NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Healthy workplaces: improving employee mental and physical health and wellbeing.

Date of quality standards advisory committee post-consultation meeting:
13 October 2016.

2 Introduction

The draft quality standard for healthy workplaces was made available on the NICE website for a 4-week public consultation period between 15 August and 13 September 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 30 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

5. It is recognised that some of the quality statements within this quality standard will be more relevant for medium and large organisations (employing 50 or more people)

than for micro and small organisations. Is this an accurate understanding? Please explain your answer.

4 General comments[1]

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Generally the aims of the quality standard were well received.
- Suggestion to include examples of physical health initiatives to balance the quality standard.
- Concern was raised that occupational health advice and professional role is not included.
- Suggestion to note that employees in SMEs may not have access to HR or occupational health services.
- The quality standard does not mention presenteeism and how it could be measured.
- The statements are a tick-box type exercise meaning employers do not need to do much.
- Sickness absenteeism requires careful monitoring. Care and support needs to be tailored to the particular workplace e.g. office, factory, hospital.
- There is little chance of influencing behaviours in diet, exercise, etc and enhancing the quality of life for people with mental illness is difficult for managers.
- The quality standard does not refer to harassment/bullying. An independent individual should be available if a line manager or employer harasses/bullies an employee.

Comments on key areas for quality improvement (consultation question 1)

- No focus on the organisation's role in designing 'good work' that promotes employee wellbeing.

[1] It is acknowledged that the outcomes for this quality standard are influenced by a number of different factors. Outcomes which the statements will contribute to have been included for each statement, though it is acknowledged that other factors will also influence their achievement.

- Support structures should be in place for managers to escalate complex cases where medical support and advice is needed.
- The quality standard focusses on stress recognition, management and training for line managers, excluding other health and wellbeing factors.
- It will not reflect the key areas for quality improvement if it is not made more relevant for smaller organisations.
- It does not note that a common cause of stress is disputes in the workplace between colleagues/staff/staff groups.
- Some of the quality standard could be more specific e.g. statement 1 could include ‘‘….. through a clear and documented strategy and delivery plan”.

Consultation comments on data collection (consultation question 2)

- The Labour Force Survey provides evidence on the employment status of people with disabilities and sensory loss.
- Most organisations do not have valid and reliable wellbeing measures in place.
- Data could be collected in large hospitals but may not be a priority due to financial pressures. However, do the measures provide meaningful data and can they be used as an accurate measurement of the success of workplace health and wellbeing interventions.
- The ability to collect the data depends on the organisation’s size and investment in management information and data capture.
- Most organisations will have systems and structures in place to achieve this. However, collection of data will vary, and some organisations may require more support to implement or maintain these systems/structures.

Consultation comments on resource impact (consultation question 4)

- Statements 1, 2 and 3 would be achievable with the most resource being required for line manager training (statement 3).
- Training resources should be available for line managers, champions and people working at board level.
- The cost of training and staff forums in the NHS may not be achievable.

- The business case for investing in improving employees' mental health and wellbeing is well established.
- The statements appear achievable, but challenging for smaller organisations for example around training, organisations requiring modernised systems/processes or the geographically dispersed.

Consultation comments on relevance to micro and small organisations (consultation question 5)

- All organisations should be able to implement the quality standard though this may be in different ways depending on their size and available resources. Local public health infrastructure should be able to support small businesses.
- Management practice and structure may significantly vary between micro and small organisations. Statement 4 may not apply in micro or small businesses.
- The responsibility should exist regardless of the size of the organisation.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Employers have a named senior manager who is responsible for making employee health and wellbeing a core priority.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- There was general support for the statement.
- Suggestions to make some additions to the rationale including lowering presenteeism and the senior manager being supported with time to carry out this role.
- The statement says there should be a senior named manager but does not refer to the need to introduce initiatives to support staff.
- This statement is achievable for employers of all sizes and is therefore applicable for all organisations.
- Suggestion to expand the employer audience descriptor to include ‘leaders’.
- Suggestion to change the statement to a ‘named member of staff’.
- Note that health and wellbeing is not only senior manager responsibility but all managers at all levels.
- Organisations may vary in the “seniority” of the manager used in this role. They should be independent of the executive team but be able to hold them to account.
- It should be a well-resourced role and receive external scrutiny.
- Having one senior manager is not sufficient.
- It would be good practice if the staff member engaged managers and employees in the process.

Consultation comments on data collection (consultation question 2)

Stakeholder comments on question 2 included:

- The three quality measures are relevant and will support an organisation's achievement of the statement.
- It is easy to add tasks to job descriptions but need to monitor progress.
- Suggestion to include and additional outcome that large organisations (employing 50 or more people) provide employees access to an occupational health service.
- Suggested additional/changes to measures, e.g. employee satisfaction rates and accident rates.
- Sickness absence and employee retention rates are only two elements of health and wellbeing and are not directly related to this named senior manager.
- Quality measure should outline practical steps for employers to take action to support the MSK health of employees.
- Potential for confusion with an organisation's legal duty, under the Management of Health and Safety at Work Regulations 1999, to appoint a '*competent person'* to provide advice on matters relating to the health and safety of the workforce.

5.2 Draft statement 2

Line managers' job descriptions and performance indicators include supporting employee health and wellbeing.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- General support for the statement.
- Achievable if line managers receive support and training from senior employees. They need the skills/knowledge to support employees with health and wellbeing.
- This would be stronger if linked with safety but a wellbeing culture is needed.
- This may result in job descriptions getting longer.
- Suggestion to add a sentence to the rationale about employees feeling able to raise concerns early.
- Suggestion to add further detail to the line manager audience descriptor to include their role in absence management, effective return to work etc.
- Suggestion to amend the definition to include being able to spot the early warning signs of stress and/or mental health problems.
- The line manager role could be conflicted; they assess performance and outcomes and support well-being.
- Emphasise this is about promoting positive wellbeing so that managers do not feel that they may be penalised for identifying staff who have poor health.
- Line managers are already stretched and this will be additional burden. There should be a dedicated individual to manage staff who are unwell.
- Reducing one person's work-load often means increasing someone else's.
- Some employees are stressed due to their line manager and worry their mental health problems will be noticed. Training can help recognition and stigma.
- There is a need to improve consistency of wording in employer and employee audience descriptors.
- Suggestion to include line manager induction training for new managers or continuous professional development training.

Consultation comments on data collection (consultation question 2)

Stakeholder comments on question 2 included:

- Data could be collected locally.
- Data collection could be difficult in organisations that do not operate formal performance management systems.
- Outcomes: gather more holistic data e.g. employee satisfaction, include attendance at leadership and management behaviour training and accident rates.
- Local data collection sources could include employee engagement surveys and exit interviews. Others could include CIPD Employee Outlook and Resourcing and Talent Management survey reports.
- Additional quality measure to evidence ongoing line manager training and support to update their skills and knowledge.
- Helpful to include examples of performance indicators and a link to a stress risk assessment tool to support the process of data collection.

5.3 Draft statement 3

Line managers are trained to recognise when employees are experiencing stress and respond to their needs.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- General support for the statement.
- Statement should not be limited to ‘stress’ but cover mental health and wellbeing and the promotion of positive mental health at work.
- Line managers should understand the relationship between common mental health disorders and obesity is complex.
- Suggestion to amend the definition of stress in line with HSE Management Standards.
- Stress risk assessment doesn’t replace managers understanding their team, daily engagement with them and exhibiting best practice as line managers.
- Suggestion to focus on the causes of stress, particularly organisational culture issues such as bullying, harassment and discrimination.
- This may apply in small organisations but line managers in the NHS have little contact with individuals so cannot recognise stress in people they manage.
- Managers should receive the training outlined prior to appointment, not after.
- Suggestion to add ‘support’ to the statement.

Consultation comments on data collection (consultation question 2)

Stakeholder comments on question 2 included:

- Recognising stress is a complex skill which some managers may be unable to do even after training.
- Suggestion to state ‘relationship difficulties with a partner or spouse’ instead of ‘family issues’.
- Simple measures can be regular ‘catch ups’ between staff and managers that include a reflection on workload and stress levels.

- Additional measures should be included such as: external supervision to support line manager health and wellbeing and the number of managers trained to recognise stress.
- Suggested data sources for outcome measures included occupational health, employee assistance programme, HSE or stress risk assessment data.
- Suggestion to include an additional outcome on identification of any organisational change issues.

5.4 Draft statement 4

Employers give employees the opportunity to contribute to decision-making through staff engagement forums.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- General agreement with statement.
- Suggestions to make additions to the definitions and equality sections such as employees with sensory loss, age discrimination and team and organisational level forums.
- This should not only focus on staff engagement forums but also employee representation in all areas of programme design, development, delivery and evaluation and using day to day interactions with employees.
- 'Staff forums' are not used in all sectors. The statement should reflect the diversity of organisational structures and management practices.
- Suggestion to update the last sentence of the rationale to '…..resulting in a more content and healthy workforce as well as higher levels of commitment, engagement and productivity'.
- Is the aim of the statement participation in all decision making or just health and well-being? Those suffering from ill health issues may not feel able to engage.
- Implies a degree of engagement from the employee which can be challenging.

Consultation comments on data collection (consultation question 2)

Stakeholder comments on question 2 included:

- Suggestion to add some wording to measure on employee feedback.
- Include a measure on uptake of engagement sessions and focus groups.
- Employee engagement is central to the statement and should be measured in a qualitative way.

The statement could include employee feedback through the line management structure and staff surveys. Local data collection should include feedback from line managers.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Musculo-skeletal (MSK) conditions should be included in the quality standard.
- Employee/ workplace health champion to support healthy workplace initiatives.
- Line managers should be alert to the early signs of hearing loss and the role of the GP in referring people for a hearing test.
- Line manager training and support to address different health conditions and seek further information for employees living with any long term condition.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[2]
1	Action on Hearing Loss		Action on Hearing Loss, formerly RNID, is the UK's largest charity working for people with deafness, hearing loss and tinnitus. Our vision is of a world where deafness, hearing loss and tinnitus do not limit or label people and where people value and look after their hearing. We help people confronting deafness, tinnitus and hearing loss to live the life they choose, enabling them to take control of their lives and removing the barriers in their way. We give people support and care; develop technology and treatments and campaign for equality. Throughout this response we use the terms 'people with hearing loss' to refer to people with all levels of hearing loss, including people who are profoundly deaf. We are happy for the details of this response to be made public. Action on Hearing Loss welcomes the broad aims of this quality standard to improve the health and wellbeing of employees, including their mental health. People with hearing loss may find it difficult to communicate with other people and have an increased risk of other health problems such as anxiety, depression and dementia. There is good evidence that hearing aids improve quality of life and reduce health risks, but many people are waiting too long to get their hearing tested. People with hearing loss are also less likely to be employed compared to the general population and often face unnecessary and costly barriers to communication that stop them from fulfilling their potential at work. **Background** There are 11 million people with hearing loss across the UK, about one in six of the population[3]. Hearing loss can be caused by regular and prolonged exposure to loud sounds, ototoxic drugs, genetic predisposition or complications from injuries or other conditions. Age related damage to the cochlear is the single biggest cause of hearing loss. Over 70% of people over 70[4] have hearing loss and due to the ageing population, the number of people with hearing

[2]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

[3] Action on Hearing Loss (2015) Hearing matters. Available at: www.actiononhearingloss.org.uk/hearingmatters

[4] Davis (1995) Hearing in adults. London: Whurr

ID	Stakeholder	Statement number	Comments[2]
			loss is set to grow in the years to come. By 2035, we estimate there will be approximately 15.6 million with hearing loss. There are also an estimated 900,000 people in the UK with severe or profound hearing loss. Some people with severe or profound hearing loss may use British Sign Language (BSL) as their main language and may consider themselves part of the Deaf Community, with a shared history language and culture. Based on the 2011 census, we estimate that there are at least 24,000 people across the UK who use BSL as their main language – although this is likely to be an underestimate. A significant body of evidence shows that hearing loss is a serious condition that can have an adverse impact on a person's health and quality of life[5]. Hearing loss has been shown to have a negative impact on overall health and studies have also found that hearing loss is independently associated with increased use of health services, an increased burden of disease amongst adults and an increased risk of mortality[6]. Hearing loss has also been associated with more frequent falls[7], diabetes[8], stroke[9] and sight loss[10]. Evidence suggests people with learning disabilities are more likely to develop hearing loss earlier compared to the general population and are at greater risk of associated health problems[11].

[5]Chisholm et al (2007) A systematic review of health-related quality of life and hearing aids: Final report of the American Academy of Audiology task force on the health-related quality of life benefits of amplification in adults. *Journal of American Academy of Audiology*, 18, 151-183; Ciorba et al (2012) The impact of hearing loss on quality of life of elderly adults. *Clinical interventions in aging*, 7,159-63; Dalton et al (2003) the impact of hearing loss on quality of life in older adults. *The Gerontologist*, 43 (5) ,661-68; Mulrow et al (1990) Quality-of-life changes and hearing impairment, a randomized trial. *Annals of Internal Medicine,* 113 (3), 188-194.

[6] Appollonio et al (1996) Effects of sensory aids on the quality of life and mortality of elderly people: A multivariate analysis. *Age and Ageing*, 25, 89-96; Genther et al (2013) Association of hearing loss with hospitalization and burden of disease in older adults. *Journal of the American Medical Association*, 309 (22), 2322; Karpa et al (2010) Associations between hearing impairment and mortality risk in older persons: the Blue Mountains Hearing Study. *Annals of Epidemiology*, 20 (6), 452-9.

[7] Lin and Ferrucci (2012) Hearing loss and falls among older adults in the United States. *Archives of internal medicine*, 172 4, 369-371.

[8] Kakarlapudi et al (2003) The effect of diabetes on sensorineural hearing loss. *Otology and Neurotology*, 24 (3), 382-386; Mitchell et al (2009) Relationship of Type 2 diabetes to the prevalence, incidence and progression of age-related hearing loss. *Diabetic Medicine*, 26(5), 483-8; Chasens et al (2010) Reducing a barrier to diabetes education: identifying hearing loss in patients with diabetes. *Diabetes Education*, 36 (6), 956-64.

[9] Formby et al (1987) Hearing loss among stroke patients. Ear and Hearing, 8 (6), 326-32; Gopinath et al (2009) Association between age-related hearing loss and stroke in an older population. *Stroke*, 40 (4), 1496–1498.

[10] Chia et al (2006) Association between vision and hearing impairments and their combined effects on quality of life. *Archives of Ophthalmology*, 124 (10), 1465-70.

[11] Kiani R and Miller H (2010) Sensory impairment and intellectual disability Advances in psychiatric treatment. 16, 228–235.

ID	Stakeholder	Statement number	Comments[2]
			Research shows that people with hearing loss may find it difficult to communicate with other people and this may lead to feelings of loneliness, emotional distress and withdrawal from social situations[12]. People with hearing loss are more likely to develop paranoia, anxiety and other mental health issues – for example, evidence shows that hearing loss doubles the risk of developing depression[13]. There is strong evidence of a link between hearing loss and dementia[14]. People with hearing loss are less likely to be employed (65% are in employment) compared with people with no long-term health issue or disability (79%)[15]. Developing hearing loss can also lead to a loss of employment[16] and difficulties gaining employment[17] . Our *Hidden Disadvantage*[18] report found that around two thirds (70%) survey respondents felt their hearing loss sometimes prevented them from fulfilling their potential at work and a similar proportion (68%) said that hearing loss left them feeling isolated at work. Two fifths (41%) of survey respondents who retired early said this was related to their hearing loss. **Diagnosing and managing hearing loss in the workplace**

[12] Hétu et al (1993) The impact of acquired hearing loss on intimate relationships: implications for rehabilitation. *Audiology*, 32 (3), 363-81; Arlinger (2003) 'Negative consequences of uncorrected hearing loss – a review'. *International Journal of Audiology*, 42 (2), 17-20; Monzani et al (2008) 'Psychological profile and social behaviour of working adults with mild or moderate hearing loss'. *Acta Otorhinolaryngologica Italica*, 28 (2), 61-6.
[13] Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. *Journal of the American Geriatrics Society*, 58 (1), 93-7; Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss. Acta Otorhinolaryngologica Italica, 28 (2), 61–66; Eastwood et al (1985) Acquired hearing loss and psychiatric illness: an estimate of prevalence and co-morbidity in a geriatric setting. *British Journal of Psychiatry*, 147, 552–556.
[14] Lin FR et al. (2011) 'Hearing loss and incident dementia'. *Archives of Neurology*, 68 (2), 214-220; Gurgel et al (2014) Relationship of Hearing Loss and Dementia: A Prospective, Population-Based Study. *Otology & Neurotology*. 35 (5), 775-781; Albers et al (2015) At the interface of sensory and motor dysfunctions and Alzheimer's disease. *Alzheimers and Dementia Journal*, 11 (1), 70–98.
[15] Office for National Statistics (ONS) (2015). Labour Force Survey January – March 2015 - Analysis cited in House of Commons debate 9 June 2015 c 1723W.
[16] Matthews (2011) Unlimited potential. Available at: www.actiononhearingloss.org.uk/unlimitedpotential
[17] RNID (2008) Opportunity blocked: The employment experiences of deaf and hard of hearing people. Available at: https://www.actiononhearingloss.org.uk/~/media/Documents/Policy%20research%20and%20influencing/Research/Previous%20research%20reports/2007/Opportunity%20Blocked.ashx
[18] Arrowsmith (2014) Hidden disadvantage; why people with hearing loss are still losing out at work. Available at: www.actiononhearingloss.org.uk/hiddendisadvantage

ID	Stakeholder	Statement number	Comments[2]
			Hearing aids are shown to improve quality of life[19] and help people communicate, stay socially active and reduce the risk of loneliness and depression[20]. New evidence suggests they may even reduce the risk of dementia[21]. However, many people are waiting too long to get their hearing tested. Research shows that people wait on average ten years before seeking help for their hearing loss and the average age for referral is in the mid-70s. Delays in treatment mean people with hearing loss are less likely to benefit from hearing aids. Evidence suggests that hearing aids are most effective when fitted early and people with severe hearing loss may find it more difficult to adapt to hearing aids[22]. There are currently no national adult screening programmes for hearing loss and more could be done to encourage people to seek help and check their hearing. Employers could also offer a range of support and simple adjustments for people with hearing loss to help them communicate well in workplace, such as: • Deaf awareness training for staff - to make sure employees are able to communicate with colleagues and members of the public with hearing loss. • Communication support - if an employee with hearing loss needs support to communicate in meetings or take notes at work, such as a British Sign Language (BSL) interpreter or speech-to-text-reporter (STTR). • Technology such as hearing loops or personal listeners that can help people hear more clearly over background noise.

[19] Chisholm et al (2007) A systematic review of health-related quality of life and hearing aids: Final report of the American Academy of Audiology task force on the health-related quality of life benefits of amplification in adults. *Journal of American Academy of Audiology*, 18, 151-183; Mulrow et al (1992) Sustained benefits of hearing aids. *Journal of Speech and Hearing Research*, 35 (6), 1402-5; National Council on the Aging (2000) The consequences of untreated hearing loss in older persons. *Head and Neck Nursing*, 18 (1), 12-16; Yueh et al (2001) Randomized trial of amplification strategies. *Archives of Otolaryngology - Head & Neck Surgery*, 127 (10), 1197-204.

[20] Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly people. *Archives of Gerontology and Geriatrics*, 52 (3): 250-2; Pronk et al (2011) Prospective effects of hearing status on loneliness and depression in older persons: identification of subgroups. *International Journal of Audiology*, 50 (12), 887-96; Dawes et al (2015) Hearing Loss and Cognition: The Role of Hearing Aids, Social Isolation and Depression. *PLoS ONE,* 10 (3): e0119616; National Council on the Aging (2000) The consequences of untreated hearing loss in older persons. *Head and Neck Nursing*, 18 (1), 12-16.

[21] Amieva et al (2015) Self-Reported Hearing Loss, Hearing Aids, and Cognitive Decline in Elderly Adults: A 25-Year Study. *Journal of the American Geriatrics Society*, 63 (10), 2099-2104; Dawes et al (2015) Hearing Loss and Cognition: The Role of Hearing Aids, Social Isolation and Depression. *PLoS ONE,* 10 (3): e0119616; Deal et al (2015) Hearing impairment and cognitive decline: A pilot study conducted within the atherosclerosis risk in communities neurocognitive study. *American Journal of Epidemiology*, 181(9), 680-90.

[22] Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. *Health Technology Assessment*, 11, 1–294.

ID	Stakeholder	Statement number	Comments[2]
			• Adjusting the layout of the meeting room to make sure employees with hearing loss can see everyone clearly – this is important for people who lipread. • Moving the employee to a quiet area of the office with good acoustics (where sound is transmitted well). Under the Equality Act 2010, employers have a legal duty to make reasonable adjustments if people face substantial difficulties in the workplace due to physical or mental impairments – including hearing loss. The government's Access to Work scheme[23] also provides grants to help fund practical support and specialist equipment that can help people with hearing loss communicate well. The scheme offers grants when an individual's support needs or adaptations are beyond the reasonable adjustments that an employer is legally obliged to provide under the Equality Act. We have concerns about the low awareness of Access to Work. In a YouGov poll of business leaders Action on Hearing Loss commissioned in April 2016[24], nearly two-thirds (63%) of business leaders had not heard of Access to Work. The scheme must be better promoted to employers. Our research shows that many people with hearing loss are not getting the support they need in the workplace. Participants in our *Unlimited Potential*[25] research reported that managers were only likely to take action or make adjustments when requested, and there were often long delays in support being provided. Our *Hidden Disadvantage* report also found that although over half (59%) of survey respondents had used Access to Work, others felt that employers do not know enough about Access to Work or promote it to their employees. In 2014/15, around 36,000 people used Access to Work and of these, 5,570 had hearing loss. Over 3 million people have hearing loss and are of working age[26] who could potentially benefit from Access to Work, so the low number of people use Access to Work suggests a high level of unmet need. **Recommendations** As the workforce grows older due to the ageing population and a rising retirement age, hearing loss will become increasingly common in the workplace in the years to come. Senior managers and line managers have an important role to play in encouraging people to seek help for their hearing loss. Early diagnosis is crucial to make sure people

[23] https://www.gov.uk/access-to-work
[24] Total sample size was 618 adults (aged 18+). Fieldwork was undertaken between 4th - 8th April 2016. The survey was carried out online. The figures have been weighted and are representative of all senior decision makers in GB businesses
[25] Matthews (2011) Unlimited potential. Available at: www.actiononhearingloss.org.uk/unlimitedpotential
[26] Action on Hearing Loss (2011) Hearing matters. Available at: https://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/our-research-reports/research-reports-2011.aspx

ID	Stakeholder	Statement number	Comments[2]
			with hearing loss get the most out of their hearing aids. In line with the NICE Mental wellbeing in care homes quality standard[27], senior managers and line managers should be alert to the earlier signs of hearing loss and the role of the GP in referring people for hearing test. Senior managers and line managers should also ensure employees are aware of their rights under the Equality Act and the financial support available through the Access to Work scheme. To support these aims, we recommend\the following: 1. Adding "disability and sensory loss awareness training" as key source of evidence for measuring quality improvement. For more information, please see comments 3 and 6. 2. Adding the provision communication support and/or accessible information and the Access to Work scheme to the definition of health and wellbeing used throughout this quality standard. For more information, please see comments 4 and 7
2	Action on Hearing Loss		The Access to Work[28] scheme should be included as policy document relevant to this quality standard.
3	Bupa UK		• Bupa's purpose is longer, healthier, happier lives. We view the workplace as a key setting in which to support individuals and their families in achieving better health and wellbeing, and in tackling some of the UK's most difficult and pressing health and wellbeing issues. • Bupa supports the sharing of best practice throughout the UK and internationally of examples where employers are prioritising workplace health support. • As an employer of 32,000 people in the UK, we work to improve the health and wellbeing of our own people in the UK and across the world. One of our most important goals is that people should be demonstrably healthier because they work at Bupa. • To support this objective and in service of those companies we work for, Bupa has invested in extensive research to build our leadership and expertise in workplace health and to trial initiatives and new approaches towards employee engagement and wellbeing with our own people. This is because we view the potential benefits offered by workplace health to individuals, to employers, and to society more widely, including the economy, as immense and a significant contributor to our efforts to fulfil our purpose. • Bupa UK welcomes this consultation as an opportunity to continue to support NICE's policy development work.
4	Central and North West	General comment	There is also a bigger point that's missed in the focus on HWB generally, which is that stress levels jumped by 10% in a 3 year period across England as a whole (as reported in the national staff survey between 2009 and 2012).

[27] NICE (2013) Mental wellbeing of older people in care homes. QS50
[28] https://www.gov.uk/access-to-work

ID	Stakeholder	Statement number	Comments[2]
	London NHS Foundation Trust		What might have caused this? staff pay flat lined? increasing CIPS? Higher demand for healthcare within a more stringent financial position? It's never mentioned. The NICE guidance and other solutions seem not to be curious about this and focuses their attention instead at organisational level solutions. Yet could the data suggest that something was going on nationally that needs to be put right.
5	CIPD	General	The CIPD very much welcomes this new NICE quality standard on healthy workplaces and the opportunity to provide feedback on it. We believe that UK workplaces can play an important role in improving people's well-being through health promotion and ill health prevention activities, through early detection of some symptoms and by encouraging lifestyle changes. Research suggests that a culture of well-being, driven by great people management, is good for employees and good for business. The CIPD has developed a large body of evidence that combines research, thought leadership and good practice guidance to help employers foster healthier workplaces. With a community of more than 140,000 HR and people development professionals, we are in a unique position to build on the experience of these practitioners who, typically, are responsible for leading on health and well-being programmes in their organisation. This response is therefore rooted in both expert and practical knowledge of how employers can develop healthy workplaces.
6	Faculty of Occupational Medicine & Society of Occupational Medicine		The Faculty of Occupational Medicine (FOM) & the Society of Occupational (SOM) welcome the focus this standard brings to improving employee mental and physical health and wellbeing. We agree with the Department of Health and Department for Work and Pensions that there is strong evidence that work is generally good for people's physical and mental health and general wellbeing. We also note that a healthy workforce, where the wellbeing of that workforce is prioritised, can have an impact on performance. We note the report 'Employee Health and Well-being in the NHS: A Trust Level Analysis' which argues that when staff are cared for they can provide outstanding professional care, and "*the strong associations between employee Health and Well-being and Presenteeism and trust performance".*[29] Occupational health is uniquely placed amongst medical specialties to enhance the productivity of the nation while keeping workers healthy and safe[30]. For example, in the NHS many Occupational Health services have a major involvement in training managers in the appropriate investigation and management of sickness absence and also training managers and staff in emotional

[29] Employee Health and Wellbeing in the NHS: A Trust Level Analysis, Anna Topakas, Lul Admasachew, Jeremy Dawson Aston Business School, Aston University
[30] Health, work and wellbeing – evidence and research https://www.gov.uk/government/collections/health-work-and-wellbeing-evidence-and-research

ID	Stakeholder	Statement number	Comments[2]
			resilience often in collaboration with other colleagues. A recent report found *"there is a substantial amount of recent evidence that the experiences of staff, particularly in the form of support received from supervisors and others, and staff engagement, are associated with the care provided to patients, in the form of patient satisfaction, health outcomes, and ratings of quality of care, as well as staff absenteeism and turnover"*[31]*.* We are therefore concerned that the role of Occupational Health Professionals in reaching these quality standards is overlooked. We are particularly concerned that in your meeting of the 16th June you noted "*that there was no evidence to support that accessing occupational health improves employee health and wellbeing".* We would dispute this. Dame Carol Black and David Frost CBE's report '*Health at work – an independent review of sickness* absence' cites case studies where the use of Occupational Health Services lead to a marked reduction in sickness absence rates. We note that **NG13** states that there are gaps in evidence and we would offer to work with NICE to build up the evidence base on the impact Occupational Health has on workplace wellbeing: *"Workplace health: management practices (NG13): This guideline covers how to improve the health and wellbeing of employees, with a focus on organisational culture and the role of line managers."* ***"Gaps in the evidence:** 4. More research is needed on the effective contribution of occupational health, human resources and health and safety to supporting line managers in promoting workplace health and wellbeing"*
7	NHS Employers		There is a lot of focus on reducing sickness absence in general and increasing employment for those with long-term health conditions, but there is no mention of presenteeism and how this could be measured.
8	NHS Employers		Similarly, it would be good to see a quality standard on promoting physical activity in the workplace.
9	NHS Employers		You have mentioned the NHS England Healthy Workforce programme. Can we suggest that reference is made to the NHS Employers health and wellbeing programme, which is commissioned by the Department of Health to support all NHS employers with their health and wellbeing strategies, using evidence based practice. We provide support, guidance and resources through our webpages, all information is free to access and is used both inside and outside the NHS to support the development, implementation of robust wellbeing strategies.

[31] Staff Experience and Patient outcomes, what do we know? A report commissioned by NHS Employers on behalf of NHS England Author: Dr Jeremy Dawson of Sheffield University Management School, July 2014

ID	Stakeholder	Statement number	Comments[2]
			NHS Employers are supporting NHS England on this work and are leading on board and senior leadership and line manager training. NHS Employers are not leading on the evaluation of the overall programme, this is NHS England.
10	National Rheumatoid Arthritis Society		We welcome this document and understand that the focus will at times be on medium and large employers but would emphasise the need for understanding of the circumstances of employees in SMEs and the self-employed for whom advice to contact Human Resources departments or Occupational health teams is fanciful.
11	Portsmouth City Council	N/A	Q1. Many links and references are made to other documents throughout the quality standard (particularly this section) and we are suggesting that the relevance and context of these are made clearer. For example, the Workplace Wellbeing Charter is cited but does not necessarily read/sit well within the section so more could be added around why this initiative is relevant for healthy workplaces and how it supports the implementation of the quality statements. This may then make the document more accessible to employers and increase the likeliness of implementation in practice.
12	Portsmouth City Council	N/A	Q1. Taking the quality standard into account as a whole the statements seem a bit like a tick-box type exercise/approach to becoming a healthy workplace with not much actually needing to be achieved by employers, i.e. having a named senior person responsible for workplace health but what will they actually do/implement?
13	The Royal College of Anaesthetists		We are concerned there is no reference to harassment and bullying. It refers at one point to referring employees to an 'outside agent' such as Occupational Health, but that referral comes from the line manager or employer. There needs to be specific notification of someone independent to go to when the harassment/bullying comes from line manager or employer. There is no other cause more likely to create stress.
14	Royal College of General Practitioners	General	This is a sensible and thoughtful document and sets an ideal which is recognised by the good employer as “The happy ship”. There will always be some tension between employer and employed, and the tension needs to be positive with each supportive and understanding of the other. The employer has to run a business and in the end to make a profit to remain viable, production is key to that and involving the work force to provide a healthy work place; healthy and happy workers get more done. There has to be agreement about training, safety, monitoring, quality control and incentive. There has to be reasonable discipline. Terms and conditions are part of the contract so that rest breaks, canteen facilities and occupational health are built in and not optional extras. The role of Trade Unions is part of the equation of care and productivity.

ID	Stakeholder	Statement number	Comments[2]
			Sickness absenteeism is an indicator and requires careful monitoring and sometimes personal intervention e.g. Monday morning absences often indicating an alcohol problem. The care and support needs to be tailored to the particular workplace-office, factory, school, hospital. (PS)
15	Royal College of Nursing	General	It is disappointing to see no standard on access to Occupational Health advice. While we appreciate that the guidance covers all sizes and types of organisations we feel that with the introduction of the 'fit for work' service a measure could be put in place to cover SMEs as well as larger organisations who may have in-house provision. This is particularly important for the health and wellbeing of disabled employees in terms of workplace adjustments and job design.
16	Royal College of Physicians and Surgeons of Glasgow		There is a distinction made according to company size. In reality, big companies are an amalgam of smaller units, each of which is probably autonomous from this point of view. Collective data from these smaller units may give an overview, but the data is more likely to be useful when assessing the progress of individual units, or comparing units, rather than as a collective whole of what might be dissimilar groups.
17	Royal College of Physicians and Surgeons of Glasgow	Table 1	The Objectives and Indicators here are laudable. There is a very low risk of success in influencing behaviours in the areas of diet, exercise, etc.
18	Royal College of Physicians and Surgeons of Glasgow	Table 2	Enhancing the quality of life for people with mental illness is also a laudable objective, but very tricky for a "normal" manager, who will expect to have logical and meaningful discussions with employees, leading to agreed commitments and behaviours.
19	Skcin Karen Clifford National Skin Cancer Charity	Table 4	NG 32 advises that outdoor workers are at risk of UV Notes and sources http://www.cancerresearchuk.org/about-cancer/causes-of-cancer/cancer-risks-in-the-workplace http://www.hse.gov.uk/pubns/indg337.pdf who.int/uv/publications/en/occupational_risk.pdf http://www.iosh.co.uk/News/New-research-reveals-scale-of-skin-cancer-among-outdoor-workers-and-lack-of-awareness-about-risks.aspx It hard to measure workplace improvement on prevention of skin cancer as no mandatory, compulsory or regulatory measures exists. The HSE advises guidelines as does NICE and WHO and HSE advises that employer's have a legal responsibility to protect workers as solar radiation is carcinogenic to humans. Our free Sun safe workplaces

ID	Stakeholder	Statement number	Comments[2]
			puts a policy in place for workplace Health and Safety Managers and OH. We do not have any data measurements of how the prevention and education of can impact work places incidences of skin cancer without a national audit of businesses and further uk study of skin cancer in the work place. Prevention and education are key to reducing incidences and mitigate future health care costs and absenteeism at work. Sun safe workplaces provides access to support resources and should be included in positive health behaviour of checking skin and screening checks.
20	Tees Esk and Wear Valleys NHS Foundation Trust		Whilst the quality standard provides a link to the HSE management standards for work related stress, there are further opportunities to provide direct quotes etc. which would enhance the draft quality standard. The existing HSE standards are used widely both within and outside the health service. This may therefore impact upon the direct uptake of this quality standard.
	QUESTION 1		
21	Action on hearing loss		Overall, Action on Hearing Loss supports the aims of this standard. Given the high prevalence and impact of hearing loss and the common barriers to communication people with hearing loss face in employment, we welcome the requirement for employers to make the health and wellbeing of their employees a core strategic priority. As stated above, employers could be doing more to ensure people with hearing loss get the support they need to communicate well in the workplace. Assigning overall responsibility for improving health and wellbeing to a senior manager (quality statement 1) and ensuring job descriptions and performance indicators include supporting employee health and wellbeing (quality statement 2) should make organisations more accountable to their employees on issues related to health and wellbeing. Further guidance is needed from NICE on how the quality standard will be promoted to employers and employees and how performance against the quality statements will be measured (see answer to question 2)
22	BT		The focus appears to be solely on the role of line managers and employee support and ignores the role of the organisation in the design of 'good work' that promotes employee wellbeing. Efforts need to address promotion, prevention, early intervention and restitution.
23	The Chartered Society of Physiotherapy	Question 1	We welcome this quality standard, in particular the emphasis on making health and wellbeing an organisational priority. However, the quality standard seems to give more emphasis to mental health and wellbeing than physical health. Whilst we recognise that both physical and mental health are equally important, there is little mention of physical health in the Quality Standard, despite the fact that musculoskeletal disorders account for 44% of work-related illnesses, as stated on page 2. Where possible, we would recommend giving examples specific to physical health initiatives in statements 1 and 2, to help make the standard as a whole more balanced.
24	Faculty of Occupational Medicine & Society of	Question 1 Does this draft quality standard accurately reflect	We feel the standards are a good step forward to embedding the role of employee wellbeing into the everyday behaviours and structures of organisations. Whilst we welcome any level of management up-skilling and employers taking a more active leadership role in employee wellbeing, the support structures should be in place for managers to escalate more complex cases where appropriate medical support and advice is needed.

ID	Stakeholder	Statement number	Comments[2]
	Occupational Medicine	the key areas for quality improvement?	
	Guys and St Thomas' NHS Foundation Trust	Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement?	We agree with the quality statement 1 'making HWB a priority' however the key measurable is to have a policy/ strategy which demonstrate the organisation's vision/ objective and the way to achieve it. Such policy will consolidate the organisation's commitment including senior management role, resource allocated and the metric they have identified to measure their success. A second key area is allocation of resources. Appointing a senior manager or including HWB in line managers' JD will not make any difference if they are deprived of resources to develop and implement HWB initiatives in their area. Therefore it is advisable to identify key measurable (e.g. direct funding allocated to HWB as percentage of turn over, % of time given to staff to partake to HWB activities etc) to capture what resources are allocated to HWB. On a more specific note, the draft quality standard is heavily weighted towards stress recognition and management and stress training for line managers. There is no reference to any other of the H&WB factors tabled on page 3 (Table 1 Public health outcomes framework for England 2016-19) which include diet, excess weight in adults, physical activity and smoking. Alcohol seems to have been overlooked and must be included. At GSTT we have also started to look at sleep (with obvious impact on physical and psychological health) and violence and aggression prevention as new addition to our HWB programme. MECC training is currently provided at GSTT for staff which looks at these and provides staff with the skills to have, sometimes difficult conversations about these key H&WB concerns. We are not clear how this aligns with other NICE workplace guidance or the additional value that it adds.
25	Portsmouth City Council	N/A	Q1. This section states that the quality standard is applicable to all employees but then acknowledges that some of the statements will not be as relevant for smaller businesses of less than 50 employees. It is important to note that these smaller SMEs are probably the ones who would benefit the most from support and guidance around creating a healthier workplace for employee wellbeing. Therefore it seems that the quality standard is not necessarily reflecting the key areas for quality improvement around healthy workplaces if it is not made more relevant for smaller organisations.
26	The Royal College of Anaesthetists	Does this draft quality standard accurately reflect the key areas for quality improvement?	Yes. The quality standards are essentially the same as the recommendations in the workplace wellbeing charter developed by Dame Carol Black and seem to cover mental health and wellbeing rather than physical health. Within that remit the aims do reflect important areas for quality improvement. If NICE wish to cover physical health as well this would be a much bigger remit as it would include (amongst other things) all the musculoskeletal elements outlined by stakeholders in the appendix. Having said that we are not sure why NICE need to produce this document given that the aforementioned charter already exists and has a series of tools and standards for organisations to work with. We would agree with the rhetoric of the quality standard although we are concerned that in practice, the standards may not be feasible. Also, the document does not mention that a common cause of stress is disputes in

ID	Stakeholder	Statement number	Comments[2]
			the workplace between colleagues/staff/ staff groups. This is an area that could be mentioned in the draft standard. These disputes cause a lot of stress/absence/ staff leaving/suspended but will have improved outcome if tackled early. We would also add that an important element should be protecting people who raise concerns and it is unlikely that current procedures are sufficiently strong.
27	Royal College of General Practitioners	General	**Does this draft quality standard accurately reflect the key areas for quality improvement?** At present the quality statements are a list of actions and could be improved organisations developing a comprehensive overall plan and specific project action plans by learning from others, which is reviewed annually. The World Health Organisation has recognised five Keys to Healthy Workplaces http://www.who.int/occupational_health/5_keys_EN_web.pdf?ua=1 Key 1: Leadership commitment and engagement Key 2: Involve workers and their representatives Key 3: Business ethics and legality Key 4: Use a systematic, comprehensive process to ensure effectiveness and continual improvement Key 5: Sustainability and integration There does not appear to be specific focus on safety and health at work in the context of an ageing workforce. (MH)
28	Turning Point		Proactive vs reactive support As well as supporting the health and wellbeing of employees (proactive), the importance of defined policies on managing ill-health could also be included (reactive), so support is readily available when people do become unwell. This is especially important for people with long-term conditions. (p11, p12) If this were to be considered, more emphasis could be provided more generally in this standard on how employees take both a preventative and reactive approach to improving the health of employees. This would fit within the introduction to set the scene and support readers in understanding the importance of both approaches in truly supporting employee health and wellbeing. (p1) The management of ill-health, as well as the promotion of good health, is of particular importance when considering our aging population and consequently workforce. Defining health and wellbeing

ID	Stakeholder	Statement number	Comments[2]
			Helpful definitions are provided throughout the document. In order to ensure clarity of meaning prior to someone reading the standards, definitions could be brought to the beginning of the document e.g. definition of health and wellbeing (p9), definition of stress (p16). <u>Stress: recognition, assessment, communication, stigma</u> Despite it being important that line managers are trained to recognise stress and respond to their needs, it should also be considered that people may not always go to, or show signs of stress to their line managers. There could be scope to expand this to also raising organisations/cross-staff group awareness of stress and how to support others. This would also make this quality statement feel less hierarchical. It could be a shared responsibility to be aware of colleagues and know what to do for both others and themselves should stress present as an issue. Reduction of stigma around stress may also reduce should the experience of stress be normalised, shared and understood in the same way by all employees. This may not require training but could be implemented through online resources or as part of team meetings. (p13) To support the ethos of self-management of stress, the "stress risk assessment" could also be made available to all so employees in order to self-assess, in addition to it being used by line managers. (p13) Identification of stress is important, however being able to communicate effectively about stress, whether that be someone elses or your own, requires a certain level of confidence. A requirement for organisations to support, managers in particular, in communicating with employees about stress may enable more helpful and supportive conversations. Confident communication may also support in reduce the stigma of stress and mental ill-health in the workplace. Ill-health affects everyone, therefore experiencing it should be normalised and managing it should be an open process. (p14) An expansion on how stress can be positive would be beneficial to balance out what is noted around the negative effects of stress and ensure a shared understanding that not all stress is bad. (p16) <u>Level of detail</u> There are some areas of this document which were felt could afford to be more specific. It is recognised that there is a balance between setting standards that can be achieved by a very varied number of organisations, however there is a marked difference between the expectations outlined in this quality statement, when compared to the outcomes within the Workplace Wellbeing Charter standards for England. For example the following requirement is included within the statement: "Employers have a named senior manager who is responsible for making employee health and wellbeing a core priority" The explanation of this statement goes on to clarify the indicators that would illustrate the statement but the statement(s) themselves could be more specific for example:

ID	Stakeholder	Statement number	Comments[2]
			"Employers have a named senior manager who is responsible for making health and wellbeing a core priority through a clear and documented strategy and delivery plan" <u>Equality and diversity</u> The draft quality standard refers to four statements which are all worthy of support and are aligned to best practice guidance. It goes on to discuss the importance of equality and diversity in this context and states that health and wellbeing in the workplace "should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English." Given the known challenges of reaching some of these groups , a fifth statement could be useful to target the health and wellbeing support at these groups specifically within organisations.
29	UK Faculty of Public Health		Although the quality standard does accurately reflect key areas for quality improvement, there are some omissions from evidence in related guidance e.g. partnership and engagement of employees, giving consideration to organisational development and creating an environment within which employee's opportunities for autonomy and control are maximised.
	QUESTION 2		
30	Action on hearing loss		The Labour Force Survey provides evidence on the employment status of people with disabilities and sensory loss. The government is also planning to collect data on the number of employers engaged in the Disability Confident campaign (see answer to question 4). Further guidance is needed from NICE on how evidence on health and wellbeing quality measures will be collected, for example evidence from job descriptions and performance metrics for senior managers.
31	BT		SA is an important business measure but insufficient to gauge improvements in Wellbeing. Most organisations do not have valid and reliable wellbeing specific measures in place such as the ONS 4.
32	Guys and St Thomas' NHS Foundation Trust	Question 2: Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?	In a large hospital like GSTT, the systems and structures are largely in place for the collection of data required and it would be feasible to make arrangements for that which currently isn't. The question may not be whether the data can be collected according to the proposed quality measures but whether or not it is meaningful data and can be used as an accurate measurement of the success of workplace H&WB interventions. Historically sickness absence has been used as a surrogate for HWB measurement. However it has been recognised that both sickness absence rate and retention rate are multi-factorial and a host of drivers many of which are not pertinent to health and wellbeing will have impact on them. Therefore the results should be interpreted with caution. One way is to look at trends rather than percentage which to some extent can eliminate the bias but still far from idea. We have developed a new evaluation score card which brings together organisational factors (sickness absence and retention rate) with process (attendance) and outcome (initiative specific, satisfaction).

ID	Stakeholder	Statement number	Comments[2]
			Quality statement 3 appears vague and non specific, would welcome further detail. It gives the impression of being reactive rather proactive. The more positive way to convey message is firstly to make the work environment stress free as far as possible (this is of course a legal requirement under Health and Safety Legislation too) which requires with all stakeholders (managers, staff side, OH, H&S etc) and stress risk assessment may be useful. Secondly the organisation as a whole and line managers specifically should foster an environment that feel empowered to raise concern and not fear of stigma of stress or being weak etc. As for identifying stressed employee, the data needs to be triangulated from line managers (identified through PDR, one to one etc), OH, EAP/counselling, HR (sickness absence/ grievance) and organisation specific outlets.
33	Lancashire Care NHS Foundation Trust		We consider the standards to be measurable, included in 2016/17 national CQUINN, data could be extrapolated from health needs assessments etc. NICE should consider influencing the national NHS staff surveys to match the wording of statement 4.
34	The Royal College of Anaesthetists	Are local systems and structures in place to collect data for the proposed quality measures?	No. Feasibility assessments should not play second fiddle to the implementation for something so important. The data described as needing to be collected would be available within NHS Trusts but might take some trawling to gather together. We are not certain that this would be a priority for many Trusts within the NHS given the financial pressures they are experiencing and are wary of the perceived need for such data. It seems from the process outlined in the document that the gathering of data might take precedence over outcomes. If data is being collected on absenteeism due to stress/ ill-health etc. then YES. However, we are not sure how the data could be collected on diet, weight, activity etc. for an entire workforce. What would be done with collected data, save it and monitor next time?
35	Royal College of General Practitioners	General	**Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?** CQC could make this a Key line of enquiry for their inspections and organisations self assessments to meet their Fundamental Standards of Quality and Safety. These could include: • Health MOTs and Health Checks • Sickness Absence • Stress Management • Smoking Cessation • Weight Management and Healthy Eating • Physical Activity • Mental health • Back and Joint Care (MH)

ID	Stakeholder	Statement number	Comments[2]
36	Turning Point		This does depend heavily on the nature of the organisation and its size and investment in management information and data capture. Robust data capture and analysis can be more of a challenge in larger multi-sited organisations. Data completion is also heavily dependent on competent managers to ensure the relevant information is captured. Additional considerations as follows: On p3 it is noted where this quality standard should contribute towards the wider Public Health Outcomes Framework (PHOF). Although measuring these outcomes directly would be challenging for employers, could more be included in Statement 1 to note that the PHOF should be considered when developing a strategy? It would be helpful to have an example format of a health and wellbeing strategy and the types of metrics which would be deemed appropriate/relevant. (p7) If it doesn't exist we could be a future case study as we are developing a health and wellbeing framework with associated metrics at present. Whilst it may not be in the scope of this standard it may be a future consideration to introduce mandatory publication requirements for organisations on their websites showing how well they meet health and well-being standards in key areas similar to those coming into place in 2017 for equality and diversity.
37	UK Faculty of Public Health		Most organisations will have systems and structures in place to achieve this. However, the extent to which relevant data are collected routinely and the capacity for additional data collection may vary, and some organisations may require more support to implement or maintain these systems/structures.
	QUESTION 3		
38	Guys and St Thomas' NHS Foundation Trust	Question 3: Do you have an example from practice of implementing the NICE guidelines that underpin this quality standard? If so submit your example to NICE local practice collection on the NICE website. Examples of using NICE	Yes. GSTT has an established and popular H&WB programme for staff with an overarching H&WB strategy. NICE guidelines inform both the programme and our H&WB strategy. An example of this will be submitted.

ID	Stakeholder	Statement number	Comments[2]
		quality standards can also be submitted.	
39	Lancashire Care NHS Foundation Trust		NB LCFT have some good examples of a recent project to develop our “People Plan”, this included “Big Engage” events where all staff were encouraged to attend a series of events held to develop this plan.We are happy to showcase / discuss these further.
40	The Royal College of Anaesthetists	Do you have an example from practice of implementing the NICE guidelines that underpin this quality standard?	No, unfortunately not.
41	Royal College of General Practitioners	General	**Do you have an example from practice of implementing the NICE guidelines that underpin this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.** Somerset council offers comprehensive review to workplace health and safety and examine all aspects to identify a wider range of effective solutions http://www.healthyworkplaces.co.uk The EU- OHSA website offers tools and advice regarding healthy workplaces https://www.healthy-workplaces.eu/en/healthy-workplaces-all-ages-e-guide (MH)
42	Turning Point		Yes – statement 1. One of Turning Point’s Assistant Chief Executives leads on health and wellbeing across the organisation. This has been a relatively recent development which has lead to the appointment of a Head of Health and Wellbeing, along with the development of a workplace wellbeing project group. The group follows an employee health and wellbeing framework which has been developed and is aligned in many ways with this quality standard. One of the achievements of these developments to date includes attainment of the London Healthy Workplace Charter (achievement level).
	QUESTION 4		

ID	Stakeholder	Statement number	Comments[2]
43	Action on hearing loss		Employers should already be meeting their requirements under the Equality Act 2010 to make reasonable adjustments if people with hearing loss find it difficult to communicate in the workplace. Senior managers and line managers may also require disability and sensory loss awareness training to ensure they are aware of the importance of early diagnosis and the different forms of support people with hearing loss may need to communicate well (see Recommendation above and comments 3 and 6 below). Action on Hearing Loss conducted a YouGov survey of businesses in April 2016 The YouGov poll revealed that over half (57%) of businesses agree that there is a lack of support or advice available for employers about employing people with hearing loss. We call on employers to engage with the government's Disability Confident campaign as a way to increase their knowledge and understanding of disability in the workplace.
44	BT		1, 2 and 3 – yes. 4 – with significant qualification. The most resource would be required in 3 – LM training. The business case for investing in efforts that will result in improving employees' mental health and wellbeing has been largely established.
45	Faculty of Occupational Medicine & Society of Occupational Medicine	Question 4 Do you think each of the statements in this draft quality standard would be achievable by employers, given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.	As stated above, the appropriate training resources need to be available to organisations to up skill line managers, champions and board level understanding of employee health and wellbeing.

ID	Stakeholder	Statement number	Comments[2]
46	Guys and St Thomas' NHS Foundation Trust	Question 4: Do you think each of the statements in this draft quality standard would be achievable by employers, given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.	The NHS is currently experiencing unprecedented financial pressure and the cost of training and, especially the cost of safely releasing staff to attend training and manage and/or attend staff engagement forums would undoubtedly have further financial implications. GSTT rely heavily on the Trust charity for financial support of their H&WB programme. This is not guaranteed to continue and therefore the case would need to be made to compete for funding for such developments. Other healthcare organisations may not have the luxury of this unguaranteed financial assistance. The financial benefit of HWB programmes is well documented (see Boorman and also NHS Employer regular case studies).
47	The Royal College of Anaesthetists	Do you think each of the statements in this draft quality standard would be achievable by employers, given the net resources needed to deliver them?	Yes - Given the resources required these quality standards could be achieved within the NHS. However, the resources are unlikely to be forthcoming in the current financial climate.

ID	Stakeholder	Statement number	Comments[2]
48	Turning Point		Yes the statement appear achievable, but challenging for smaller organisations or organisations requiring modernised systems/processes or the geographically dispersed. Crucial to influencing employers to get on board with supporting improvements in health and wellbeing is ensuring there is an understanding of how improvements and investment in this agenda will payback in terms of staff engagement, retention and reduced absenteeism and therefore impact on the bottom line. <u>Resources that you think would be necessary for any statement</u> • An accurate way in which to capture sickness absence recording. Depending on the size of the organisation this will differ • Available Occupational Health support and services • Resource to fund an Employee Assistance Programme provider or Cognitive Behavioural Therapy services • Resource to undertake staff surveys or hold and release staff to attend employee forums • Support from representative bodies and protected time to attend health and wellbeing meetings • Funding to continue to provide health and wellbeing support consistently, rather than, for example, it becoming a health and wellbeing week launched with enthusiasm with no further initiatives until the following year • Good practice guidance and/or case studies on effective and valued staff engagement <u>Potential cost savings or opportunities for disinvestment</u> • The use of Occupational Health support from the new Fit for Work service. An expansion of the services available to provide advice to employers. • The use of on-line resources and tools to reach many managers in multiple locations
49	UK Faculty of Public Health		Much of the recommended action is around changes in working practice and culture rather than implementing specific actions. Where actions such as staff training are recommended, smaller organisations may find this more difficult to achieve due to costs.
	QUESTION 5		
50	Action on hearing loss		Yes, organisations may implement the requirements of this quality standard in different ways depending on their size and available resources. For example, in medium and large organisations, a senior manager may need to co-ordinate activities across different directorates, whereas smaller organisations may implement the quality standard more directly through the day-to-day management of employees. Also medium and large organisations may have knowledgeable Human Resources (HR) teams (and sometimes Occupational Health teams) who can advise, this infrastructure is less likely in small businesses.
51	BT		All should be achievable at some level by most organisations. The time and financial resources will be more difficult for smaller organisations but local public health infrastructure should be mobilised in support.

ID	Stakeholder	Statement number	Comments[2]
52	Guys and St Thomas' NHS Foundation Trust	Question 5: It is recognised that some of the quality statements within this quality standard will be more relevant for medium and large organisations (employing 50 or more people) than for micro and small organisations. Is this an accurate understanding?	This is difficult to assess as the management practice and structure may significantly vary between micro and small organisation. Whilst it is expected that there is a senior manager (e.g. the owner of the enterprise) it is not clear whether there is a hierarchical management structure and whether there is proper JD in place. Also there may not be robust HR function in place which means sickness absence and retention are not measured regularly. The type of employees will also influence e.g. micro and small employers may rely on self employed contractors, temporary workers which reduces the likelihood investing in HWB or measuring any outcome. The 4th quality statement refers to forums which may not be suitable for micro or small businesses.
53	The Royal College of Anaesthetists	It is recognised that some of the quality statements within this quality standard will be more relevant for medium and large organisations (employing 50 or more people) than for micro and small organisations. Is	The responsibility should exist regardless of the size of the organisation.

ID	Stakeholder	Statement number	Comments[2]
		this an accurate understanding?	
54	Turning Point		There are challenges to all sizes of organisation. For example large organisations may find the following: • One Senior Manager alone can lead but will need other managers often in multiple locations to also be responsible for the leadership of Health and Wellbeing • Training and support may be difficult to deliver due to the cost of needing to train large numbers of managers often over multiple sites • There is an increased risk of things being done differently by different managers and a challenge to maintain consistency of standards and approaches • Data capture and meaningful usage can be a challenge in a larger organisation • Established systems and culture may have developed which has not always championed health and wellbeing as a priority for the workplace • Communicating with staff in a large organisation can be more challenging even with the use of email and modern technologies. The messages and two-way dialogue can easily be diluted when not delivered face-to face • Extra support is needed to engage with staff in larger organisations to ensure it is not seen as a head office initiative Smaller organisations could find challenges in: • Identifying a suitable lead with the knowledge time and commitment to support the agenda • Funding Employee Assistance Programmes/Cognitive Behavioural Therapy/Occupational Health provision. • May not have access to on-site HR support or guidance in terms of absence management/performance appraisal/staff surveys etc. • Smaller organisations may not have the same level of technology or funding to keep the technology up to date in order to support and monitor health and wellbeing initiatives
55	UK Faculty of Public Health		This is accurate, however smaller organisations can implement guidance and ensure health and wellbeing is part of management structure and engage employees in this. NICE guidance re: mental wellbeing at work - rec 2 suggests that small organisation systems may be more informal. It may be helpful for all employers to understand some key principles which underpin health and wellbeing with some examples, such as the benefits that flexible working may bring in terms of greater control, leading to positive wellbeing, leading to higher productivity etc.
	Statement 1		
56	Action on Hearing Loss	1	We welcome the rationale behind this quality statement. Senior managers have an important role to play in ensuring organisational policies and practices promote the benefits of early intervention and the different forms of support

ID	Stakeholder	Statement number	Comments[2]
			people with hearing loss may need to communicate well in workplace. This includes the provision of reasonable adjustments and also financial support available through the Access to Work scheme. Our research shows that people with hearing loss are less likely to be employed compared to the general population and without appropriate support, people with hearing loss may be risk of social isolation or leaving employment altogether. For more information and a full list of references please see comment 1.
57	Action on Hearing Loss	1	People with hearing loss often struggle get the support they need in the workplace due to poor deaf awareness among senior managers and other staff. For example, our *Hidden Disadvantage*[32] research shows that almost 8 out of 10 survey respondents identified employer attitudes as a major barrier to employment. We recommend rewording the "Data Source" section of "Structure a) Evidence of arrangements for a named senior manager to have responsibility for making employee health and wellbeing a core organisational priority" to include "disability and sensory loss awareness training" as a key source of evidence for measuring quality improvement. For example: "Data source: Local data collection, for example, job descriptions, **records of senior managers undertaking disability and sensory loss awareness training,** minutes of senior management and company policies related to health and wellbeing" We also recommend including "disability and sensory loss awareness training" as a key source of evidence for "Structure b) Evidence of arrangements for implementing an employee health and wellbeing strategy" for example: "Data source: Local data collection, for example, an employee health and wellbeing strategy with metrics and the progress made, **for example records of staff undertaking disability and sensory loss awareness training**"
58	Action on Hearing Loss	1	People with hearing loss may find it difficult to communicate with other people and have an increased risk of other health problems such as anxiety, depression and dementia. There is good evidence that hearing aids improve quality of life and reduce health risks but many people are waiting too long to get their hearing tested. Our research also shows that employers are often unaware of the Access to Work scheme and different forms of support people with hearing loss may need. Early diagnosis and prompt access to employment support are crucial to ensure people with hearing loss are able to communicate well in the workplace. For more information and a full list of references, please comment 1.

[32] Arrowsmith (2014) Hidden disadvantage; why people with hearing loss are still losing out at work. Available at: www.actiononhearingloss.org.uk/hiddendisadvantage

ID	Stakeholder	Statement number	Comments[2]
			With this in mind, we recommend adding the following to the definition of health and wellbeing: "Employees with disabilities and sensory loss may need additional support to communicate well and understand information in the workplace. The Access to Work scheme can provide a grant to help employees pay for assistive equipment and communication support."
59	Arthritis and Musculoskeletal Alliance (ARMA)	Rationale Quality measures: b)	A named senior manager responsible for making employee health and wellbeing a core priority needs to be supported with adequate time given to this aspect of their role and supported by a wider ethos of health and wellbeing within the wider organisation. The 'health and wellbeing' part of the role should not be tokenistic but instead reflect a culture of support, flexibility and empathy. To evidence arrangements for implementing an employee health and wellbeing strategy see section 5.3 'Messages for Employers' of the ARMA position statement on work (page 3) which outlines practical steps for employers to take action to support the MSK health of employees: *'Musculoskeletal conditions are a major cause of sickness absence. No matter what size or type of business you have, you need to be aware of the musculoskeletal health needs of your staff and take action to support musculoskeletal health in your workplace.* *You should:* *1 Audit the musculoskeletal health needs of your staff;* *2 Develop a plan to promote musculoskeletal health of all your employees;* *3 Make reasonable adjustments to support employees with musculoskeletal conditions;* *4 Provide training for your line managers.* *Understanding the potential effects and limitations of musculoskeletal conditions means that, together with the employee, adjustments can be made to improve outcomes for everybody.'*
60	Barts Health NHS Trust	1	The standard as written says that there should be a senior named manager but does not refer at any point to the need to introduce initiatives to support staff wellbeing other than management support It is applicable in so far as it looks at management practices, however it would be useful to link standards to those in the Occupational Health Accreditation scheme "SEQOHS" which requires that OH services in the NHS meet further standards in terms of early intervention, rehabilitation, prevention and health promotion which are all featured in the National CQUIN for 2016/17 and will directly affect improving wellbeing. The core priority of a strategy and plan is good but needs more meat on the bones.
61	British Dietetic Association		• Guidance is needed for employers and managers to improve knowledge how to select and appoint quality providers for wellbeing initiatives. In particular for wellbeing programmes relating to lifestyle change, managers find it difficult to determine who is qualified to give advice and deliver interventions on an individual level. There is potential

ID	Stakeholder	Statement number	Comments[2]
			for poor outcomes and also litigation in relation to possible union/industrial claims if they appoint a provider without, for example, indemnity insurance or who is not regulated by a credible organisation such as the HCPC.
62	BT	Employers have a named senior manager who is responsible for making employee health and wellbeing a core priority	H&S law and practice already requires this. It is not only important to have an accountable officer but also a governance structure throughout the organisation.
63	Bupa UK		We welcome this Quality Standard Statement and the explicit recognition that leadership is a fundamental factor in improving employee mental and physical health and wellbeing. We also believe that this statement is achievable for employers of all sizes and is therefore applicable for all organisations. This is because in order to realise the full potential of employee health, initiatives must be approached strategically and embedded in core business strategy. This approach is needed to ensure that employee health and wellbeing is part of the performance metrics, the priorities that are set, the policies that managers create and the investments that they make. Naming a senior manager with responsibility for employee health and wellbeing, reinforces the view that employee health and wellbeing is a responsibility for leaders throughout the organisation and not just considered to be an activity confined to HR, Occupational Health or individual teams. It can also ensure that health and wellbeing is not only viewed as a perk for leaders, but a consistent, positive approach for all employees. Senior level buy-in and sponsorship is critical in ensuring that the impact of health and wellbeing programmes is measured. In order to create a genuine culture of health and wellbeing in an organisation, all managers, including directors and board members should be able to demonstrate their commitment to health and wellbeing initiatives and lead by example.
64	Central and North West London NHS Foundation Trust	Standard 1: Make health and wellbeing a priority.	This makes sense and is in the NG13 guidance. There is also a national CQUIN on HWB that reinforces the organisational and senior commitment. The various strands all seem to be coming together. Within our Trust HWB strategy sets out vision, actions and long term metrics; we have a HWB working group to establish progress. Our Director of people and Organisational Development is the CNWL director responsible for HWB.
65	CIPD	Statement 1	CIPD welcomes **the Quality Statement 1** to have a named senior manager who is responsible for making employee health and wellbeing a core priority.

ID	Stakeholder	Statement number	Comments[2]
			We support the '**Rationale**' for this statement, and we think that consideration could be given in the final sentence to expanding the outcomes to include '**lowering presenteeism'** [in addition to increasing productivity and lowering staff sickness levels]. It is now considered by some that presenteeism can have equal, if not more, negative impacts on employee and organisational health and wellbeing; presenteeism needs to be recognised and tackled. The 2015 CIPD Absence Management survey found that third of organisations reported an increase in people coming to work ill in the previous 12 months. 'Presenteeism' is more likely to have increased where long working hours are seen to be the norm and where operational demands take precedence over employee wellbeing. Those who detected an increase in presenteeism are nearly twice as likely to report an increase in stress-related absence and more than twice as likely to report an increase in mental health problems. Nearly three-fifths (56%) of those who noticed an increase in presenteeism had not taken any steps to discourage it. The three '**Quality measures'** are relevant and will support an organisation's achievement of the Quality statement. Under b) '**Evidence of arrangements for implementing…etc'** it's absolutely right that, ideally, the goal for an employer is to show evidence of arrangements for implementing an employee health and wellbeing strategy. However, CIPD research indicates a significant gap in employer practice in this area, with just 8% of organisations having a standalone health and wellbeing strategy in support of its wider organisation strategy, although a further 21% have a wellbeing plan or programme as part of its wider people strategy. It could therefore be a more achievable measure to provide a more flexible approach and amend the wording to read '**Evidence of arrangements for implementing a strategic approach to employee health and wellbeing through a standalone wellbeing strategy and/or a wellbeing plan or programme as part of the organisation's wider people strategy.'** Under the '**data source'** for **b),** CIPD research finds that very few employers (just 14%) evaluate the impact of their health and wellbeing spend although this is more likely if they have a well-being strategy or plan (34%). It is essential that employers measure the impact of their wellbeing strategy to demonstrate the business case but there is a need for guidance here on the range and type of key performance indicators needed including health, employee satisfaction and organisational measures. Under '**What the quality statement means for employers and line managers'**, we feel that consideration could be given to including another category of '**Leaders**'. In addition to owning the health and wellbeing strategy, this section could articulate leaders' responsibility for embedding a positive and supportive health and wellbeing philosophy and culture in the organisation to help ensure that employee health and wellbeing is not just an 'add-on' but is a central part of the organisation's day-to-day operations and ways of working. Leaders should also lead on communicating to

ID	Stakeholder	Statement number	Comments[2]
			employees the wellbeing initiatives at work and the behaviour it expects to encourage employees' participation in the health and wellbeing programme and ability to access the appropriate support services when needed. Under '**What the quality statement means for employees'**, we think that consideration could be given to expanding this section to include reference to employees being aware of their own responsibilities for health and wellbeing, and also being aware of the organisation's health and wellbeing priorities, policies and provision. In addition, we feel there could be scope for considering the addition of a further quality measure (d) '**Evidence of arrangements to induct and train all line managers in awareness and understanding of their role in supporting employee health and well-being.'** Although quality statement 2 (covering the role of line managers) refers to employers ensuring that line managers have adequate time, training and resources to support the health and wellbeing of employees, emphasising this as a specific evidence requirement under statement 1 would reinforce and make explicit the accountability requirement of senior managers in ensuring that line managers are trained to be competent and confident in promoting and managing employee health and wellbeing. In CIPD's view, line managers are the crucial link in the chain of any organisation's effective health and wellbeing programme and it is the senior management team's responsibility to develop line manager capability and ensure every manager is trained and educated for this role. CIPD research shows that many line managers are ill-equipped for the people management aspects of their role and most employers do not train line managers in health and well-being areas, with less than one-third (30%) training line managers in managing mental health, for example. NICE Guidance NG13 page 12 paras 1.9.1 and 1.9.3 outline the appropriate scope/content of line manager training for health and wellbeing. The '**data sources'** for this additional 'Evidence' category could include local data collection such as induction and training programmes and guidance for line managers and their content and manager attendance levels.
66	Faculty of Occupational Medicine & Society of Occupational Medicine	**Statement 1**. Employers have a named senior manager who is responsible for making employee health and wellbeing a core priority	**Outcomes: Employee sickness absence rates and employee retention rates.** *"In organisations where health and wellbeing is a core priority, there will be a health and wellbeing strategy or plan"* We would take this one step further and say in large organisations employees would have access to a quality occupational health service. Organisations should also assure themselves of the quality of the service provider. SEQOHS is a well-recognised accredited quality standard in Occupational Health. SEQOHS stands for Safe, Effective, and Quality Occupational Health Service and is a set of standards and a voluntary accreditation scheme for occupational health services in the UK and beyond.

ID	Stakeholder	Statement number	Comments[2]
			SEQOHS accreditation is a formal recognition that an occupational health service provider has demonstrated that it has the competence to deliver against the measures in the SEQOHS standards. *"The type of senior manager depends on the size and type of organisation. For a medium or large organisation (employing 50 or more people) this would usually be a member of the executive team or another manager with significant responsibility within the organisation."* In the cases of large organisations we would expect the senior manager to be at board level and advised by someone with a background in occupational health, such as an Occupational Health Nurse, Occupational Health Physician or occupational health provider company.
67	Hartlepool Borough Council	1	Our only comment would be to consider rephrasing the quality statement from a 'named senior manager' to a 'named member of staff', as the person leading on health and wellbeing does not necessarily need to be a senior manager, as long as they have senior management support. This will give more flexibility to organisations of varying sizes, where senior managers may lack time, resources or knowledge to lead on the agenda, whereas other members of staff may have the enthusiasm and support to lead the agenda very capably. There are many examples from workplaces in the North East for example, as part of the Better Health at Work Award, where 'shop floor' staff or low paid employees have led on the agenda as a 'health advocate' and developed very well into the role.
68	Lancashire Care NHS Foundation Trust		Agree with the statement, however noted health and wellbeing is not only senior managers responsibility, but rather all managers at all levels.
69	The Migraine Trust	**1**	For this quality statement to be effectively achieved additional quality measures need to be put in place. The standard should stipulate that named senior manager must have appropriate training and ongoing support to fulfil the duties required to make employee health and wellbeing a core priority. This may involve outsourcing external, impartial support and training, both for the line manager and employees, where specialist guidance or specific problems occur e.g. health charities, training providers etc. in response to employee/employees needs. Evidence of this arrangements should be included as a Quality Measure.
70	The Migraine Trust	**1**	An additional outcome measure should be added: c) Employee satisfaction rates Data source: Local data collection Data can be collected through anonymised health and wellbeing surveys which can serve to audit health and wellbeing initiatives and measure success (medium to large employers)

ID	Stakeholder	Statement number	Comments[2]
71	NHS Employers		When asked, employers in the NHS said that this statement would be quite easy to measure. It is important to note, however, that sickness absence and employee retention rates are only two elements of the bigger picture r of health and wellbeing, but are not directly related to the named senior manager responsible for health and wellbeing.
72	NHS Practitioner Health Programme	1	Rationale – Sound general principle to raise profile of the issue and support the area for quality improvement. A good first step. However, organisations may vary in the "seniority" of the manager used in this role and it is possible that the role and standard could be diminished if the wrong person is appointed. As this is likely to only be one part of someone's job, their other role may be incongruent with this role, for example a Human Resource Lead may be seen as involved in conflicting areas such as disciplinary or grievance procedures. More guidance on the level and role of such appointees should be provided, as well as clarity on any "conflicts of role". Transparency and supportive organisational cultures are essential if the quality standard is to be effective. The standard can be an important part of this, but on its own cannot deliver such an environment.
73	NHS Practitioner Health Programme	1	Quality Measure A – Local systems should be able to be to demonstrate this. Employees may be concerned about disclosing health – especially mental health or addiction issues – to a Senior Manager, fearing a lack of confidentiality and consequences for employment.
74	NHS Practitioner Health Programme	1	Quality Measure B – Local systems should be able to be to demonstrate this. However the content of the strategy should be agreed with employees and this should cover all employees in all roles within the organisation, different groups may have different perspectives and needs and this should be reflected e.g. doctors can be a hard to reach group to disclose issues about their own health. The strategy needs to be part of a holistic approach to employee well-being and should ensure confidentiality of disclosure, and support for identified needs which does not expose the employee to and stigma (mental health unfortunately often remains stigmatised).
75	NHS Practitioner Health Programme	1	Quality Measure C – Local systems should be able to be to demonstrate this. As above metrics should be sensitive to different group's needs. Policies, procedures and organisational culture need to support individuals without fear or question, whilst sensitively ensuring that patients safety is ensured. NHS staff, and especially clinical staff with mental ill health should be supported and cared for, whilst recognising that their patients – and their safety – needs to be prioritised. Punitive strategies will drive employees away from seeking care and thereby undermine patient safety. Equally the regulators do have a legitimate and important role and balancing this can be difficult but will be essential. By caring for our employees we care best for our patients.
76	NHS Practitioner Health Programme	1	Outcome A - Local systems should be able to be to demonstrate this. A high level outcome that cannot be directly attributed to the appointment of a Senior Manager, perhaps a staff survey could provide a more qualitative insight. Staff absence may be the right action if it means that staff have the support and care to recover their health. Continuing to work when ill may only exacerbate the employees condition and impact on patient care.
77	NHS Practitioner Health Programme	1	Outcome B - Local systems should be able to be to demonstrate this. A high level outcome that cannot be directly attributed to the appointment of a Senior Manager, perhaps a staff survey could provide a more qualitative insight. Retention rate may be a better longer-term indicator of employee well-being, although a "healthy organisation" may

ID	Stakeholder	Statement number	Comments[2]
			encourage employee promotion and so mobility, exit questionnaires may give a clearer indication of what retention is demonstrating. Junior Doctors on rotation well-being would not be adequately captured by this measure as it is.
78	National Rheumatoid Arthritis Society		The named senior manager responsible for employee health and wellbeing should not be a tokenistic role, it should be a well resourced one and receive external scrutiny e.g. from an official at a health and wellbeing board. We suggest that there should be regional workshops on either a compulsory or a heavily incentivised basis to give proper training on issues of MSK, long-term, fluctuating and progressive conditions.
79	The Royal College of Anaesthetists	1	The RCoA and FPM agrees with the statement. Having a senior responsible manager is deliverable in all organisations and is not difficult to measure - it is ordinal. Whether or not they have any real power is another matter. The demands on the NHS are such that this role is likely to significantly conflict with the imposed priorities of the health service. Any person holding such a role must, therefore, be independent of an organisation's executive but be able to hold them accountable, perhaps through the trustees. There is a pressing need to ensure the wellbeing of trained/permanent staff as it does affect clinical service and patient safety. There is a need for a named senior manager at the Trust Board level to be entrusted with this role given that we are faced ever increasing rates of absence due to sickness and stress related illness. That said this person will require support staff to assist them to carry out this role effectively. Hospitals' used to have gymnasiums swimming pools, squash courts etc. in the past. It may be an opportunity to bring back these facilities for employees but this will be difficult to justify given the current financial climate.
80	Royal College of Nursing	1	There is the potential for some confusion in this quality statement (QS) in relation to an organisation's legal duty, under the Management of Health and Safety at Work Regulations 1999, to appoint a '*competent person'* to provide advice on matters relating to the health and safety of the workforce. While the QS is on health and wellbeing there is potential for overlap in responsibility for improving working conditions and in issues such as implementation of work related stress risk assessments.
81	Royal College of Nursing	1	Accident rates would be a useful outcome measure. Long working hours, stress, fatigue, workplace relationships and other factors which make up a poor workplace culture can impact on accident rates.
82	Royal College of Physicians and Surgeons of Glasgow	1,2,3	Data sources, such as Job Descriptions are easily manipulated by adding the duties to the job description – everyone should therefore score 100%. The assessment of progress against such criteria, for example at Appraisal time, is equally easily dealt with in that the item may have been addressed. It would be helpful to consider how effectively progress can be measured.
83	Royal College of Physicians and Surgeons of Glasgow	1	Local data collection of sickness absence rates is subject to abuse by employees, who may certify their own absence for up to 7 days (soon to be 14?). Causes of absence given are also likely to be unreliable – especially in the area of mental health. An employee would be unlikely to admit to, or claim, a stigmatising diagnosis. An employee might, however, choose to declare a diagnosis which might have implications both for their management (and future litigation). "Occupational Stress" is a case in point.

ID	Stakeholder	Statement number	Comments[2]
84	Royal Mail Group		- Having only one senior manager does not seem sufficient. For larger organisations it may not be practical for a manager with an existing portfolio of work to take on the development of a wellbeing strategy as well. I think the statement should clarify whether the senior manager is a champion (showing leadership in this area) or the person who develops the strategy. Perhaps this could read Employers have a senior manager who champions health and wellbeing at all levels of the organisation and a committee (H&W Committee or Board) made of cross functional representatives to develop and deploy a H&W strategy. For organisations of over 1000 people they should be encouraged to invest in a Health and Wellbeing Manager role or HR Business Partner (or equivalent) who leads on H&W for the organisation. - It is not clear how the quality measures will be audited. B) "Evidence of arrangements for implementing a H&W strategy" – this could be stronger – it could just be evidence that a H&W Strategy is in place and actions implemented and achieved. - Outcomes – sickness absence. I recognise this is probably the most easily accessible metric for businesses but it is influenced by a broad range of motivational/behavioural and health factors. The quality statement and the outcome measure seem quite far removed from one another. Perhaps suggest employee survey data – a company could survey employees on how they feel about wellbeing and what programmes they might like to see, in addition to the traditional Engagement Survey data and use of the HSE Management Standards tool. It might be worth encouraging employers to look at developing leading as well as lagging health metrics. It is also worth noting that businesses often measure sickness absence in different ways so will only be compared year on year in house, rather than for industry benchmark. Again this may be different for smaller businesses (for those of us with 130,000 plus employees it may be more complex!).
85	UK Faculty of Public Health		It would be good practice to also include engaging managers and employees in this process. We appreciate that there is a recommendation about employee forums but this is the member of staff responsible engaging staff in the process. See NICE guidance re: community engagement and NICE guidance re: mental wellbeing at work. A key action in the latter document proposes working in partnership with employees and taking a strategic approach which is more ambitious than a named manager. - Recommendation 1 strategic and coordinated approach to promoting mental wellbeing (NICE Mental Wellbeing at work) -
86	UK Faculty of Public Health		Both outcomes should be interpreted with caution, taking into account the relevant context. Low sickness absence rates, for example, may mask high levels of presenteeism among the workforce, and/or punitive sickness absence policies that will in themselves have a detrimental effect on health and wellbeing.

ID	Stakeholder	Statement number	Comments[2]
			Variation in retention rates may reflect the nature of the role (e.g. short-term contracts vs. permanent roles), or the availability of alternative, comparable work in the area.
87	UK Faculty of Public Health		Suggested amendment (addition in italics): The senior manager will lead on initiatives to improve employee health and wellbeing *and engage employees in this process*.
88	UK Faculty of Public Health		May be useful to add that this is a positive concept. See definition in NICE Mental wellbeing at work strategy - 'Mental wellbeing is a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society. https://www.nice.org.uk/guidance/ph22/chapter/1-Recommendations
89	UK Faculty of Public Health		Suggested amendment (addition in italics): In addition, health and wellbeing will be included in all relevant corporate policies, for example *organisational development,* absence and recruitment policies…
	STATEMENT 2		
90	Arthritis and Musculoskeletal Alliance (ARMA)		This is achievable if Line Managers are given adequate support and training by senior employees. Line Managers need to feel confident that they have the skills and knowledge to be able to support an employee with their health and wellbeing. They should be signposted to organisations which can provide advice and support for employees with a particular health condition as well as guidance for the manager. For MSK there are several resources available to support people to remain in and return to work as outlined in the ARMA position statement. The relevant health professionals (physiotherapists, occupational health nurses and occupational therapists) provide skilled support for an employee who needs reasonable adjustments to remain in work.
91	Barts Health NHS Trust	2	Sickness absence rates and employee retention are influenced by far more than line managers actions and robust absence management, levels of engagement, consistently result in better attendance (engaging for success, Mcleod, Dept of Business innovation & skills 2004)
92	British Dietetic Association		• Guidance is needed for employers and managers to improve their knowledge and critical appraisal skills concerning: • 1. the most effective type of programmes suited for their workplace • 2. what outcomes to expect / what should be measured during wellbeing interventions. In addition, guidance is needed on the theory of public health promotion to encourage the adoption of multi-level interventions. Interventions that include higher level environmental components tend to be more cost-effective and are less likely to generate inequalities than interventions using individually focussed components alone. There is strong evidence to support multi-level interventions from systematic reviews, which have consistently found that

ID	Stakeholder	Statement number	Comments[2]
			health interventions addressing both individual and environmental determinants of health are the most effective. (Geaney F, Kelly C, Greiner BA et al (2013) The effectiveness of workplace dietary modification interventions:a systematic review. Prev Med; 57(5):438-47 and Lemon SC, Wang ML, Wedick NM et al (2014) Weight gain prevention in the school worksite setting: results of a multi-level cluster randomized trial. Prev Med; 60:41-7). It should also be noted that multi-component interventions for weight management, such as behaviour change in diet combined with physical activity, are more effective than single component interventions (Shroer et al.Evidence based lifestyle interventions in the workplace-an overview Occup Med (Lond). 2014; 64 (1): 8-12; Ausburn et al. Reviews of worksite weight management programs. 2014; Workplace Health Saf; 62 (3): 122-6; Verweij et al. The application of an occupational health guideline reduces sedentary behaviour and increases fruit intake at work: results from a RCT. 2012; Occup Envir Med; 69 (7): 500-7). Employers and managers need to be critically aware of the evidence base when examining potential workplace initiatives and require direction concerning reputable sources of guidance.
93	BT	Line managers' job descriptions and performance indicators include supporting employee health and wellbeing.	This would be stronger if linked with safety and will send a message about the importance of wellbeing but more will be required to embed a wellbeing culture.
94	Bupa UK		We support the Quality Standard Statement that health and wellbeing should be part of a line managers' role and that these competencies should be identified in job descriptions and performance indicators. Line managers are an important link between their people and the organisation as a whole. There are three domains where manager intervention can be effective: • compliance and health and safety – this is a basic minimum, but one where employers can do more particularly in the area of mental health and the identification of work related stress • absence management and presenteeism – to address the main causes of ill health in each workplace • wellness and the promotion of healthy habits Improvements across these domains, and particularly wellness, have a strong correlation with the levels of engagement from employees. In this capacity, line managers can be effective by reinforcing organisational efforts to engage their people, adding these items to team agendas and one-to-one meetings.

ID	Stakeholder	Statement number	Comments[2]
			Line managers can also ensure that an individual's objectives and their team's are all linked to the organisation's core purpose. An example of this can be that all employees have objectives which set out their own personal health and wellbeing goals, which are then supported but not dictated by the performance management system. Line managers can also reinforce their important leadership role by facilitating open dialogue about the importance of these issues outside of the performance management system. This encourages greater levels of health literacy among their teams. Our view is that the above approaches can be achievable for employers and do not require additional financial resource. However, our experience from working with employers in the UK is that many struggle to know how to prioritise investments to support line managers in this area. Systems to understand trends and data about their own teams, or training programmes and modules to build manager capability to manage these issues will require financial investment and knowledge of what will make the biggest impact. It should be noted that it may be more difficult for smaller organisations to resource access to training or support for line managers in this regard.
95	Central and North West London NHS Foundation Trust	Standard 2: Role of line managers and Standard 3: Identifying Stress	This makes sense and is in the current guidance. Within the Trust we have incorporated a focus on HWB into our training for new managers and are looking to pilot the NHS Employees supportive leadership behaviours training too, - supporting HWB is a central element. We are also investigating the possibility of doing this in conjunction with People at Work, who provide our employee assistance programme (through Occupational Health) which will help to make links through to more formal stress risk assessments etc.
96	Central and North West London NHS Foundation Trust	Statement 2 Role of line managers	The focus on JDs is a bit lame. It is the first place any new issue turns too, resulting in JDs that get ever longer. Is this a solution that delivers the change that's needed.
97	CIPD	Statement 2	CIPD welcomes the Quality Statement 2 relating to the role of line managers, and the rationale for making health and wellbeing a central part of their role. Under '**Rationale**', we feel that consideration could be given to expanding the last sentence to read: "This, in turn, will help to make them feel more content and **able to flag up an issue of concern before it reaches a crisis point, and should enhance engagement and productivity'** [Thus recognising the emerging body of evidence demonstrating the link between improvements in employee health and wellbeing and employee engagement and hence productivity].

ID	Stakeholder	Statement number	Comments[2]
			However, the quality statement focuses on just two aspects of how to embed and develop line management capability in this area – job descriptions and the performance management system. The principle of encouraging accountability for health and wellbeing via performance management is a good one; however, it should be noted that some organisations have moved away from operating formal performance management systems [for example, in favour of more informal approaches based on ongoing feedback to employees] and if an organisation doesn't have a formal PM system it could be difficult to collect the requisite data for this evidence requirement. Also, there could be scope for broadening the quality statement beyond line managers' duties and performance/accountability in relation to health and wellbeing to reflect the importance of the organisation's wider framework for supporting them in this role and providing them with the people management and leadership skills and competencies to support employee health and wellbeing. We recognise that this wider context for line managers' role is reflected in the 'Employers' section of 'What this quality statement means for employers and line managers' with the reference to ensuring 'that line managers have adequate time, training and resources to promote and support the health and wellbeing of employees', but expanding the quality statement 2 to reflect this wider organisational context would recognise the health and wellbeing and competency requirements of line managers themselves who have a challenging role in this area. Under '**Outcome**', we feel that these could be expanded beyond the measure of sickness absence and employee retention rates to take on board a more holistic set of benchmarking data relating to the role of line managers in supporting health and wellbeing including, for example, employee satisfaction and /or engagement rates. The local data collection sources could include the results from employee engagement and/or attitude surveys and exit interviews/separation questionnaires. CIPD also provides twice-yearly 'Employee Outlook' survey report that is representative of the UK workforce and tracks employee motivation and satisfaction rates over time, so this data source could provide a useful benchmark for employee attitude and engagement levels. Under **b) 'Employee retention rates'**, as well as local data collection for the data source, CIPD produces an annual Resourcing and Talent Management survey report – this survey provides data on organisations' employee retention and staff turnover rates, including voluntary resignation rates by broad sector, against which employers could benchmark their own staff attrition levels. Under the section '**What the quality standard means for employers and line managers'**, for '**Line managers**', we feel that it could be helpful to expand this paragraph on putting their role into practice beyond how they manage employees and design jobs and person specifications. For example: reference their role in effective attendance and absence management including effective return to work such as liaising with other professionals eg occupational health and HR to manage employee health and rehabilitation; ensuring their own management style is open and

ID	Stakeholder	Statement number	Comments[2]
			supportive and promotes healthy relationships; consulting employees on changes that could impact on health and wellbeing; being proficient in commissioning/carrying out stress risk assessments and monitoring workloads and working hours in their teams; awareness and understanding of policies and provision related to health and wellbeing. Under '**Supporting employee health and wellbeing'**, we feel that consideration could be given to adding a further bullet point to read: • '**Being able to spot the early warning signs of stress and/or mental health problems in employees and being able to signpost them to appropriate support services**.'
98	Faculty of Occupational Medicine & Society of Occupational Medicine	**Statement 2**. Line managers' job descriptions and performance indicators include supporting employee health and wellbeing.	**Outcomes: Employee sickness absence rates and Employee retention rates.** *"They ensure that line managers have adequate time, training and resources to promote and support the health and wellbeing of employees."* This is a welcome standard and would highlight the need for managers to support good safety management, a good work environment, sensible hours, fairness, suitable adjustments for those that need them, flexible working, and good attendance management interviews etc. FOM and SOM would be happy to support this by providing input for any online training for line managers to raise the awareness of risk factors and behaviours to enable managers to better identify when employees are struggling. Alternatively, we could look into providing training sessions and webinars for managers with an introduction to Occupational Health and some of the prominent concerns, like stress and musculoskeletal disorders.
99	The Migraine Trust	**2**	As per comment number 1 an additional quality measure in relation to the training and support of line managers is needed. Evidence that line managers are provided with ongoing training and support to update their skills and knowledge in relation to supporting employee health and wellbeing should be required. This should stipulate that this support and training may need to be outsourced from an external provider and will need to be reactive to employee/employees needs rather than simply routine e.g. immediate access to support/training.
	NHS Employers		Employers in the NHS said that health and wellbeing could be included in line manager job descriptions and in a number of organisations this is already the case. Measurable objectives would be key to ensure that managers are being measured against this. . The outcome of sickness absence rates may not be a fair measure, as different staff face different pressures, such as increased violence and aggression in certain areas. It is important that performance indicators are used to measure this. It is also suggested that an outcome might be the number of line managers attending a supporting leadership and management behaviour training to reinforce the need for the provision of robust training for line managers.

ID	Stakeholder	Statement number	Comments[2]
100	NHS Practitioner Health Programme	2	Rationale – Sound general principle to raise profile of the issue and support the area for quality improvement. However, the line managers role could be seen to be conflicted; on the one hand they assess performance and outcomes and on the other are supporting well-being, do they have the skills to do both and does the employee have the confidence to see them as both? It may be difficult for a Senior Manager or Clinician to confide in a peer even if this is someone has a line management role to the employee. The line manager role relies on a cascade of good management, but if one line manager does not fulfil the role properly then the chain breaks, what happens then? Is their provision for "external" or "independent" support for well-being to catch those who cannot achieve the standards aims through their line management?
101	NHS Practitioner Health Programme	2	Quality Measure A – Local systems should be able to be to demonstrate this. However, the measure can be seen to be just "on paper" and the outcome of reduced sickness absence rates is a proxy as it is just one factor and cannot be directly attributed to the measure. What does "supporting employee health and well-being" mean in practice; clear systems, a transparent and open culture and associated funding is needed to make this meaningful.
102	NHS Practitioner Health Programme	2	Quality Measure A – Local systems should be able to be to demonstrate this. However, again the measure can be seen to be just "on paper" and the outcome of reduced sickness absence rates is a proxy as it is just one factor and cannot be directly attributed to the measure.
103	NHS Practitioner Health Programme	2	Quality Measure B – Local systems should be able to be to demonstrate this. However, the measure can be seen to be just "on paper" and the outcome of reduced sickness absence rates is a proxy as it is just one factor and cannot be directly attributed to the measure.
104	NHS Practitioner Health Programme	2	Outcome A – Local systems should be able to be to demonstrate this. However, the measure can be seen to be just "on paper" and the outcome of reduced sickness absence rates is a proxy as it is just one factor and cannot be directly attributed to the measure.
105	NHS Practitioner Health Programme	2	Outcome B – Local systems should be able to be to demonstrate this. However, the measure can be seen to be just "on paper" and the outcome of reduced sickness absence rates is a proxy as it is just one factor and cannot be directly attributed to the measure.
106	National Rheumatoid Arthritis Society		A culture of looking out for the wellbeing of staff is one we will always support. As the first port of call for employees seeking support, the role of the line manager is vital.
107	Portsmouth City Council	2	Q2. Again some examples of performance indicators would be useful here alongside link(s) to a stress risk assessment tool to support the process of data collection. From experience, gaining buy-in from organisations requires a strong evidence base with specific examples of what could be done to make their workplaces healthier.
108	The Royal College of Anaesthetists	2	No. The Line Manager topic is the area that we have identified as our biggest concern. Line managers or clinical directors are already stretched and this will load additional burden on their busy schedules. Furthermore it is recognised that managing a sick individual (through no fault of their own) can take up a lot of time and effort. We feel that there should be an experienced and dedicated individual nominated or appointed exclusively for this purpose.

ID	Stakeholder	Statement number	Comments[2]
			This would also limit or eliminate any conflict of interest accusations. Including health and wellbeing in Job Descriptions is irrelevant in many organisations. The role of the line manager is to drive productivity and in the NHS this is set against unmeetable demand and gross under resourcing. The line managers live or die on their success and many have their own health and wellbeing severely comprised by those who manage them. The pressures on colleagues in NHS managerial roles is now overwhelming. The standards can be aspirations but are unlikely to become a reality whilst central control is driving savings of £22billion over the next 4-5 years. Having your Line Manager who is responsible for hitting targets/patient waiting-times in ED, waiting times for OPD, numbers of patients seen in OPD, discharge of patients from hospital etc. also 'supporting employee health and wellbeing', and trained to recognise stress etc. seems to be to be a non-starter', even if their performance indicators are these. Line Managers often know people are stressed/stretched but often there is not much they can or want to do about it, if they want the department or service to hit targets and they see their job as just getting people to do more with less resources - as their bonus depends on. We are unsure how Line Managers can facilitate people to temporarily reduce their workload. One person's reduced work-load often means someone else picks up an increased work-load.
109	Royal College of General Practitioners	Statement 2 and statement 3	The RCGP agrees that line managers should receive training and make employees' health and wellbeing priorities. Some employees feel stressed because of the attitude of their line manager and a fear of being discovered as having mental health problems. Perhaps training would help recognition and the stigma. (JA) (AR) Although the Government website GOV.UK clearly states that "Employees only need a fit note from a doctor after 7 days off work sick", many employers have informal policies in place which require employees to produce notes signed by doctors for shorter periods, including just 1 day of sick leave. As well as causing distress to employees who have to fill in these additional forms, it is also creating increased demand in general practice, which is already under strain nationally. As part of statement 2, explicit mention of adhering to national sickness reporting policy should be an important part of the duty of line managers. (AR)
110	Royal College of Nursing	2	We warmly welcome the reference to employers ensuring that line managers have the time, training and resources to promote and support health and wellbeing of employees. This is a particular challenge within the health sector. The health and wellbeing of employees should include the mental and physical health as well as supporting those with visible and non-visible disabilities.

ID	Stakeholder	Statement number	Comments[2]
111	Royal College of Nursing	2	Consistency of language: some sentences refer to '*protect and support'* employee wellbeing while others say *'promote and support*'. We would suggest using all three words in a consistent manner.
112	Royal College of Nursing	2	As suggested earlier, 'accident rates' would be a useful outcome measure.
113	Royal College of Physicians and Surgeons of Glasgow	2	The role of Line Managers indicates that "Making health and wellbeing a central part of their role will help ensure that they make employees feel valued and supported". True, but it is well to remember that we all have duties in our place of work. In particular, the HSE takes the view that the primary responsibility for the health and safety of employees is down to employers, but that workers also have a duty for their own health and safety and that of others who may be affected by their actions at work. Workers must co-operate with their employers and co-workers in this respect to help everyone meet their legal requirements.
114	Royal Mail Group		- As well as evidence of job descriptions (where wellbeing may be implied through people management tasks and not directly mentioned) it may be worth suggesting looking at line manager induction training for new managers or continuous professional development training that some organisations may require their managers to complete. Embedding wellbeing into these reinforces the business commitment to support line managers to support their teams. - Perhaps the Statement could be less prescriptive perhaps this is a softer alternative – "Line Managers are trained and required to support employee health and wellbeing." - Surely all Line Managers have a legal duty under the HASAWA and MHSWR to look after the health of employees – so perhaps it is worth reiterating the legal duty line managers have as well as the ethical and good management angles. - Manager awareness is also important – just because something is in a job description does not mean a manager will act on it. If it is part of their performance appraisal and a goal they have to report on then they will. Especially if they are given training and it is clearly communicated why they need to support H&W. - I would add in Employee Engagement Survey data as a possible measure of success if companies measure it.
115	UK Faculty of Public Health		We advise caution that this indicator could potentially be misapplied or misinterpreted and managers. It will be important to emphasise that this is about promoting positive wellbeing or manager may feel that they are likely to be penalised for identifying staff who have poor health - particularly with emphasis on sickness absence as a quality indicator. It would also be better practice if this was a two way process and line managers provided feedback about issues identified by employees which require organisational changes.

ID	Stakeholder	Statement number	Comments[2]
			- See rec 2 in Mental wellbeing at work: What Action should be taken -Ensuring systems are in place for assessing and monitoring the mental wellbeing of employees so that areas for improvement can be identified and risks caused by work and working conditions addressed.
116	UK Faculty of Public Health		Expectation that managers will gain feedback from employees for improving health and wellbeing. See previous note.
	STATEMENT 3		
117	Arthritis and Musculoskeletal Alliance (ARMA)		To ensure adequate data collection simple measures can be incorporated into the workplace with regular 'catch ups' between staff and managers that can include a reflection on workload and perceived stress levels. Employers can put practical steps in place to help improve employee's mental health, e.g. as outlined in the Mental Health toolkit for Employers.
118	British Dietetic Association		• Lack of knowledge - Line managers should understand that the relationship between common mental health disorders such as depression and anxiety and obesity is complex. Obesity can lead to common mental health disorders, and people with such disorders are more prone to obesity. Both disorders share similar symptoms such as sleep problems, sedentary behaviour and poorly controlled food intake. There is growing evidence to suggest that good nutrition is just as important for mental health as it is for physical health (Gatineau M, Dent M (2011) Obesity and Mental Health. Oxford: National Obesity Observatory) and that a number of conditions, including depression, may be influenced by dietary factors. Assisting people to effectively manage stress may have a positive impact on the ability to control both mood and weight. Wider knowledge of this may assist managers in selecting appropriate sources for external support when stress is identified.
119	BT	Line managers are trained to recognise when employees are experiencing stress and respond to their needs.	This should not be limited to 'stress' but cover the range of mental health and wellbeing. Line managers need to be able to recognise the continuum from signs of distress to more severe indicators, look at whether work is a causal factor, and support the individual to address root causes and obtain appropriate timely support. There are well established training courses for line managers (Mental Health First Aid is the best known but is not unique or necessarily the most appropriate for a given organisation) - there are also several stress risk assessment tools including the one produced by the HSE (again guidance shouldn't be prescriptive).
120	Bupa UK		We agree with this Quality Standard Statement. We also agree that this is one of the key areas for quality improvement given the weight of evidence that suggests line managers often feel discomfort at taking a hands-on approach to enquiring or supporting the health of their people.

ID	Stakeholder	Statement number	Comments[2]
			Our experience from working with employers in the UK is that many struggle to know how best to support line managers, how to identify hot-spots, influence culture change and prioritise financial investments. Training modules should include an understanding of the range of mental and physical health and wellbeing issues that might affect their people and the ways in which they might be able to provide or sign post support for those that need this. The business and financial benefits of early intervention in situations where employees report absent due to work related stress are important factors in managing employees. At a systems level, an organisation can provide easy access for line managers to a comprehensive range of interventions intended to support health and wellbeing. This should be accompanied by clear and detailed information about how employees can access these services. This information should back up a manager's capabilities so that when dealing with a distressed employee, they can feel confident in asking the right questions that will lead to the right care pathways and outcomes. Our experience is that organisations often struggle to join up the services they offer into a coherent package that the manager and employee can navigate. An important consideration for line manager support is to ensure that training is provided through mechanisms that suit the type of working environment in which people operate. Similarly, there needs to be recognition that the most appropriate way to deliver training may vary according to job role and location of the workforce within an organisation. In Bupa's experience, we have found that for our people working in our care homes, programmes which review managers' skills and development have the greatest impact when delivered in short interventions of less than three hours, so that these can be delivered on-site and online, while fitting in with managers' day to day work patterns.
121	CIPD	Statement 3	The draft NICE quality standard on healthy workplaces refers to improving employee mental and physical health and wellbeing and we welcome this holistic approach; however, **quality statement 3 Identifying stress** focuses on managing stress only and we believe it could be helpful to broaden this statement to include specific provision on mental health as well. A mentally healthy workplace relies on having provision to support the mental health risks and needs of employees beyond work-related stress. NICE Guidance PH22 Mental wellbeing at work [p.7] helpfully points out that 'prolonged stress is linked to psychological conditions such as anxiety and depression as well as physical conditions such as…etc' While it's helpful to point out the potential link between stress and poor mental health, particularly if an individual has a pre-existing mental health problem, it is possible to experience stress without experiencing poor mental health and vice versa. Promoting good mental health and supporting employees when they experience poor mental health goes

ID	Stakeholder	Statement number	Comments[2]
			beyond an employer's ability to manage work-related stress although the two areas can be inter-related. CIPD research and other evidence shows that many employers lack knowledge and awareness about stress and mental health issues and it could be helpful to explain both [and their potential relationship to each other] in more depth in this quality statement. Quality statement – suggest including reference to poor mental health throughout so: '**Quality statement 3: Identifying stress and poor mental health'** **'Line managers are trained to recognise when employees are experiencing stress or poor mental health and respond to their needs.'** **Rationale:** insert '**or poor mental health**' at end of first sentence. **Structure a):** Suggest adding '**and/or poor mental health'** after 'stress' in sentence Suggest adding a further section **d) Proportion of line managers who are trained to understand mental health issues and how to support someone with mental health issues, for example in handling disclosure.** Under 'What the quality statement means for employers and line managers', under '**Employers**', suggest including '**and/or experiencing poor mental health'** at end of first sentence. Ditto for '**Line managers'** section. Under '**What the quality statement means for employees'**, we suggest adding another sentence after first sentence: '**This should include being able to approach their line manager to have an open conversation and raise difficult and/or personal issues about their mental health.'** Under **'Definition of terms used in this quality statement: Stress,** we suggest amending the definition of stress in line with the HSE Management Standards – ie '**the adverse reaction people have to excessive pressures or other type of demand placed on them at work.'** It would also be helpful in this '**Definitions'** section to have a definition of mental health and outline the potential relationship, as well as the differences, between poor mental health [particularly common mental health problems] and stress. This should include reference to the fact that we all have mental health, and explain the spectrum of poor mental health conditions.

ID	Stakeholder	Statement number	Comments[2]
			We also feel it could be helpful to mention the importance of having an **inclusive and open culture** at work that supports disclosure of a mental health problem. CIPD research shows that well under half (44%) of employees would feel confident disclosing unmanageable stress or mental health problems to their current employer or manager. Creating an open culture around mental health is the first fundamental step in raising awareness about mental health issues and fostering an environment where people feel comfortable to disclose their own experience of poor mental health: if individuals don't disclose their mental health problem at work, they will not receive any organisational support if it is available. Reference to this aspect could be included under **What the quality statement means for employers and line managers'**
122	Faculty of Occupational Medicine & Society of Occupational Medicine	**Statement 3**. Line managers are trained to recognise when employees are experiencing stress and respond to their needs	**Outcome: Identification of stress in employees and support for employees experiencing stress.** *"Proportion of line managers who are trained to use a stress risk assessment to identify and respond to sources of stress"* We would need to see the stress risk assessment, but would expect suitable input from Occupational Health Psychologists into any framework. Ultimately a stress risk assessment doesn't replace the insight from managers understanding their team and engaging them on a day to day basis and exhibiting best practice as line managers, managing individuals' workloads, engaging employees and responding to concerns. Line managers would need to be confident in understanding what services they can offer to a distressed employee and the best ways to support them or refer them.
123	The Migraine Trust	**3**	External supervision for the line manager can ensure that their health and wellbeing, in particular their mental health and ability to manage stress, is supported particularly when supporting employees with health conditions. Evidence of arrangements for external supervision for line managers should be in place as a specific quality measure.
124	NHS Employers		Employers suggested that this could be measured by the number of managers trained to interpret stress risk assessments plus the number of stress risk assessments completed locally. This could also be measured by the number of managers trained to recognise stress in their team.
125	NHS Employers		Employers felt that there needs to be a greater focus on the causes of stress, particularly issues identified within an organisational culture, such as bullying and harassment.
126	NHS Practitioner Health Programme	3	Rationale – Sound general principle to raise profile of the issue and support the area for quality improvement. However, being trained in identifying stress does not mean that a manager has the skills to implement the training. If the manager is themselves stressed they may not be able to identify the stress in others. Equally the needs of the employee may be beyond the manager – they may need professional mental health, physical health or other advice (such as financial or life coaching). Identifying this need - even assuming that the manager can be trained to do so -

ID	Stakeholder	Statement number	Comments[2]
			is not enough if the need cannot then be supported and the employee enabled to deal with the issues. This may require funding.
127	NHS Practitioner Health Programme	3	Quality Measure A – Local systems should be able to be to demonstrate this. However, the measure can be seen to be just "on paper" and the outcome of reduced sickness absence rates is a proxy as it is just one factor and cannot be directly attributed to the measure. Recognising stress in others is a complex skill, and importantly being able to then engage with the employee and support appropriate action to address the stress is essential. Even assuming that the training is able to deliver this, will the services and support be available to follow up on individual needs?
128	NHS Practitioner Health Programme	3	Quality Measure A – Local systems should be able to be to demonstrate this. Again this is a quantitative measure not a qualitative one. It could be seen to "tick the box" but it does not ensure that the managers are properly trained and skilled and themselves supported in necessary subsequent actions.
129	NHS Practitioner Health Programme	3	Quality Measure B – Local systems should be able to be to demonstrate this. Again this is a quantitative measure not a qualitative one. It could be seen to "tick the box" but it does not ensure that the managers are properly trained and skilled and themselves supported in necessary subsequent actions.
130	NHS Practitioner Health Programme	3	Quality Measure B – Local systems should be able to be to demonstrate this. Again this is a quantitative measure not a qualitative one. It could be seen to "tick the box" but it does not ensure that the managers are properly trained and skilled and themselves supported in necessary subsequent actions. Is there sufficient resource within the organisation to deal with the issues cited e.g. excessive workload, financial worries, work-home conflict or family issues.
131	NHS Practitioner Health Programme	3	Quality Measure C – Local systems should be able to be to demonstrate this. Are there sources of support inside and outside the workplace? The NHS has long waits for talking therapies and services that support individuals with stress, so what else can be provided? One suggestion could be on-line CBT solutions with organisations providing funded access.
132	NHS Practitioner Health Programme	3	Quality Measure A – Local systems should be able to be to demonstrate this. Stress, and mental Health generally, are often stigmatised, individuals may be reluctant to acknowledge that they are suffering with stress. By actively – but in correctly or heavily headedly – engaging with an individual about their stress, managers could actually increase the levels of stress within the organisation and resistance to support through fear of stigma and the potential impact on an employees work position.
133	NHS Practitioner Health Programme	3	Quality Measure B – Local systems should be able to be to demonstrate this. What is the support on offer? How do employees know that their health issues will be addressed and not unfairly conflated with performance issues and employment status. To admit to mental health issues (such as stress) may feel to the employee as if they are admitting failure and inviting manager/HR to criticise their ability and competence to full fill their work role. Denying it could just increase the stress and make the situation worse.

ID	Stakeholder	Statement number	Comments[2]
134	Relationships Alliance		While we acknowledge that the items listed in each of the first two paragraphs of page 14 ("the internal and external causes of stress such as excessive workload, financial worries, work–home conflict or family issues") derive from section 1.9.1 of NICE Guideline 13 on Workplace Health, we believe that this list should be expanded to make explicit mention of 'relationship difficulties with a partner or spouse'. The use of the term 'family issues' in the current wording is too vague, in our view, since it will not sufficiently communicate to line-managers the fact that relationship problems are a significant source of stress which they should be prepared to recognise and respond to (for example through the provision of couple therapy/relationship counselling/coaching, online support or other relationship support within EPAs). The fact that the training which line managers are sent on may well cover relationship difficulties with a partner or spouse does not mean, in our view, that it is acceptable to leave these particular kinds of difficulties unmentioned explicitly in the quality standard itself. Given that this quality standard is 'expected to contribute to improvements in wellbeing of employees and sickness absence rates, we believe that it should explicitly mention 'relationship difficulties with partner or spouse'. Supporting evidence • 18% of all adults are in relationships which could be characterised as 'distressed' – i.e. one with a severe level of relationship problems, which has a clinically significant negative impact on partner's wellbeing, according to data gathered recently by Relate (Relate, 2016 https://www.relate.org.uk/sites/default/files/relationship_distress_monitor_0.pdf) • The overlap between relationship distress and depression is very high (for example, 70% of all clients accessing Tavistock Relationships couple therapy service have mild, moderate or severe depression (Tavistock Relationships, 2016 - http://tavistockrelationships.ac.uk/news/press-release/911-nhs-therapy-london-couples) while research shows that people in distressed relationships are three times as likely to suffer from mood disorders (e.g. depression), and two-and-a-half times as likely to suffer from anxiety disorders as people who do not experience such relationship distress (Whisman, M.A., Uebelacker, L. A. (2003) Comorbidity of Relationship Distress and Mental and Physical Health Problems. In Snyder, D. K., Whisman, M. A. (eds.) Treating Difficult Couples, Guilford Press), this particular stressor warrants being named explicitly in the Quality Standard. •

ID	Stakeholder	Statement number	Comments[2]
			• Work engagement (defined as 'a positive work-related state of fulfilment that is characterised by 'vigour, dedication, and absorption'') and relationship quality are positively associated with each other (One Plus One, 2016 - http://www.oneplusone.org.uk/wp-content/uploads/2012/05/HHPW-full-report.pdf). A further review of the evidence indicates that conflicts between couple/family relationships and work have been associated with lower job satisfaction, self-rated work performance and manager-rated work performance. This suggests that when couple and family relationships conflict with work, work outcomes may suffer. This may come about through factors such as reduced concentration or work absences. The interactions between an individual's personal life and work life are not always direct. Poor relationships may impact upon work outcomes indirectly through associations with stress, health problems, depression and psychological strain (Braybrook, D., Coleman, L., Houlston, C., Martin, A., & Green, H, 2015. Improving work outcomes: the value of couple and family relationships. OnePlusOne). • The link between good couple/family situations and work is also supported by the concept of skill transference, whereby skills learned and/or practised in the couple/family domain might be utilised at work, to improve work outcomes. For example, learning how to recognise and respond to emotions in couple and family relationships can be important in improving working relationships, particularly between supervisors and their employees. Communication in couple and family relationships is also linked to work outcomes. Constructive ways of communicating within a couple relationship is associated with less conflict between work and family, and is related to greater relationship satisfaction. This suggests that good couple communication benefits work as well as relationships (Braybrook et al., 2015). <u>Developing a training response</u> The OnePlusOne study referred to above built on the established link between relationship quality and overall wellbeing. From a survey completed by over 2,000 employees in the UK, the collaborative study reported a strong positive association between relationship quality and work engagement – essentially that high levels of work engagement are predicted by high quality relationships (and vice-versa), just as low levels of work engagement are predicted by low quality relationships. This link, operating as a cycle of reinforcement, persisted even when a whole host of additional factors were controlled for such as gender, sector of employment, levels of seniority, etc. (Burnett et al. 2012). Building on this research, OnePlusOne developed an innovative training programme, Brief Encounters® Skills & Training (BEST), to provide line managers with skills and knowledge to effectively support their staff with relationship and family issues.

ID	Stakeholder	Statement number	Comments[2]
			The objectives of BEST are: • To demonstrate how supporting employees with family and relationship issues can enhance performance, engagement, and productivity • To recognise line managers' responsibility for the health, safety, and well-being of their team within their Duty of Care • To identify how to use the Brief Encounters® model to support staff with relationship and family issues • To practice the key listening and questioning skills required and receive feedback. Awareness of such training and other ways employees can be supported during relationship difficulties (such as awareness of and signposting to relationship support services) may offer an important way to improve overall employee well-being and we suggest should be included in the NICE guidelines.
135	The Royal College of Anaesthetists	3	Yes; but easier said than done. This may be applicable in small organisations. Line managers in the NHS have little or no contact with individuals and are thus, even if they are suitably trained and appropriately sensitive, not in any sort of a position to spot stress in the vast majority of those for whom they have nominal responsibility. We agree that appropriate training should be provided to recognise signs of stress such as deteriorating performance, absences etc. The manager should be a senior person for obvious reasons; but despite systems in place one has to recognise that some may slip through the net.
136	Royal College of Nursing	3	We would like to see this statement widened beyond stress to encompass mental health issues and the promotion of positive mental health at work (including supporting those with mental health issues). This QS is too focused on individual level rather than collective level interventions to reduce stress. Employers should carry out proactive stress risk assessments (preferably using the HSE's management standards) to identify work related causes of stress in all the workforce and put measures in place to reduce the impact on all employees. These should be regularly reviewed especially in case of organisational change. There is a place for individual risk assessments but this should not be in place of collective risk assessment. We are coming across an increasing number of organisations who are implementing individual level interventions such as resilience training rather than looking at addressing the work related causes of stress. This QS must be in line with the recommendations in the NICE NG13 and PH22 guidance. We consider it needs rewording in order to link with the source and recommendations from the guidance.
137	Royal College of Physicians and Surgeons of Glasgow		The concept of a Quality Standard for improving employee mental and physical health and wellbeing is to be applauded, but is not without pitfalls. The duties and measures outlined here should be fundamental aspects of the role of all managers, and are intrinsic to the role, not additive to it. It is therefore essential that managers receive the training and preparation, well described in Statement 3, prior to appointment, and do not have to learn it by osmosis when in service.

ID	Stakeholder	Statement number	Comments[2]
138	Royal College of Physicians and Surgeons of Glasgow	3	This statement is the nub of the whole issue. It explains that line managers should be trained to recognise stress, and should be in regular contact with the employees for whom they are responsible. These are cornerstones of good management, but are intrinsic to management, not additional. These issues are part of the correct training and preparation of managers and should not be learned the hard way, once appointed. A poor manager who has had lots of (documented) training may well be outperformed by an intuitive manager who has had much less formal preparation, but has much greater empathy with employees.
139	Royal College of Physicians and Surgeons of Glasgow	Data	Data on issues such as staff turnover and sickness absence are indeed key indicators of the health of a group. They are best used in helping the group monitor its own improvement (or deterioration) over time, and perhaps to compare similar groups (or even to encourage competition between similar groups). These data should not be used to compare dissimilar groups or enterprises, or even similar groups in different geographic loci., as other factors may well confound such a comparison.
140	Royal Mail Group		- Could this statement be widened to include mental wellbeing? For example: Line managers are trained to support mental wellbeing of employees, especially through recognising if they are experiencing stress. - Larger organisations may be doing a lot in the area of mental health but not specific to stress. We are training managers in Line Manager Mental Health First Aid, we have an EAP and OH, and we are launching new Stress Guidance in addition to this but all of the programmes overlap. But not all companies will do all of these and perhaps a more general statement might make this more accessible to businesses. - Outcome a) the identification of stress in employees – other data could include OH, EAP, HSE or stress risk assessment data. - Outcome b) support for employees experiencing stress – does this mean how many programmes does an organisation have or how many people in the organisation access the support that is available? Just having a programme in place is meaningless, companies need to be able to show that it is utilised. - What the quality statement means for employers and line managers – in the section on Line Managers – Line Managers "also trained to develop workplace solutions to reduce the risk" – I would suggest changing this to line managers are trained on how to access programmes, signpost employees to appropriate support, or develop workplace solutions…". Larger organisations may not want line managers developing new programmes when existing ones are available.
141	UK Faculty of Public Health		Suggested amendment (addition in italics): Line managers are trained to recognise when employees are experiencing stress, *support them* and respond to their needs.
142	UK Faculty of Public Health		May be better to change the order so that b is first, as b is more general about internal and external causes of stress.

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143	UK Faculty of Public Health		Would like to see an additional outcome - c) identification of any organisational change issues.
144	UK Faculty of Public Health		Note: While the quality standard clearly states that stress may lead to mental or physical health problems, in practice there is often a tendency to label all mental health problems as 'stress'. An employee who has chronic anxiety or depression, for example, may have very different support needs to one that is experiencing reactive stress related to their work.
	STATEMENT 4		
145	Action on Hearing Loss	4	We recommend adding the following to the definition of health and wellbeing: "Employees with disabilities and sensory loss may need additional support to communicate well and understand information in the workplace. The Access to Work scheme can provide a grant to help employees pay for assistive equipment and communication support". For more information, please see comment 4
146	Action on Hearing Loss	4	We welcome the recommendations in this section. Under the Equality Act, employees have the right to expect reasonable adjustments if they find it difficult to participate in organisational decisions or practices due to their hearing loss. Employees with hearing loss may need colleagues to follow simple communication tips such as speaking clearly and ensuring their lip movements are clearly visible. People who use hearing aids may benefit from a hearing loop system which makes speech clearer by reducing background noise. A qualified communication professional, such as a speech-to-text-reporter or BSL interpreter should be provided to everyone who needs one.
147	British Dietetic Association		Weight bias - Whilst weight is often chosen as a proxy for health, it is generally recommended that programmes focus on wellness. Use of scientific literature in communications which rely on medical terminology such as overweight and obesity may create a stigma and prejudices associated with overweight and obesity rather than improvement in health and wellbeing. This could be detrimental in a workplace where weight bias can already be prevalent and fuel a bullying culture undermining team-based workforces and attempts at employee engagement. A focus on measures including 'change of feeling' and quality of life factors may be more appropriate and potentially more successful for a cohesive workforce. (Refs - O'Hara L, Taylor J. Health at Every Size: a Weight-neutral Approach for Empowerment, Resilience and Peace. International Journal of Social Work and Human Services Practice 2014; 2(6):272-282; Giel K, Thiel A, Teufel M et al. Weight bias in work settings-a qualitative review. Obes Facts 2010;3(1):33-40; Puhl R, Brownell K. Bias, discrimination and obesity. Obesity Research 2001;9(12):788-805). Therefore extra caution must be taken in the implementation of any wellness programme which discusses weight. The Association for the Study of Obesity has a useful position paper on weight bias and stigma (Ref - ASO Position

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			Paper: Weight Bias and Stigma, June 2015 http://aso.freestyleinternet.co.uk/wp-files/uploads/2015/07/ASO-weight-bias-and-stigma-position.pdf)
148	British Dietetic Association		Active participation of employees in the full range of actions - planning, decision making, implementation, working with partners and evaluation is beneficial in increasing effectiveness of workplace health programmes through increased take up and employee ownership.(Refs: Ferraro et al Workplace-based participatory approach to weight loss for correctional employees J Occ Envir Med 2013;55(2):147-55; Andres et al Evaluation of a cardiovascular Risk Reduction Program at a workplace medical clinic. Workplace Health Saf. 2013;61(10):459-66;Hopkins et al. Implementing organisational physical activity and healthy eating strategies on paid time:process evaluation of the UCLA WORKING pilot study. Health Ed Res;27 (3):385-98; C3 Collaborating for Health. Workplace health initiatives: evidence of effectiveness. http://www.c3health.org). Managers need to be aware that this may not be limited to staff engagement forums but should also include employee representation in all areas of programme design, development, delivery (through Workplace Champions for example) and evaluation.
149	BT	Employers give employees the opportunity to contribute to decision- making through staff engagement forums	"Staff forums" are not a universal concept, particularly in the private sector. Companies use a variety of methods to engage employees and then to monitor impact. This statement should reflect the diversity of organisational structures and management practices across the economy.
150	Bupa UK		We agree that Quality Standard Statement 4 addresses one of the key areas for improvement as it focuses on the risk that employer initiatives to support health and wellbeing are interpreted as nannying employees or an invasion of privacy. Effective health and wellbeing policy should ensure that all aspects of employee relationships are looked at and evaluated. This approach should also encourage participatory planning; for example, performance diagnostic exercises which empower people to have a voice in the way employee wellbeing is delivered. There is a risk that by referring to staff engagement forums in the Quality Standard Statement, employers could overlook straightforward and day to day interactions between leaders, managers and employees and the ways in which these can generate useful insight for health and wellbeing initiatives.

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			Given this and the range of simple ways in which employee participation and feedback can be achieved by employers, we do not think that this is a barrier for small or medium size employees from adopting this Quality Standard.
151	Central and North West London NHS Foundation Trust	Quality Statement 4: Employee decision making	Yes, it makes sense. All of the evidence indicates that well engaged employees are more productive.
152	CIPD	Statement 4	We welcome Quality statement 4 on employee involvement in decision-making – opportunities for employee involvement and voice, including communication, consultation, genuine dialogue and involvement in decision-making form a vital element of the collective and social domain of well-being according to the CIPD well-being model. However, the Quality statement specifies staff engagement forums as *the* mechanism through which employees contribute to decision-making, which we feel could be too prescriptive for some employers. An employee engagement forum can be a very effective and appropriate format for some organisations but could be less appropriate for others, for example if the organisation is small or micro and/or if many people work remotely and would find it difficult to physically attend a forum. Effective voice/employee involvement is unlikely to result from any one single initiative, but rather from a number of complementary channels supported by leadership at all levels of the organisation. Employees can have voice directly, by giving management their views themselves, or indirectly through representatives; both can play their part in a mix of mechanisms that's appropriate for the organisational setting. There's a range of different and often complementary techniques for employee voice and enabling a two-way exchange between the employer and employees, including upward problem-solving and representative participation. The former includes methods such as: digital media; two-way, face-to-face communication; suggestion schemes; attitude surveys, and working groups. Representative participation can include a staff engagement forum but can also include approaches such as: collective representation; joint consultation, and partnership schemes. Typically, the most effective approach to encouraging employee involvement in decision-making will involve an organisation developing a range of methods to optimise the involvement of as many employees as possible. Therefore, it could be helpful to consider expanding **Quality statement 4** and the sentence under '**Quality measures, Structure a)** to recognise these other employee involvement techniques so that organisations have more flexibility in designing employee voice mechanisms that are most appropriate to their workforce. This could just involve replacing the word '**forums**' with '**mechanisms**'.

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			Under '**Rationale**' we would suggest considering expanding the last sentence to read: '…resulting in a more content and healthy workforce as well as higher levels of **commitment, engagement and** productivity.' [Thereby recognising the link between genuine, two-way forms of employee involvement and employee engagement and commitment which *in turn* can enhance productivity outputs.] Under **Quality Measures, item b) 'evidence of arrangements for feedback to employees on actions taken as a result of their contribution'** we would suggest adding '**or not'** to read: **b) 'evidence of arrangements for feedback to employees on actions taken <u>or not</u> as a result of their contribution'** as we feel that feedback on all employee suggestions are important, even if to explain why an employee suggestion hasn't been adopted; otherwise, employees may feel their idea wasn't considered. **Section: what the quality statement means for employers and line managers.** Again, we would suggest changing 'forums' to mechanisms' throughout the Quality statement and supporting text. For the 'line managers' section, we would also suggest including reference to 'encouraging open, genuine and two-way dialogue', as this approach lies at the heart of effective employee involvement and voice. In addition to giving employees the time to participate, this section could also emphasise the importance of encouraging employees to contribute their thoughts, ideas and concerns at any time.
153	Lancashire Care NHS Foundation Trust		What the "staff engagement forums" look like could be made clearer, ie at team level, trust level etc.
154	NHS Employers		This could be measured through uptake/attendance of engagement session and focus groups organised.
155	NHS Practitioner Health Programme	4	Rationale – Sound general principle to raise profile of the issue and support the area for quality improvement, but what is the aim of this standard? Participation in all decision making or just around issues of improvinf employee mental and physical health and well-being. Either way, the nature and level of decisions being discussed is important, trivial issues may reduce the use of the engagement, too high a level and employees may feel removed from the outcomes and believe in reality that their important would not carry weight. It is unlikely that those who are most in need i.e. those suffering from ill health issues, would feel able to engage in such events.
156	NHS Practitioner Health Programme	4	Quality Measure A – Local systems should be able to be to demonstrate this. Again this is a quantitative measure not a qualitative one. Putting on events does not mean that employees will attend.
157	NHS Practitioner Health Programme	4	Quality Measure B – Local systems should be able to be to demonstrate this. The analysis of the feedback, who does it, who receives it and what if any action is taken is the important part of this measure.

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158	NHS Practitioner Health Programme	4	Quality Measure A – Local systems should be able to be to demonstrate this. Employee satisfaction must be at the heart of this standard. An upward trajectory of improvement – or for high achieving organisations maintenance should be the aim. To achieve outcomes A, B and C good quality analysis and a baseline position are a prerequisite.
159	NHS Practitioner Health Programme	4	Quality Measure B – Local systems should be able to be to demonstrate this. Employee engagement is central to the standard. But it needs to be properly measured in a qualitative way, employees may feel compelled to attend but may not engage. Equally those who cannot or do not attend may be the employees most at risk and be the ones who would really benefit from the standard.
160	NHS Practitioner Health Programme	4	Quality Measure C – Local systems should be able to be to demonstrate this. Ultimately if the standard works across the board in an organisation then employee retention should be high.
161	The Royal College of Anaesthetists	4	Without a shadow of doubt; but it does imply a degree of engagement from the employee. Can be challenging in a few cases. It will be difficult to achieve in the top down, micromanaged, process driven NHS – the UK's largest employer.
162	Royal College of Nursing	4	This QS lacks any reference to working with trade union employee representatives. While we appreciate not all organisations will have a recognition agreement with a trade union, the complete lack of reference goes against the source guidance. As ACAS point out a trade union employee representative can help build trust and cooperation, help improve performance and amongst other things help the understanding of the management of change (ref: http://www.acas.org.uk/index.aspx?articleid=1745) We would suggest that this is amended to include trade union employee representatives.
163	Royal College of Psychiatrists (Faculty of old Age psychiatry)	Page 19	It is not noted anywhere within the briefing paper that age discrimination can also be an issue that contributes to work based stress and employee needs, as well as the equality and diversity impact of older workers increasingly remaining within the work force.
164	Royal Mail Group		- No comments on this one. Reads well.
165	UK Faculty of Public Health		This should not just be limited to staff engagement forums - could included line management structure, and wellbeing champions in teams and departments.
166	UK Faculty of Public Health		May include wellbeing champions in each department, and employee feedback through the line management structure and staff surveys. Local data to include feedback from line managers.

ID	Stakeholder	Statement number	Comments[2]
167	UK Faculty of Public Health		Where local surveys are used, they should be supported by guidance on content and methods, e.g. what specific dimensions should be addressed, and ensuring anonymity of responses so that staff can respond honestly without fear of discrimination. As stated above, using retention rates (Indicator c) as a quality indicator should be interpreted with caution, taking account of the relevant context. e.g. availability of comparable employment elsewhere, and the nature of employment (e.g. permanent vs. temporary or short-term contracting).
168	UK Faculty of Public Health		See point above re: local data collection.
	ADDITIONAL AREAS		
169	Arthritis and Musculoskeletal Alliance (ARMA)		We welcome the inclusion of statistics about the impact of musculoskeletal (MSK) health on work loss and related illness. As the leading cause of disability within the working age population the quality standards should emphasise the importance of effective, early interventions by employers to ensure that employees with MSK conditions can remain in work. A key resource is the ARMA position statement on work ARMA is the alliance representing the musculoskeletal (MSK) community in the UK, bringing together all professional bodies, patient-led and research charities for whom MSK is a priority. The ARMA position statement on work reflects the collaboration of ARMA members.
170	The Chartered Society of Physiotherapy		We welcome this quality standard, in particular the emphasis on making health and wellbeing an organisational priority. However, the quality standard seems to give more emphasis to mental health and wellbeing than physical health. Whilst we recognise that both physical and mental health are equally important, there is little mention of physical health in the Quality Standard, despite the fact that musculoskeletal disorders account for 44% of work-related illnesses, as stated on page 2. Where possible, we would recommend giving examples specific to physical health initiatives in statements 1 and 2, to help make the standard as a whole more balanced.
171	Lancashire Care NHS Foundation Trust		If Musculoskeletal disorders accounted for 44% of work-related illnesses and stress accounted for 35% of work-related illnesses; MSK should be included as a standard. Measures could include for example, number of employees with a DSE assessment, compliance with mandatory training / number who have attended moving and handling courses.
172	NHS Employers		Stress and mental health are mentioned but there is not enough focus on physical wellbeing. Musculo-skeletal disorders are one of the highest reasons for sickness absence in the NHS, but there is no mention of the manual handling risk assessment or any further support for MSK and how this could be measured.

ID	Stakeholder	Statement number	Comments[2]
173	Portsmouth City Council		Q1. This statement could highlight the need for workplace health champion roles for managers/employees who could support healthy workplace initiatives alongside the role of the senior management lead. It would also be useful to have some specific examples of initiatives, such as cycle to work scheme, weight management sessions, and quit smoking support. Similarly, giving examples of and links to specific wellbeing policies would also be useful here for implementation (within the 'core priority' paragraph).
174	Royal College of General Practitioners		The appointment of an employee Health Champion who was offered training and support would assist quality improvement in this area.
175	Royal Mail Group		- Having only one senior manager does not seem sufficient. For larger organisations it may not be practical for a manager with an existing portfolio of work to take on the development of a wellbeing strategy as well. I think the statement should clarify whether the senior manager is a champion (showing leadership in this area) or the person who develops the strategy. Perhaps this could read Employers have a senior manager who champions health and wellbeing at all levels of the organisation and a committee (H&W Committee or Board) made of cross functional representatives to develop and deploy a H&W strategy. For organisations of over 1000 people they should be encouraged to invest in a Health and Wellbeing Manager role or HR Business Partner (or equivalent) who leads on H&W for the organisation. - It is not clear how the quality measures will be audited. B) "Evidence of arrangements for implementing a H&W strategy" – this could be stronger – it could just be evidence that a H&W Strategy is in place and actions implemented and achieved. - Outcomes – sickness absence. I recognise this is probably the most easily accessible metric for businesses but it is influenced by a broad range of motivational/behavioural and health factors. The quality statement and the outcome measure seem quite far removed from one another. Perhaps suggest employee survey data – a company could survey employees on how they feel about wellbeing and what programmes they might like to see, in addition to the traditional Engagement Survey data and use of the HSE Management Standards tool. It might be worth encouraging employers to look at developing leading as well as lagging health metrics. It is also worth noting that businesses often measure sickness absence in different ways so will only be compared year on year in house, rather than for industry benchmark. Again this may be different for smaller businesses (for those of us with 130,000 plus employees it may be more complex!).
176	Action on Hearing Loss		We welcome the rationale behind this quality statement. Despite good evidence that hearing aids improve quality of life and reduce the risk of other health problems such as anxiety, depression dementia, many people are waiting too long to get their hearing tested. Line managers are in a good position to encourage employees to seek help for their hearing loss. In line with the NICE quality standard for mental wellbeing in care homes[33], line managers should be

[33] NICE (2013) Mental wellbeing of older people in care homes. QS50

ID	Stakeholder	Statement number	Comments[2]
			alert to the early signs of hearing loss and the role of the GP in referring people for a hearing test. Line managers should also ensure employees with hearing loss are aware of the Access to Work scheme and their rights under the Equality Act to make sure they get the support they need to communicate well in the workplace. For more information and a full list of references, please see comment 1.
177	Action on Hearing Loss		This section should include "evidence of line managers undertaking disability and sensory loss awareness training" as an example of a data source for "Process b) Proportion of line managers whose performance indicators include supporting employee health and wellbeing" for example: "Data source: local data collection, for example appraisal documentation and **records of staff undertaking disability and sensory loss awareness training"**
178	Action on Hearing Loss		We recommend adding the following to the definition of health and wellbeing: "Employees with disabilities and sensory loss may need additional support to communicate well and understand information in the workplace. The Access to Work scheme can provide a grant to help employees pay for assistive equipment and communication support". For more information, please see comment 4
179	National Rheumatoid Arthritis Society		A culture of looking out for the wellbeing of staff is one we will always support. As the first port of call for employees seeking support, the role of the line manager is vital. We agree that line manager should be trained and supported to address both the general health and wellbeing needs of their employees but also the specifics with regards to different health conditions. We suggest that all line managers and employers seek further information when presented with an employee living with any LTC. For example we have a patient support booklet on employment but also, more unusually and possibly uniquely, a booklet aimed at employers, *When an employee has rheumatoid arthritis.* We would advise training to recognise the links between mental and physical health and wellbeing.
	NO COMMENTS		
180	Department of Health		Thank you for the opportunity to comment on the draft for the above quality standard. **I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**

Registered stakeholders who submitted comments at consultation

- Action on Hearing Loss
- Arthritis and Musculoskeletal Alliance (ARMA)
- Barts Health NHS Trust
- British Dietetic Association
- BT
- BUPA UK
- Central and North West London NHS Foundation Trust
- Chartered Society of Physiotherapy
- Chartered Institute of Personnel and Development (CIPD)
- Department of Health
- Faculty of Occupational Medicine and Society of Occupational Medicine
- Guys and St Thomas' NHS Foundation Trust
- Hartlepool Borough Council
- Lancashire Care NHS Foundation Trust
- Migraine Trust
- National Rheumatoid Arthritis Society
- NHS Employers
- NHS Practitioner Health Programme

- Portsmouth City Council
- Relationships Alliance
- Royal College of Anaesthetists
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Physicians and Surgeons of Glasgow
- Royal College of Psychiatrists
- Royal Mail Group
- Skcin
- Tees Esk and Wear Valleys NHS Foundation Trust
- Turning Point
- UK Faculty of Public Health