: "*I think the training/development of managers is crucial and critical and not just around Mental Capacity. It's about the managers being professional in their role and seeing the importance of good practice and good quality care; seeing this as an integral part of their role and promoting that at every turn. MCA [Mental Capacity Act] and DoLS [Department of Liberty Schemes] would be part of that"* (Gough et al 2012). 4.2) The consideration of "Culture and practice of the workplace" when considering and implementing training. 4.3) In-house training was considered favourably - access, safe space allowing discourse

Perceived impact of training	**1) Perceptions of mental health.** 1.1) Increased understanding, empathy and understanding of stigma (5 studies) but knowledge was not always new: *"Why we. . .were disappointed, it was mainly because we expected that the training would be useful for us, that we would receive advice, but it seemed to be more for the general public. . .As firefighters we've already touched upon these subjects in our training. . ..We didn't get much new knowledge targeted at our profession"* (Svensson et al 2015). 1.2) Increased empathy linked to increased awareness, compassion, humility, sensitivity, and patience; transformation from being judgemental to non-judgemental about people with mental health problems: '*I will have a better understanding of mental illness rather than just being a nutter'* (Walsh et al, 2009). 1.3) Training challenged prejudice against people with mental health problems and allayed the tensions around the topic of mental health. 1.4) Training enabled a sense of `shared empathy', where they felt less alone in realising that other people also experienced similar issues. **2) Response in situations involving mental health**. 2.1) Some participants would change their approach some would not. 2.2.) Training improved communication skills so interaction with people with mental health problems became less problematic e.g. recognise symptoms of mental health problems, assess situations, adjust their method of handling situations and make decisions that were more likely to de-escalate a situation. 2.3) Training affirmed their approach to addressing issues; reinforce existing skills. *'I feel a confirmation that I feel right or think right. You can need to recapitulate your knowledge with regular intervals./. . ./. You can forget that you need to ask (about mental illness/suicide thoughts or plans)'* (Svensson et al 2015). 2.4) Increased confidence and inclination to help: asking questions about patients' mental health; dealing with people with mental health problems in general.

	2.5) Improved ability to recognise symptoms of mental health problems, enhanced skills in assessing the situation and better make decisions; remaining calm, not showing fear during a crisis situation, action planning and goal setting: *'Once you establish and you know that they have. . .that this person is not all right or something is going on here, so you start asking the questions, then you end up talking about medications and all that stuff.'* (McGriff et al., 2010). 3) **Impact of training on trainees**. 3.1) encouraged self-reflection, increased awareness of and challenged their own prejudice towards people with mental health problems. '*In retrospect, I reflected upon things and got an explanation about certain behaviours after the training. Simultaneously, the prejudice that mentally ill persons are dangerous-I was one of them–I. . .I, it's not as dangerous anymore, after the training.*' (Svensson et al 2015). 3.2) Training lacked measurable outcomes and as a result managers were unclear what levels of understanding participants achieved post-training. *'The thing is you go away to your course, come back and don't think about it again for however many weeks, and as a manager I cannot gauge where my staff understood'.* (Gough et al 2012)

D.9 Wyatt 2015

Bibliographic Reference	Wyatt, Katrina M; Brand, Sarah; Ashby-Pepper, Julie; Abraham, Jane; Fleming, Lora E; Understanding How Healthy Workplaces Are Created: Implications for Developing a National Health Service Healthy Workplace Program; International journal of health services : planning, administration, evaluation; 2015; vol. 45 (no. 1); 161-85

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes *(We sought to understand how successful workplace health and well-being programs were developed and implemented to inform the development of a program for a National Health Service (NHS) hospital.)*

Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes *(The study sought to 'understand' how the conditions for a successful healthy workplace program can be created and to explore the relevance of these findings for developing such a program in an NHS Trust. The case study approach allows describing, interpreting, and theorizing of poorly understood areas)*
Research Design	Was the research design appropriate to address the aims of the research?	Yes *(A case study approach provides a methodology for describing, interpreting, and theorizing about poorly understood areas. Items of the consolidated criteria for reporting qualitative research (COREQ) for improving the quality of reporting of qualitative research were used.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes *(Four organizations with gold awards for their healthy workplace programs who had interactions with a NHS ward were identified and recruited. A maximum variation sampling approach was used to identify which workplace programs to study as a range of different workplace contexts (number of employees, shift patterns, and the nature of the business) was desirable. Within each case study, the program coordinator was asked to identify individuals with different roles in the organization (director, manager, healthy workplace champion/representative, employee) and different levels of engagement in the healthy workplace program to participate in individual in-depth interviews. Study authors then worked with the Senior Management Team of an NHS acute hospital to identify possible wards and a convenience sampling approach was used to identify one ward; all permanent ward staff were invited to participate in an individual in-depth interview.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(Interviews were open-ended seeking to gain an understanding of how participants conceptualized health and well-being; what it meant for them to be a member of their workplace; how the healthy workplace programs were introduced; and the barriers and facilitators to engaging in these programs. A feedback sheet for the four organizations, summarizing the main findings, was sent to all the participants from a workplace and they were encouraged to clarify/add any additional comments. Semi-structured script outlined for the four case-studies which was modified for interviews with NHS-staff. NHS Staff were asked to reflect on what a healthy workplace program would look like and what they thought the barriers or facilitators to engaging in activities would be, what it was like to work on the ward and how they viewed their own health and well-being. Two feedback sessions*

		were held with NHS staff to review the themes and to offer a further opportunity to contribute any thoughts or clarifications.)
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes *(All the interviews were carried out by one author who identified as an experienced qualitative researcher and did not have a direct relationship with the participants nor represented any of the organizations involved. Limitations of the study identified that there was a lack of recruitment of those who did not participate in healthy workplace programs which may have resulted in different themes and provided insights into 'their' lack of participation, potential barriers, and facilitators. The approach is retrospective thus findings could be subject to recall bias regarding barriers and facilitators to program development or participation)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Before the start of each interview, an explanation as to the purpose of the study and who the interviewer was working for was given and the participant was assured of the confidential nature of the information he or she was offering. Each participant signed an informed consent form before the start of the interview. Ethical permission from the Peninsula College of Medicine and Dentistry was granted for this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(All interviews were transcribed verbatim and analyzed using thematic analysis. The interviews from each case study were analyzed separately before researchers looked for patterns across the four cases. Independent double-coding of the interviews and discussion of the major emerging themes relevant to the study was undertaken. Codes were then developed to classify data inductively within each theme allowing for "an understanding of meaning in complex data through the development of summary themes or categories from the raw data".)*
Findings	Is there a clear statement of findings?	Yes - *Findings are explicit, with researcher discussions undertaken to facilitate final coding set and themes in the context of the original research question.* *Case studies themes: Facilitators and barriers to engaging in the healthy workplace programs across 4 organizations.*

		1) Facilitator: Visible high level support - management support and endorsement of participation. *“The key was having him (director of corporate services) drive it (HWP) from a sort of high management, senior management level. I think if it had started from my level or another colleague it would never have gathered as much weight or speed.”* 2) Collective sense of ownership for the program 2.1) Facilitator: staff input (what they want) at the start and during the program. *"When we first started this the key was the actual members of the healthy workplace team were from the floor, so it wasn’t like a bunch of senior managers saying you are all going to do this, you are all going to do that and while bringing in people in the team from the floor, if you like, they were all involved, they will talk to their team members and they would get ideas from them.”* 2.2) Barrier: Perceived lack of ownership when employees do not feel the program is driven by them. *“I think they (management) got it slightly wrong (at the start of the program) in that, ‘Right this is how we’re going to do it.’ Yeah, possibly getting a bit more buy-in prior to saying that by saying, look, we’d like to do this, what do you think.”* 2.3) Starting small and being responsive - incremental and responsive approach ensured on-going participation in their program. *“I think we got a lot more buy in with people being asked as opposed to just being told. That was the biggest success I think.” [MCS2]* 3) Effective communication of the program

		3.1) Facilitator: Regular updates through a variety of sources including e-mail, staff intranet, posters, word of mouth, meetings, and newsletters. *"One of the things we have is a regular newsletter that goes out. So we are able to talk about what we are doing in there and make that again focus on the things that we've done, you know we are interested to get your input, your ideas, here's what we've got coming up in the future and there's a word -of-mouthpiece."* 3.2) Barrier: Only using 1 or 2 methods of communication activities and events. *"If you just send an e-mail you can guarantee that 90 percent of the people won't read an e-mail. If you stick a notice on the wall probably only 5 percent of people will look at a notice on the wall. Poster blindness is one of the biggest issues, you know, you leave it there for a week and you know people who are going to notice it have seen it and everybody else just walks straight past it."* 3.3) Visibility of activities: 3.3.1) Implementers felt that visibility is key. "quick wins" helped to engage the workforce with the program and to create a positive feeling about the program; participants commented that these events or free produce were seen as expressions that their health and well-being mattered to the organization. *"The employer has like a positive attitude in terms of well-being of the employee which has been demonstrated especially over the last year, year and a half in a more erm positive way if you like. I mean for instance erm I think the first thing they started to do was introduce things like fruit in the canteen." [MCS2]* 4) Types of activities

		4.1) Facilitator: Making participation fun and understanding what activities people would like to do. *"It's horses for courses; some people might be keen walkers and love the pedometer challenge; others hate it. It's the last thing they want to do. It's trying to do different things that engage with different people."* 4.2) Barrier: Feeling like you have to participate/feeling preached at *"I mean it's like if you smoke and they have a stop smoking service here but if you were forced to join it, then there would be, well, you wouldn't achieve anything."* 5) Finding out what people want/providing opportunities 5.1) Facilitator: Responding to employees' ideas/requests, being supportive where possible, and if certain activities/suggestions cannot be achieved, explaining why. *"The healthy workplace, it's just providing opportunities for people. So I don't think it's about making people do anything. I think it's about providing choice."* 5.2) Barrier: Asking for ideas and not responding to them. *"If you do a survey and the people then come up with half of them wanting something and you don't deliver on it and they are totally ignored, they are not going to be interested in it again."* 6) Enthusiastic champions 6.1) Facilitator: People involved in the HWP being positive and encouraging participation. *"Morale and motivation from people within the business is what makes it (HWP) successful."*

		6.2) A perceived threat was when “champions” and organizers moved away from the company. *“For very little cost you can organize a game of rounders on the beach, the barrier is finding someone who will organize a game of rounders on the beach, you know going back a couple of years, we have a couple of people who were really excellent at that. They’ve moved on and then you need to find another sort of natural champion to sort of really replace what they were doing.”* 7) Positive relationships supported development and participation in the health and well-being program *"It’s important to have that really good environment. I don’t want to sound cheesy but they are a good bunch of people.” [MCS2]* 8) Barriers to engagement (n=2 across 4 case studies) 8.1) Physical barriers (cost, time, age) to activity participation based on a personal choice (e.g. I don't want to spend my lunch break on this or I don't want to spend my money on this) and not resentment. Facilitators and barriers to engaging in specific activities within the healthy workplace program. 1) Physical activity - Competitive challenges to be more physically active were a barrier and facilitator *“I sense that they like those things that allow some small element of shared competition. Such as the pedometer challenge because they’ve got these team identities, they like the notion of comparing themselves to others and that’s true in a work sense but it’s also true with simple activities such as the pedometer challenge, such as the sunflower competition last year which took off like you wouldn’t believe ‘cos it was something simple and visual.” (MCS4)*

		"Well, some people are disappointed if they don't win things . . . like the pedometer challenge when people realized how much one team was doing, they dropped out and didn't bother any more then and it was quite sad really 'cos probably only about a third of the people that started it finished it, you know." (FCS1) 1.2) Living close to/too far away from work to walk/cycle were a barrier and facilitator. *"I don't mind the walk back, it's a lane way, so it's nice and peaceful and quite scenic so yeah it doesn't bother me the walk home." (FSC3)"I mean until recently I lived in ... so I was 25 miles away so I had to drive (FCS1)* 1.3) Having informal walking groups was a facilitator. *"I mean I am terrible for doing exercise and things like that I would rather not do it. So to do it with a group of people is a lot better. I try, every day I try at least in two of my breaks to walk round the block."* 1.4) Healthy eating - Organizational support for healthy eating/seen as an organizational norm to eat at the desk and not take a proper lunch break. *"So things like your free fruit day, and probably you don't have to do anything other than just let them walk past and grab a piece of fruit. But that might stop you buying a bar of chocolate that day and have a piece of fruit instead." (FCS4)"I sometimes would eat at my desk and carry on doing stuff, which is probably you know. . . . It's not good and I know it's not good and I do get told off and I do tell myself off sometimes but it's just, other than that . . ." (MCS2)* 1.5) Stopping smoking. 1.5.1) Smoking cessation classes/a "norm" of smoking in breaks *"The Stop Smoking Support Group, people want it and again it's a small group but year on year there's still people who want it and there's somebody from last year who wants to come back again this year because he fell off the wagon and he knows he wants to try*

		again. So, to me that's a success." (FCS4)"You sort of meet the group outside, you get that . . . the magic circle [LAUGHS] . . . the best time to get all the gossip." (FCS4) 1.5.2) Wanting to quit/enjoying smoking (individual) *"I gave up, I've always wanted to give up but we had someone here who was trying to tell you to give up and if people keep telling me to do it, I won't do it. In fact it makes me more stubborn to the fact that you know I'm not going to be told what the hell to do, if I want to do it, I'll do it myself and I wanted to do it myself and so I did it myself." (FCS3)"They are all doing the kind of job that isn't conducive to giving up, it's a sort of, if you are on the phone to someone ranting you probably want to have a fag if you already smoke so it kind of makes giving up harder." (MCS2)* 1.6) Psychological well-being - Keeping employees informed about stress management/having stress-aware managers. *"They are very open-minded here about stress. It is important because sometimes just getting it off your chest and you think oh well it's not a big deal now you know but you can, if you sit on something it becomes big." (FCS3)"Not applicable as all the organizations had proactive approaches to stress management that participants felt able to access."* Themes from NHS Ward staff interviews - interpreted by NICE analyst in terms of potential impact on health and wellbeing program. 1) Time - Hierarchy of care (they put themselves last in terms of self-care), unpredictable workload (lack of control to enable planning), Break taking (felt to be contrary to patient care and care of other staff) 2) Ability to bring about change - Environmental Barriers to Health and Wellbeing (powerlessness to bring about change - reference made to staff room reallocated as office space)
Research value	How valuable is the research?	The research is valuable *(UK context; Placed in the context of current UK policy and research; Makes*

		recommendations for the focus of future Health and Wellbeing projects and the conditions for development and engagement.)
Overall risk of bias and relevance	Overall risk of bias	Low
	Relevance	Highly relevant

Appendix E GRADE-CERQual tables

E.1 Facilitators to the successful implementation or delivery of mental well-being interventions, programmes, policies, or strategies at work

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
Ensuring management and leadership buy-in						
The **visible support, involvement and endorsement of management and leadership for health and wellbeing in the workplace** facilitated employee engagement in workplace health and wellbeing programmes	Quirk et al 2018. Wyatt et al 2015	**Minor concerns** (One study with low risk of bias; One study with moderate risk of bias)	**No concerns** Findings reflects all the data reported on this theme.	**No concerns** Data obtained from two studies	**Minor concerns** Included studies related to the views and experiences of NHS senior leaders and managers, health and wellbeing practitioners and employees. Limited information on non-NHS sectors.	**High confidence**. Data from NHS settings only impacting applicability to other settings. Views expressed from across the work force (managers and employees) and those developing and delivering health and wellbeing programs

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
Having management and leadership buy-in allowed '**strategic oversight'** and '**informed strategic approach**'. This allowed the '**setting of priorities'** and '**gave strategic direction'** facilitating initiation and development of health and wellbeing programs. It facilitated the integration/embedding of health, and well-being strategy into the business planning.	Carmichael et al 2016; Mellor et al 2013a; Mellor et al 2013b; Quirk et al 2018; Robinson et al, 2014	**Minor concerns** (one study with low risk of bias. Two studies with moderate risk of bias; three studies with high risk of bias)	**No concerns** Findings reflects all the data reported on this theme.	**No concerns** data obtained from 5 studies	**No concerns** included studies outlined views and experiences of senior and middle management, and non-management employees of receiving and implementing workplace health and wellbeing programs. Included studies also considered the views of those who commissioned and lead on health and wellbeing projects	**High confidence** Data from a range of settings and sectors. Views expressed from across the workforce (managers and employees) and those developing and delivering health and wellbeing programs

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
Having management and leadership buy-in facilitated '**resource commitment and allocation**' which was critical for health and well-being program implementation for example allocation of internal resources to support managers, set up of steering groups to co-ordinate activities and allow line manager commitment.	Mellor et al 2011; Mellor et al 2013a	**Major concerns** (one study with moderate risk of bias; one study with high risk of bias)	**No concerns** Findings reflects all the data reported on this theme.	**No concerns** data obtained from 5 studies	**No concerns** included studies consider views from Government, Public Health and Private sector organisations and included: Health and Safety, and Occupational Health managers or advisors	**Moderate confidence**. Methodological limitations of the included studies. Data from a range of settings and sectors. Views expressed from across the workforce and those developing and delivering health and wellbeing programs.
Strategy and strategic approach						
Participants outlined that **establishing or having an established wellbeing policy** facilitated action regarding workplace health and wellbeing. Participants considered having a strategy as helping to **communicate the approach** to staff and encouraged senior manager engagement. The presence of a coherent, strategic approach established a **common goal** which was considered to be consistent with the prioritisation of health and wellbeing and	Mellor 2013b; Quirk et al 2018; Robinson, 2014	**Major concerns** (two studies with moderate risk of bias; one study with high risk of bias)	**No concerns** Findings reflects all the data reported on this theme, with sub-themes qualifying the overarching theme.	**No concerns** data obtained from 3 studies	**No concerns** included studies consider views from Government, Public Health and Private sector organisations and included: Health and Safety, and Occupational Health	**Moderate confidence**. Methodological limitations of the included studies. Data from a range of settings and sectors. Views expressed from across the workforce and those developing and delivering health and wellbeing programs.

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
mainstreaming of the health and wellbeing agenda in the workplace.					managers or advisors	
Establishing the business case						
Establishing and evidencing the business case was perceived as a key facilitator for action in workplace health and wellbeing programs. This included '**clarifying program benefits in work terms**' for example **reduction in sickness absences** and **staff turnover**; **more effective**, **loyal and resilient workforce**; **business reputation**. Linked to this was **establishing the cost-effectiveness** of proposed programs in terms of cost incurred from failure to comply with 'health and safety frameworks' (construction)	Carmichael et al 2016; Mellor 2013a; Robinson, 2014;	**Major concerns** (one study with low risk of bias; two studies with high risk of bias)	**No concerns** Findings reflects all the data reported on this theme, with sub-themes qualifying the overarching theme.	**No concerns** data obtained from 3 studies	**No concerns** included studies outlined views and experiences of senior and middle management, and non-management employees of receiving and implementing workplace health and wellbeing programs. Included studies also considered the views of those who commissioner and lead on health and wellbeing projects	**Moderate confidence**. Methodological limitations of the included studies. Data from a range of settings and sectors. Views expressed from across the workforce and those developing and delivering health and wellbeing programs

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
The role of **contractor/client demands** in ensuring a workforce were fit for purposes was perceived to alleviate barriers to management (development and implementation) and staff (participation) engagement with workplace health and wellbeing program.	Hanna, 2019; Carmichael et al 2016	**Minor concerns** (one study with low risk of bias; one studies with high risk of bias)	**No concerns** Findings reflects all the data reported on this theme, with sub-themes qualifying the overarching theme.	**Minor concerns** data from 2 studies	**Minor concerns** included studies outlined views and experiences of health services and Government sectors in the implementation of the management standards approach; and the views of management, and non-management employees in the construction sector of receiving and implementing workplace health and wellbeing programs.	**Moderate confidence** Methodological limitations: The themes were generated from limited data but across two separate sectors.
The role of training						
There was a recognition by study participants **that new skills were required** to improve practice in the management of mental wellbeing at work. Having line managers trained and with an understanding of stress	Carmichael et al 2016; Mellor et al 2011, Mellor 2013a. Scantlebury et al 2018;	**Minor concerns** (two studies with low risk of bias; one study with moderate risk of	**No concerns** Findings reflects all the data reported on this theme,	**No concerns** data obtained from 4 studies	**No concerns** included studies outlined views and experiences of senior and middle	**High confidence**. Methodological limitations of the included studies. Data from a range of settings and sectors. Views expressed from

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
management and leadership was outlined as **key to subsequent action planning** for workplace health and wellbeing programs. Participants outlined the need for **buy-in from management and staff** regarding the need and value of training to facilitate its achievement with issues such as **staff time, cost of attendance and accessibility to training** outline as key training consideration. Studies outlined that making **training mandatory** and **providing incentives** could facilitate implementation. Studies outlined that training needs to be **tailored, context specific; provide insight into laws, policy, and procedures;** and **provide practical skills to deal with real-life scenarios**. This could be facilitated by using and **experienced trainer**, **integrating training into other aspects of the job/workplace** which could also **facilitate practical implementation.**		bias one study with high risk of bias)	with sub-themes qualifying the overarching theme.		management, and non-management employees of receiving and implementing workplace health and wellbeing programs. Included studies also considered the views of those who commissioner and lead on health and wellbeing projects	across the workforce and those developing and delivering health and wellbeing programs. Sub-themes were not all expressed across all studies but they all support the overarching theme
Needs assessment						
Needs assessment was identified as a key process in **informing the strategy** for workplace health and wellbeing strategy. Participants highlighted that it provided an	Mellor, 2011; Mellor 2013a; Quirk et al 2018; Wyatt et al 2015	**Major concerns** one study with low risk of bias two studies with moderate risk of	**No concerns** Findings reflects all the data reported on	**No concerns** data obtained from 4 studies	**No concerns** included studies outlined views and experiences of senior and	**Moderate confidence**. Methodological limitations of the included studies. Data from a range of settings and sectors but

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
opportunity for employee engagement, allowed the **identification of employee need** and **facilitated strategic development**. Participants identified that **asking for ideas and not responding** to them without communicating the rationale as to why could impact interest and subsequent engagement in programs.		bias; one study with high risk of bias)	this theme, with sub-themes qualifying the overarching theme.		middle management, and non-management employees of receiving and implementing workplace health and wellbeing programs. The studies were predominantly focused in the public sector. Included studies also considered the views of those who commissioner and lead on health and wellbeing projects.	predominantly public sector. Views expressed from across the workforce and those commissioning, developing, and delivering health and wellbeing programs. Sub-themes were not all expressed across all studies but they all support the overarching theme.
Considerations and content of programs						
Needs assessment is outlined as key to facilitate **specificity of approach** with the consideration of employee **psychosocial factors** and **community/workplace environment** outlined as important. Participants in one study outlined that a focus on **quick wins** within a	Mellor 2013b; Quirk et al 2018; Robinson, 2014; Wyatt et al 2015	**Major concerns** (one study with low risk of bias; one study with moderate risk of bias two studies with high risk of bias)	**No concerns** Findings reflects all the data reported on this theme, with sub-themes qualifying the	**No concerns** data obtained from 4 studies	**No concerns** included studies outlined views and experiences of senior and middle management, and non-	**Moderate confidence**. Methodological limitations of the included studies. Data from a range of settings and sectors but predominantly public sector. Views expressed from across the workforce

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
proposed program encouraged engagement. They emphasised the importance of **fun and understanding employee wants** but emphasised that these varied and meeting all needs is challenging. Participants in studies highlighted the **need for clarity** regarding how the employee engaged in a proposed workplace health and wellbeing program and demonstrate how **actions in proposed programs address expressed needs**. One study outlined that they enjoyed success by starting small and being responsive and provided a number of examples of activities undertaken including: Physical activity (walking and cycling), Healthy eating (free fruit), smoking cessation support groups and psychological wellbeing sessions. **Evaluation** was highlighted as a key process in two studies as it facilitated the identification of what worked well, allowed the sharing of success with both employees and executive board which may garner further support and endorsement.			overarching theme.		management employees of receiving and implementing workplace health and wellbeing programs. Included studies also considered the views of those who commissioner and lead on health and wellbeing projects	and those developing and delivering health and wellbeing programs. Sub-themes were not all expressed across all studies but they all support the overarching theme
Workplace capacity						

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
Participants outlined that sufficient financial, technical, and human resources for example adequate **line management competency** or **dedicated health and wellbeing staff** were key facilitating factors. Linked to this was the impact and role of a **workplace champion** which was perceived as **facilitatory** and **activating** health and wellbeing activity in the workplace. The workplace champion role **coordinated and embedded activities** and it was suggested that this type of role should be **built into** workplace health and wellbeing programs.	Mellor, 2011; Quirk et al 2018; Robinson, 2014;	**Major concerns** (two studies with moderate risk of bias; one study with high risk of bias)	**No concerns** Findings reflects all the data reported on this theme, with sub-themes qualifying the overarching theme.	**No concerns** data obtained from 3 studies	**No concerns** included studies outlined views and experiences of senior and middle management, and non-management employees of receiving and implementing workplace health and wellbeing programs. Included studies also considered the views of those who commissioner and lead on health and wellbeing projects.	**Moderate confidence**. Methodological limitations of the included studies. Data from a range of settings and sectors. Views expressed from across the workforce and those developing and delivering health and wellbeing programs. Sub-themes were not all expressed across all studies but they all support the overarching theme

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
Access to and awareness of resources						
Participant in one study outlined that **initial resource investment** in terms of time were key for assessment and planning to take place. Participants in one study highlighted awareness of **Government schemes and funding** acted as an incentive for action on workplace health and wellbeing. Awareness **pre-existing tools** and **examples of best-practice** appeared to be valued and useful by those initiating workplace health and wellbeing programs. The **role and awareness of guidance and legislation** was outlined as a key lever for action with some participants in studies supportive of more regulation, legislation and enforcement outlining that it **raised the profile** and **importance** of workplace health and wellbeing, **dissuaded avoidance**, **provided a structure to follow** and **encouraged consistency**. However participants in one study highlighted that **Government support was not enough**. The **role of specialists with expertise** in human resources, employment assistance and occupational health were valued by	Carmichael et al 2016; Mellor 2013a; Mellor 2013b; Quirk et al 2018; Robinson, 2014;	**Major concerns** (one study with low risk of bias; one study with moderate risk of bias; three studies with high risk of bias)	**No concerns** Findings reflects all the data reported on this theme. Sub-themes do not all appear in all studies but all underpin the overarching theme	**No concerns** data obtained from 5 studies	**minor concerns** included studies outlined views and experiences of senior and middle management, and non-management employees of implementing and receiving workplace health and wellbeing programs. 3 out of 4 studies focused on the public sector.	**Moderate confidence**. Methodological limitations of the included studies. Data from a range of settings predominantly the public sector. Views expressed from various roles and included those developing and implementing interventions as well as those receiving the interventions.

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
managers and were perceived to provide support and advice and ensure consistency in workplace health and wellbeing programs provided. Linked to this was **establishing links with and utilising external partners** which study participants outlined as key to successful workplace health and wellbeing programs						
The role of communication						
Regular updates using a **multi-pronged communication approach** (including word of mouth techniques, newsletters, e-mails, in meetings and staff intranet) was outlined by study participants as key to raising awareness of workplace health and wellbeing programs and facilitating feedback after intervention initiation. Some study participants outlined that having a **focused and targeted communication strategy in place** engaged senior staff and initiated action regarding health and wellbeing but highlighted that there are challenges within large and complex organisations.	Mellor 2013a; Mellor 2013b; Quirk et al 2018; Wyatt et al 2015	**Major concerns** (one study with moderate risk of bias; three studies with high risk of bias)	**No concerns** Findings reflects all the data reported on this theme	**No concerns** data obtained from 4 studies	**minor concerns** included studies outlined views and experiences of senior and middle management, and non-management employees of implementing and receiving workplace health and wellbeing programs. 3 out of 4 studies focused on the public sector.	**Moderate confidence**. Methodological limitations of the included studies. Data from a range of settings predominantly the public sector. Views expressed from various roles and included those developing and implementing interventions as well as those receiving the interventions.

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
Trade Union						
Participants outlined that **trade unions encouraged staff involvement** and key in **communicating** what the workplace health and wellbeing programme was about to employees. The lack of trade union involvement was seen to reduce employee participation.	Mellor, 2011; Mellor 2013b;	**Major concerns** (one study with moderate risk of bias; one study with high risk of bias)	**No concerns** Findings reflects all the data reported on this theme	**Minor concerns** data obtained from 2 studies	**Minor concerns** included studies outlined views and experiences of senior and middle management, and non-management employees of implementing workplace health and wellbeing programs. There was a lack of views and experiences of those receiving the interventions. The settings for studies are all public sectors.	**Moderate confidence**. Methodological limitations of the included studies. Data from a range of settings but all in the public sector. Views expressed from an implementation perspective and lack content from those receiving the interventions.

E.2 Barriers to the successful implementation or delivery of mental well-being interventions, programmes, policies, or strategies at work

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
Target driven culture						
Managers and employees (Construction industry and NHS) highlighted that **Target driven** working culture meant that health and wellbeing were not always a priority and that releasing staff for training and participation in workplace health programs could be difficult.	Carmichael et al 2016; Hanna, 2019; Mellor 2013b	**Minor concerns** (two studies with low risk of bias; one study with moderate risk of bias)	**No concerns** Finding reflects all the data reported on this theme.	**No concerns** Data obtained from three studies (across work sectors)	**No concerns** Included studies related to the views and experiences of higher management, senior and middle management, and non-management employees of receiving and implementing workplace health and wellbeing programs. The views of those who may have delivered interventions were included	**High confidence**. Studies provided data on views and experiences of those across the workforce, and included those with roles in facilitating, implementing, and receiving intervention. Samples were small and representativeness and subsequent generalisability may be an issue but the theme was present across different sectors.
Lack of management and leadership buy-in						
Study participants indicated that a perceived lack of support can mean **less health and well-being activity and no follow-ups in terms of interventions or training**. Support	Carmichael et al 2016; Mellor, 2011; Mellor 2013a; Mellor 2013b; Quirk et	**Minor concerns** (two studies with low risk of bias; two	**Minor concerns** Findings reflects data reported and the sub-	**No concerns** Data obtained from six	**No concerns** Included studies outlined views and experiences of senior and middle	**Moderate confidence**. Studies provided data on views and experiences of those across the workforce, and included those with

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
could be 'manager availability' or 'understanding the value of health promotion in the workplace' or 'the value of training'. Linked to this was the need for managers to understand their **role in establishing the workplace culture** and **understanding of the current legislative landscape**, the lack of which were considered barriers to implementation	al 2018; Scantlebury et al 2018;	studies with moderate risk of bias; two studies high risk of bias)	themes identified are linked to the theme of a 'lack of management and leadership' but not all studies outlined all sub-themes.	studies (across work sectors)	management, and non-management employees of receiving and implementing workplace health and wellbeing programs. The views of those who have delivered health and wellbeing programs interventions were included	roles in facilitating, implementing, and receiving intervention across different sectors. The theme of lack of 'management and leadership buy-in' have been linked to sub-themes generated from the analysis – not all sub-themes appeared in every study outlined.
Financial and resource availability						
Study participants across included sectors indicated that there are **financial barriers to implementation**. The current financial climate has meant that health and wellbeing programs have been deprioritised impacting development and implementation. In construction reference is made to **tight deadlines and low profit margins**, and the **need to maintain a competitive edge** as restricting resource availability for workplace health and wellbeing programs. In the NHS reference is made to **austerity**, the current financial deficit	Carmichael et al 2016; Hanna, 2019; Quirk et al 2018	**Minor concerns** (two studies with low risk of bias; one study with moderate risk of bias)	**Minor concerns** Findings reflects data reported and the sub-themes identified are linked to the overarching theme of a 'Financial and resource availability' but not all studies outlined all sub-themes.	**No concerns** Data obtained from three studies (across work sectors)	**No concerns** Included studies outlined views and experiences of senior and middle management, and non-management employees of receiving and implementing workplace health and wellbeing programs. The views of those who have delivered health	**High confidence**. Studies provided data on views and experiences of those across the workforce, and included those with roles in facilitating, implementing, and receiving intervention. The theme of lack of 'Financial and resource availability' has been linked to sub-themes generated from the analysis – not all sub-themes appeared in every study outlined, but all sub-themes are considered to

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
and **funding shortages** as constraining the ability to invest in and deliver effective workplace health and wellbeing programs.					and wellbeing programs interventions were included	reflect the overarching theme.
Workplace factors						
Workforce stability in terms of **organisational change**, **restructures** and **replacement of senior management** was outline as leading to delays, amendments and ending of workplace health and wellbeing programs. The **complexity of employment structure** for example the **employment mix**, **transient and layered nature of some sectors employment structure**, **working patterns** for example shift work impacted employers ability to develop adequate workplace health and wellbeing plans and for employees to attend them.	Carmichael et al 2016; Hanna, 2019; Mellor, 2011; Quirk et al 2018	**Minor concerns** (two studies with low risk of bias; two studies with moderate risk of bias)	**Minor concerns** Findings reflects data reported and the sub-themes identified are linked to the overarching theme of a 'Financial and resource availability' but not all studies outlined all sub-themes.	**No concerns** Data obtained from four studies (across work sectors)	**No concerns** Included studies outlined views and experiences of senior and middle management, and non-management employees of receiving and implementing workplace health and wellbeing programs. The views of those who have delivered health and wellbeing programs interventions were included	**High confidence**. Studies provided data on views and experiences of those across the workforce, and included those with roles in facilitating, implementing, and receiving intervention. The theme of lack of 'Financial and resource availability' has been linked to sub-themes generated from the analysis – not all sub-themes appeared in every study outlined, but all sub-themes are considered to reflect the overarching theme.
Staff barriers to engagement						
Individual Study participants highlighted staff resistance to change due to **traditional ways of working** and a feeling that health and wellbeing	Carmichael et al 2016; Mellor 2013b; Quirk et al 2018; Wyatt et al 2015.	**Minor concerns** (two studies with low risk of bias; one study	**Minor concerns** Findings reflects data reported and the sub-	**No concerns** Data obtained from four	**No concerns** Included studies outlined views and experiences of senior and middle	**High confidence**. Two studies were of moderate and high risk of bias; Studies provided data on views and experiences

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
intervention is an **intrusion into their non-working life** and that you were **forced to do it**. Participants highlighted that taking time to engage in programs could **impact earning potential**. Participants outlined that **long-working hours**, **fatigue** and a **lack of opportunities** were barriers to engagement. One study highlighted communication barriers as a potential issue especially with **migrant workers**. Some respondents in studies commented that the success of workplace health and wellbeing interventions required a **motivated and engaged workforce**. Linked to this a sense of workforce ownership of the intervention; with **lack of ownership** and **choice** outlined as a barrier. **Workplace** Access to facilities was highlighted as a barrier to engagement in the workplace health and wellbeing programme by participants in one study due to multi-site nature of the workplace		with moderate risk of bias; one study with high risk of bias)	themes identified are linked to the overarching theme of a 'staff barriers to engagement' but not all studies outlined all sub-themes.	studies (across work sectors)	management, and non-management employees of receiving and implementing workplace health and wellbeing programs. The views of those who have delivered health and wellbeing programs interventions were included	of those across the workforce, and included those with roles in facilitating, implementing, and receiving intervention. The theme of lack of 'Staff barriers to engagement' has been linked to sub-themes generated from the analysis – not all sub-themes appeared in every study outlined, but all sub-themes are considered to reflect the overarching theme.

E.3 Barriers to and facilitators of implementing interventions: Themes grouped by sector.

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
Public sector organisations, construction industry and retail sector						
Included studies covered public sector organisations (Government organisations and NHS), the construction industry and retail sector. The **nature and culture of the organisation** reflected the **proposed priorities and drivers** for health and wellbeing. In studies focused on construction and the public sector, **budget and resources** were a key driver for action but how these financial and resource issues manifest was different. Competition for contracts, client demands and profitability were drivers in construction. In the public sector reference was made to austerity and continued budgetary restrictions One study which looked at retail and construction sectors highlighted that whilst both acknowledged the importance of mental health and wellbeing causes it was considered more of a hidden issue in the construction sector with more barriers to action.	Carmichael et al 2016; Hanna, 2019; Mellor, 2011; Mellor 2013a; Mellor 2013b; Quirk et al 2018; Robinson, 2014; Wyatt et al 2015	**Minor concerns** (three studies with low risk of bias; three studies with moderate risk of bias; two studies high risk of bias).	**No concerns** Findings reflect data reported on the sub-themes outlined which all reflect the differences between the sectors outlined.	**No concerns** Data obtained from eight studies (across work sectors)	**Minor concerns** Included studies outline the views and experiences of higher management, senior and middle management, and non-management employees of receiving and implementing workplace health and wellbeing programs. The views of those who may have delivered interventions were included. The sub-themes outlined were not common across all included studies but do underpin the overarching	**Moderate confidence**. Four studies were of moderate to high risk of bias. Studies provided data on views and experiences of those across the workforce, and included those with roles in facilitating, implementing, and receiving intervention. The sub-themes were not common across all studies but all underpin the overarching theme of differences between sectors.

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
					theme of the differences between the sectors.	
Construction In **construction** physical health, exposure to risk and danger were the key drivers with mandatory regulation and client demands driving action regarding health and wellbeing; with mental health secondary or conditional on physical safety being met first. Reference was made to the size of construction company and how size and budget impacted approaches to health and wellbeing – larger companies were better able to develop and implement approaches to health and wellbeing than smaller companies due to resources and the size of the contracts competed for and the demands from bigger clients for fit for purpose employees made work in this area more feasible. Linked to this was macroeconomic pressures and competition which were seen to impact the ability for some companies to consider workplace health and wellbeing. Construction faced challenges due to **employee mix** and **employment status** (permanent or contractor) was	Carmichael et al 2016; Hanna, 2019;	**No concerns** two studies with low risk of bias	**No concerns** Finding reflects all the data reported on this theme.	**No concerns** Data obtained from three studies (across work sectors)	**No concerns** Included studies related to the views and experiences of higher management, senior and middle management, non-management employees of receiving and implementing workplace health and wellbeing programs. The views of those who may have commissioned, developed and delivered interventions were included	**High confidence** included studies were assessed as being at low risk of bias with themes consistent across the studies. The studies included a wide range of views from within the construction sector.

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
a key driver in accessing health and wellbeing interventions. Factors such as **working equals earning**, **transient nature of employees** in the industry and the **working culture with reference made to a predominantly male workforce and a 'Macho' culture** were all factors in implementing and participating in workplace health and wellbeing interventions.						
Retail sector Participants in one study from the Retail sector conveyed a **holistic approach** to workplace health and wellbeing in retail with **work satisfaction**, **happiness at work** considered and a **focus on mental health and stress**. There was no reference to a system or strategy for addressing health and wellbeing within the retail sector from participants interviewed.	Carmichael et al 2016	**No concerns** One study with low risk of bias	**Minor concerns** one study reported findings with 3 participants representing the retail industry	**Minor concerns** one study reported findings with 3 participants representing the retail industry	**Minor concerns** considered the views of 3 participants outlined as sector experts and it is not clear if this included non-managerial employees and their roles in developing and delivering workplace health and wellbeing	**Moderate concerns** the study was assessed as being of low risk of bias. It is unclear how representative the views of participants are of the retail sector.
Public sector In studies that considered the public sector there was more reference to a **broader holistic consideration** and understanding of health wellbeing.	**Mellor, 2011; Mellor 2013a; Mellor 2013b; Quirk et al 2018;**	**Major concerns** (one study with low risk of bias; three studies	**No concerns** Findings reflects data reported and the sub-themes	**No concerns** findings reported from 6 studies	**No concerns** Included studies related to the views and experiences of	**Moderate confidence** five studies were assessed as being at moderate to high risk of bias. Sub-themes were present in the majority of studies and all sub-

Summary of review finding	Studies contributing to review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
There was reference to **trade union as a key facilitator** to development and implementation of workplace health and wellbeing. There was reference to **specific tools** such as the HSE Management Standard and HSE Indicator Tool; and **Government initiatives** such as FYFV and CQUIN; and reference to existing systems and experience in dealing with workplace health and wellbeing. The role of **austerity, budget cuts and systems pressures** were outlined as impacting the ability to engage with workplace health and wellbeing in the public sector. The role of **workplace champion** was only mentioned in the context of the public sector (NHS)	**Robinson, 2014; Wyatt et al 2015**	with moderate risk of bias; two studies high risk of bias)	identified are linked to the overarching themes within the public sector.		higher management, senior and middle management, non-management employees of receiving and implementing workplace health and wellbeing programs in the public sector. The views of those who may have commissioned, developed and delivered interventions were included	themes underpinned the overarching themes.

Appendix F Excluded studies.

Study	Code [Reason]
Agarwal, Bhavya; Brooks, Samantha K; Greenberg, Neil (2020) The Role of Peer Support in Managing Occupational Stress: A Qualitative Study of the Sustaining Resilience at Work Intervention. Workplace health & safety 68(2): 57-64	- Study not concerned with implementation
Banerjee, Moitree; Cavanagh, Kate; Strauss, Clara (2017) A Qualitative Study with Healthcare Staff Exploring the Facilitators and Barriers to Engaging in a Self-Help Mindfulness-Based Intervention. Mindfulness 8(6): 1653-1664	- Study not concerned with implementation
Biron, Caroline; Gatrell, Caroline; Cooper, Cary L (2010) Autopsy of a failure: Evaluating process and contextual issues in an organizational-level work stress intervention. International Journal of Stress Management; 2010; vol. 17 (no. 2); 135-158	- not retrieved
Byrne, Kate; McGowan, Iain; Cousins, Wendy (2015) Delivering Mental Health First Aid: An exploration of instructors' views. International Journal of Mental Health Promotion 17(1): 3-21	- Study not concerned with implementation
Carolan, Stephany and de Visser, Richard O (2018) Employees' Perspectives on the Facilitators and Barriers to Engaging with Digital Mental Health Interventions in the Workplace: Qualitative Study. JMIR mental health 5(1): e8	- Study not concerned with implementation
Chiocchi, John, Lamph, Gary, Slevin, Paula et al. (2019) Can a carer (peer) led psychoeducation programme improve mental health carers well-being, reduce burden and enrich empowerment: a service evaluation study. The Journal of Mental Health Training, Education, and Practice 14(2): 131-140	- Intervention has no employer involvement
Coffey, M.; Dugdill, L.; Tattersall, A. (2009) Designing a stress management intervention in social services. International Journal of Workplace Health Management 2(2): 98-114	- Study is concerned with the design of an intervention not its implementation
Cross, M, Lee, S, Bridgman, H et al. (2019) Benefits, barriers and enablers of mentoring female health academics: An integrative review. PloS one 14(4): e0215319	- Systematic review
Donnelly, Elizabeth; Valentine, Colby; Oehme, Karen (2015) Law enforcement officers and Employee Assistance Programs. Policing 38(2): 206-220	- Study conducted outside the UK

Study	Code [Reason]
Flexman, A.M. and Gelb, A.W. (2011) Mentorship in anesthesia. Current Opinion in Anaesthesiology 24(6): 676-681	- Systematic review
Gartshore, Emily; Briggs, Lydia; Blake, Holly (2017) Development and evaluation of an educational training package to promote health and wellbeing. British journal of nursing (Mark Allen Publishing) 26(21): 1182-1186	- Study not concerned with implementation
Gruber, June, Borelli, Jessica L, Prinstein, Mitchell J et al. (2020) Best practices in research mentoring in clinical science. Journal of Abnormal Psychology 129(1): 70	- Overview of best practice
Hewison, Alistair, Gale, Nicola, Yeats, Rowena et al. (2013) An evaluation of staff engagement programmes in four National Health Service Acute Trusts. Journal of health organization and management 27(1): 85-105	- Study intervention not concerned with mental wellbeing
Lier, LM; Breuer, C; Dallmeyer, S (2019) Organizational-level determinants of participation in workplace health promotion programs: a cross-company study. BMC public health 19(1): 268	- Study conducted outside the UK
Lloyd, Lisa K; Crixell, Sylvia H; Bezner, Janet R; Forester, Katherine; Swearingen, Carolyn (2017) Genesis of an Employee Wellness Program at a Large University Health Promotion Practice; 2017; vol. 18 (no. 6); 879-894	- not retrieved
Malik, Fatima; McKie, Linda; Beattie, Rona; Hogg, Gillian (2010) A toolkit to support human resource practice Personnel Review; 2010; vol. 39 (no. 3); 287-307	- not retrieved
Meng, Annette; Borg, Vilhelm; Clausen, Thomas (2019) Enhancing the social capital in industrial workplaces: Developing workplace interventions using intervention mapping. Evaluation and Program Planning 72: 227	- Study conducted outside the UK
Moll, SE, VandenBussche, J, Brooks, K et al. (2018) Workplace Mental Health Training in Health Care: key Ingredients of Implementation. Canadian journal of psychiatry 63(12): 834-841	- Study conducted outside the UK
Moore, A.; Parahoo, K.; Fleming, P. (2011) Managers' understanding of workplace health promotion within small and medium-sized enterprises: A phenomenological study. Health Education Journal 70(1): 92-101	- Study not concerned with barriers and facilitators
Rucker, Michael Raymond (2017) Workplace wellness strategies for small businesses. International Journal of Workplace Health Management 10(1): 55-68	- Study conducted outside the UK

Study	Code [Reason]
Seath, Robert J G, Radford, David R, Mudford, Lawrence P A et al. (2019) Should mentoring be routinely introduced into general dental practice to reduce the risk of occupational stress? British dental journal 227(2): 121-125	- Study not concerned with implementation
Terry, J (2010) Experiences of instructors delivering the mental health first aid training programme: A descriptive qualitative study. Journal of Psychiatric and Mental Health Nursing 17(7): 594-602	- Study not concerned with implementation
Wan Mohd Yunus, Wan Mohd Azam; Musiat, Peter; Brown, June SI (2019) Evaluating the Feasibility of an Innovative Self-Confidence Webinar Intervention for Depression in the Workplace: A Proof-of-Concept Study. JMIR mental health 6(4): e11401	- Study not concerned with implementation
Wiman, Virginia; Lydell, Marie; Nyholm, Maria (2016) Views of the workplace as a health promotion arena among managers of small companies. The Health Education Journal 75(8): 950-960	- Study conducted outside the UK
Wright, Nicola; Zakarin, Melissa; Blake, Holly (2016) Nurses' views on workplace wellbeing programmes. British journal of nursing (Mark Allen Publishing) 25(21): 1208-1212	- Study not concerned with implementation

Appendix G Research recommendations

G.1.1 Research recommendation

What are the views of organisations about the benefits of investing in mental wellbeing?

G.1.1.1 Why this is important.

The committee agreed that overall a supportive, inclusive work environment and climate is crucial for good mental wellbeing in the workforce. Social interactions, including those between managers and employees, play an important role in this. Having the right policies can help to create a supportive workplace environment and culture and help put in place ways to ensure that leadership is supportive and engaged, that there are effective peer support networks, and there is good organisational-wide mental health literacy. Organisations can also promote mental wellbeing interventions by reducing any potential barriers to using them and supporting employees to access them. This would embed the importance of mental wellbeing into the organisational culture. The committee noted that there was little evidence on the views of organisations about mental wellbeing.

G.1.1.2 Rationale for research recommendation

Importance to 'patients' or the population	Poor mental wellbeing at work is a significant public and political concern. A supportive, inclusive work environment and climate is crucial for good mental wellbeing in the workforce. The committee noted that there was little evidence on the views of organisations about mental wellbeing.
Relevance to NICE guidance	Universal organisational approaches have been considered in this guideline and there is a lack of evidence on the views of organisation about mental wellbeing.
Relevance to the NHS	The outcome would increase understanding of mental wellbeing in organisations including the NHS and inform approaches to universal organisational approaches.
National priorities	High – outlined in the NHS long term plan
Current evidence base	Minimal evidence on the views of organisations about mental wellbeing
Equality considerations	None known

G.1.1.3 Modified SPIDER table

Sample	• Everyone aged 16 years or older in full or part time employment. • Employers from micro, small, medium and/or large organisation across private and public sector
Phenomenon of Interest	What are the views of organisations about mental wellbeing?
Study Design	• Studies with a qualitative component including focus groups and interview-based studies.

	• Mixed-methods studies containing relevant qualitative data
Evaluation	Views and experiences regarding the intervention of: • employees receiving the interventions. • those delivering the interventions. • employers
Research type	Qualitative or mixed methods

G.1.2 Research recommendation

What are the specific needs of small and medium size enterprises (SMEs) in promoting mental wellbeing in the workplace, including organisational, targeted and individual level approaches?

G.1.2.1 Why this is important

The committee noted that a lot of the evidence was from larger organisations, and that small and medium enterprises (SMEs) are likely to have fewer resources to help them address mental wellbeing in the workplace, such as occupational health and human resource professionals. This is particularly important considering that SMEs employ 61% of all private sector employees in the UK. The committee also discussed that medium-sized organisations can have more in common with larger organisations compared with micro and small businesses. The committee also discussed that some interventions may not be feasible for smaller organisations, and further research is required to determine the specific needs of SMEs.

G.1.2.2 Rationale for research recommendation

Importance to 'patients' or the population	Poor mental wellbeing at work is a significant public and political concern. The committee noted the lack of evidence around the specific needs of SMEs to improve mental wellbeing at work.
Relevance to NICE guidance	Organisational, targeted, and individual-level interventions have been considered in this guideline. However, most of the evidence came from studies conducted in large organisations and there is a lack of evidence around interventions conducted in SMEs.
Relevance to the NHS	SMEs employ a large proportion of the UK population, and improving the mental wellbeing of employees in these organisations may reduce the burden placed on the NHS due to mental ill health.
National priorities	High - outlined in the NHS long term plan
Current evidence base	There is a lack of evidence around interventions conducted in SMEs
Equality considerations	None known

G.1.2.3 Modified SPIDER table

Sample	• Everyone aged 16 years or older in full or part time employment.

	• Employees from micro, small, and medium organisations across private and public sector
Phenomenon of Interest	What are the specific needs of small and medium size enterprises (SMEs) in promoting mental wellbeing in the workplace?
Study Design	• Studies with a qualitative component including focus groups and interview-based studies. • Mixed-methods studies containing relevant qualitative data
Evaluation	Views and experiences of employers and employees regarding: • Their specific needs around mental wellbeing • Barriers and facilitators to implementing interventions
Research type	Qualitative or mixed methods