NICE National Institute for Health and Care Excellence

NICE guideline

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

NICE guideline

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Contents

What is this guideline about?

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

The aim is to:

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

The guideline is for employers, senior leadership and managers (including line managers) and employees. It will also be of interest to those working in human resources, learning and development teams, professional trainers and educators, occupational health, health and safety, trade unions and professional bodies. In addition, it may be of interest to other members of the public. (For further details, see who should take action?)

See about this guideline for details of how the guideline was developed and its current status.

1 Recommendations

1 Organisational commitment

Employers, senior leadership and managers, human resource teams, and all those with a remit for workplace health should:

- Make health and wellbeing a core priority for the top management of the organisation. Value the strategic importance and benefits of a healthy workplace. Employers should encourage a consistent, positive approach to all employees' health and wellbeing.
- Establish the business case for ensuring employees' health and wellbeing. Make clear the link between employees' health and wellbeing and improved productivity.
- Ensure all managers in the organisation, including directors and board members, are committed to the health and wellbeing of their workforce and act as good role models.
- Incorporate health and wellbeing in all relevant corporate policies and communications. For example, by ensuring employees work reasonable hours and have regular breaks.
- Make communication clear to ensure that employees have realistic expectations of what's possible, practical and affordable.
- Be aware that a return to work from sickness does not necessarily indicate that an employee's health and wellbeing has improved. When developing return to work polices, take into account that aggressive return to work procedures can encourage presenteeism to the detriment of the organisation.
- Recruit managers who have the positive leadership traits associated with improved employee health and wellbeing. These traits include being open and approachable and encouraging new ideas.
- Ensure health and wellbeing policies are included in any induction, training and development programmes for new staff.
- Have a proactive and visible commitment to health and safety and its role in improving the health and wellbeing of employees, that is, view health and safety as part of the culture of a caring and supportive employer – not only a statutory requirement.

2 Physical work environment

Employers, senior leadership and managers, human resource teams, and all those with a remit for workplace health should:

- Develop and implement workplace policies and procedures to reflect statutory requirements and existing best practice (for example, manual handling and display screen equipment).
- Ensure all facilities and equipment are clean, safe, well maintained and of a good standard.

3 Mental wellbeing at work

Employers, senior leadership and managers, human resource teams, and all those with a remit for workplace health should:

- Create a supportive environment that enables employees to be proactive when and if possible to protect and enhance their own health and wellbeing.
- Develop policies to support the workplace culture such as respect for work–life balance. For example, in relation to stress organisations could refer to the principles of the Health and Safety Executive's Management standards for work related stress. These cover the following 6 aspects of work and the process for assessing and managing these:
    - demands (workload, work patterns and work environment)
    - control (how much say the employee has in the way they do their work)
    - support (from the organisation, line manager and colleagues)
    - relationships (promoting positive working to avoid conflict and dealing with unacceptable behaviour)
    - role (if employees understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles)
    - change (how change is managed and communicated in the organisation).

4 Fairness and justice

Employers, senior leadership and managers, human resource teams, and all those with a remit for workplace health should:

- Ensure any unfair treatment of employees is addressed as a matter of priority.
- Ensure line managers know how to direct employees to support if the employee feels that they are being treated unfairly.

5 Participation and trust

Employers, senior leadership and managers, human resource teams, and all those with a remit for workplace health should:

- Ensure employees feel valued and trusted by the organisation by:
    - offering support and training to help them feel competent
    - promoting team working and a sense of community.
- Encourage employees to have a voice in the organisation, and actively seek their contribution in decision-making through staff engagement forums and (for larger organisations) by anonymous staff surveys.
- Value and acknowledge employees' contribution across the organisation. If practical, act on their input and explain why this action was taken. If employees' contributions are not acted on, then clearly explain the decision.
- Encourage employees to engage with trade unions, professional bodies and employee organisations whenever possible.

6 Senior leadership

Senior managers, employers, and those with a leadership responsibility in workplace health should:

- Provide consistent leadership from the top, ensuring the organisation actively supports a positive approach to employee health and wellbeing and that policies and procedures are in place and are implemented. This should be part of the everyday running of the organisation, as well as being integrated in management performance reviews, organisational goals and objectives.
- Provide support to ensure workplace policies and interventions for health and wellbeing are implemented for line managers, so that they in turn can support the employees they manage.

- Ensure line managers are aware that supporting employee health and wellbeing is a central part of their role, for example by including it in line managers' job descriptions and emphasising it during recruitment.
- Display the positive leadership behaviours they ask of their line managers, such as spending time with people at all levels in the organisation and talking with employees.
- Act as a role model for leadership and proactively challenge behaviour and actions that may adversely affect employee health and wellbeing.

7 Role of line managers

Employers, senior leadership and managers, human resource teams, and all those with a remit for workplace health should:

- Recognise and support the key role that line managers have as the primary representative of the organisation and seek their input. Use line managers as a 2-way communication channel between the employee and organisation, and to encourage staff to be motivated and committed to the organisation. Regularly seek line managers' views on staff morale and staffing and human resource issues.
- Acknowledge that line managers have an important role in protecting and improving the health and wellbeing of their employees through involvement in job design, person specifications and performance reviews. Give line managers adequate time, training and resources to ensure they balance the aims of the organisation with concern for the health and wellbeing of their employees.

8 Leadership style of line managers

Line managers should:

- Adopt a positive leadership style that includes:
  - encouraging creativity, new ideas and exploring new ways of doing things and opportunities to learn
  - offering help and encouragement to each employee to build a supportive relationship; acting as a mentor or coach; being open and approachable to ensure that employees feel free to share ideas; recognising the contribution of each employee

  - having a clear vision that they can explain and make relevant to employees at all levels; ensuring employees share the same motivation to fulfil their goals
  - becoming role models who are trusted and respected by employees
  - providing a sense of meaning and challenge, and building a spirit of teamwork and commitment.

- Use the following approaches:
  - consult regularly on daily procedures and problems
  - promote employee engagement and communication
  - recognise and praise good performance
  - work with employees to produce and agree employees' personal development plans
  - be proactive in identifying and addressing issues and concerns early, and take preventive action at the earliest opportunity, identifying sources of internal and external support.
- Avoid negative behaviour such as:
  - detachment from colleagues and ignoring employees' suggestions
  - failure to monitor and manage their employees as a group
  - showing no interest in employees' ideas and projects
  - feeling threatened by competent employees
  - being guarded in communications, such as withholding information from colleagues and not keeping them fully informed.

9 Training of line managers

Employers, senior leadership and managers, executive team, human resource teams, and all those with a remit for training should:

- Ensure line managers receive training in:
  - effective leadership (see recommendation 8)

  - the importance of maintaining people's health and wellbeing at work and what this entails
  - the effect of health and wellbeing on improved organisational performance
  - keep up to date with changes in the legal obligations and official advice to employers
  - the implications of organisational change and how to manage it
  - communication skills, including how to have difficult conversations with employees
  - developing people's skills and resolving disputes
  - how to support employees by agreeing relevant and realistic targets
  - how to recognise when someone may need support (for example, because of problems achieving a work–life balance, demands of home life or unfair treatment at work) and awareness of the services they could be directed to
  - how to use stress risk assessment to identify and deal with sources of stress, as well as develop workplace solutions to reduce this risk
  - the internal and external causes of stress, such as excessive workload, financial worries, work–home conflict or family issues
  - how to give advice to employees about further support for stress both in and outside the workplace
  - equality and diversity training on employee health and wellbeing
  - how to manage sickness absence in line with NICE's guideline on managing long-term sickness and incapacity for work.

- Ensure the above skills and behaviours are set out in any documents outlining the skills and knowledge line managers need, and in their performance indicators.
- Ensure line managers receive training to improve their awareness of mental health and wellbeing issues. This includes increasing their awareness of how they can affect the psychological wellbeing of employees. It also includes equipping managers to identify when someone may have a mental health problem, for example learning to identify signs and symptoms and looking for changes in behaviour and performance. Ensure line managers can give employees advice on where to get further support.

10 Job design

Line managers should:

- Encourage employees to be involved in the design of their role to achieve a balance in the work demanded of them. Allow them to have a degree of control, appropriate to their role, over when and how work is completed. This should take into account the resources and support available.
- If possible and within the needs of the organisation be flexible about work scheduling, giving employees control and flexibility over their own time.
- When implementing flexible working, balance the needs of the business with the workloads and needs of other employees.
- Take into account the effect on physical health when designing jobs. This could include, for example, ergonomic reviews, and giving advice on posture and on moving and handling physical loads. Design jobs to promote and improve the physical health of employees by, for example, helping people to be physically active in their working day. See NICE's guideline on promoting physical activity in the workplace.

11 Monitoring and evaluation

Employers, senior leadership and managers, human resource teams, and all those with a remit for workplace health should:

- Regularly monitor and evaluate the effect of new activities, policies, organisational change or recommendations on employee health and wellbeing and identify and address any gaps.
- Ensure managers regularly review their own progress in promoting workplace health and wellbeing and acknowledge any gaps in their competencies. Organisations should support line managers in this activity.
- Identify and use reliable and validated tools to monitor impact.
- Give line managers a role in monitoring impact.

2 Who should take action?

Introduction

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

It will also be of interest to those working in:

- human resources
- learning and development
- organisational development
- occupational health
- trade unions
- professional and trade bodies
- business organisations
- recruitment teams and organisations
- education and training
- health and safety.

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

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

Who should do what at a glance

Who should take action?	Recommendation
Employees	2, 3, 4, 5, 11

Line managers	1, 2, 3, 4, 5, 7, 8, 9, 10, 11
Employers	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
Senior managers including directors and board members	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
Occupational health	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
Vocational rehabilitation specialists	1, 2, 9, 10, 11
Trade unions and employee representatives	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
Business organisations and employer representatives	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
Human resource organisations	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
Management training organisations	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
Local authorities	1, 2, 11
Recruitment teams or organisations	1, 6, 10
Professional educators and trainers	1, 7, 8, 9, 10, 11
Department for Work and Pensions, Department of Health, Department for Business, Innovation & Skills, and Public Health England	1, 2, 3, 4, 5, 6, 7, 9, 10, 11

Who should take action in detail

All recommendations are for:

Line managers, employers, senior managers including directors and board members, occupational health, trade unions and employee representatives, business organisations and employer representatives, human resource organisations and management training organisations.

Specific recommendations are also for the following people

Recommendation 1

Vocational rehabilitation specialists, local authorities, recruitment teams or organisations, professional educators and trainers and Department for Work and Pensions (DWP), Department of Health (DH), Department for Business, Innovation & Skills (BIS) and Public Health England (PHE).

Recommendation 2

Employees, vocational rehabilitation specialists, local authorities, and DWP, DH, BIS and PHE.

Recommendation 3

Employees and DWP, DH, BIS and PHE.

Recommendation 4

Employees and DWP, DH, BIS and PHE.

Recommendation 5

Employees and DWP, DH, BIS and PHE.

Recommendation 6

Recruitment teams or organisations and trainers and DWP, DH, BIS and PHE.

Recommendation 7

Professional educators and trainers and DWP, DH, BIS and PHE.

Recommendation 8

Professional educators and trainers.

Recommendation 9

Vocational rehabilitation specialists, professional educators and trainers and DWP, DH, BIS and PHE.

Recommendation 10

Vocational rehabilitation specialists, recruitment teams or organisations, professional educators and trainers and DWP, DH, BIS and PHE.

Recommendation 11

Vocational rehabilitation specialists, local authorities, professional educators and trainers, and DWP, DH, BIS and PHE.

3 Context

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

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

However, these benefits do depend on the type of work involved (Good work and our times Good Work Commission). There is also a positive association between wellbeing, job satisfaction and an employee's job performance. Many studies have also shown a relationship between supportive supervision and job satisfaction. These findings provide a strong case for employers to consider investing in the wellbeing of their employees on the basis of likely performance benefits (Does worker wellbeing affect workplace performance, Department for Business, Innovation & Skills).

During 2013/14, 1.2 million working people had a work-related illness. Half a million of these were new illnesses (Health and Safety Statistics Annual report for Great Britain 2013/4 Health and Safety Executive). Work-related illness and workplace injury led to the loss of an estimated 28.2 million working days in 2013/2014. Injuries and new cases of ill health resulting largely from current working conditions cost society an estimated £14.2 billion in 2012/13 (based on 2012 prices).

People's health can be damaged at work by, for example:

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

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

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

The World Health Organization has highlighted the importance of ensuring the culture of an organisation promotes health and wellbeing (Healthy workplaces: a model for action). A 'healthy' culture, for example, would include having fully implemented policies on:

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

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

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

A Confederation of British Industry (CBI) report highlighted the importance of providing adequate training for line managers to help them support employees with a health condition to remain at work (Getting better: workplace health as a business issue). Furthermore, the Workplace Wellbeing Charter (which provides an opportunity for employers to demonstrate their commitment to the health and wellbeing of their workforce) recognises the importance of line managers in their standards.

Evidence suggests that people going to work while they are sick ('presenteeism') is a more costly problem for employers than absenteeism (Mental health at work: developing the business case.

Policy paper 8 Sainsbury Centre for Mental Health). This is partly because it is more likely to occur among higher-paid employees.

'Presenteeism' may be caused by the culture of an organisation or the nature of the work – or both (people may come to work when they are unwell because they don't want to let their team members down). It leads to poorer longer-term health outcomes (Kivimäki et al. 2005; The future of health and wellbeing in the workplace Advisory, Conciliation and Arbitration Service). A study examining the prevalence of presenteeism in the UK found that nearly 60% of the sample reported presenteeism during a 3-month period (Robertson et al. 2012). The majority of participants (67%) indicated that the primary pressure to go to work while sick came from themselves. A substantial minority (20%) also indicated that their manager was a source of pressure.

4 Considerations

This section describes the factors and issues the Public Health Advisory Committee (PHAC) considered when developing the recommendations. Please note: this section does **not** contain recommendations. (See recommendations.)

4.1 The Committee was mindful that self-employed people are not included in this guideline. However, many self-employed people are also line managed, for example on a fixed-term contract or for a particular project. The guideline applies to the line management of contract, temporary and agency employees.

4.2 The Committee acknowledged that the relationship between line management and employee wellbeing is complex and can vary by occupation, organisation size, sector and a number of other factors.

4.3 The Committee acknowledged the different cultures and working practices between organisations. These can vary widely by organisation size, from large multinational organisations, small and medium-sized enterprises to micro-organisations. These differences will affect how recommendations are implemented.

4.4 The evidence reviews showed that studies conducted in different countries often yielded similar results. The applicability of findings to the UK were taken into account.

4.5 All the findings showed a positive association between all interventions and employee health and wellbeing. Causation could not be determined by the studies included in the qualitative reviews.

4.6 The Committee considered whether employers should be required to promote 'traditional' workplace health interventions such as exercise, healthy diet and stopping smoking. However the committee felt it was not appropriate to mandate employers to do this.

4.7 The consequences of implementing workplace health policies or interventions need careful consideration because they may have unexpected (and often undesirable) knock-on effects on other employees. The core principle of workplace health policies or interventions is to 'cause no harm'.

4.8 The Committee acknowledged that people management is as important as task management. The Committee noted that organisations committed to workplace health and wellbeing consult employees and perform needs assessments. The Committee also noted the importance of health and wellbeing as a consideration during business planning and any organisational change, given the possible impact this may have on all staff.

4.9 The Committee agreed the importance of good management and acknowledged that a number of leadership styles are discussed widely in the literature. The evidence reviews for the guideline reported findings for both positive and negative leadership styles including transformational, authentic and self-centred leadership. Although the Committee has recommended the need for line managers to develop a positive leadership style, it does not endorse any particular positive leadership style.

4.10 The Committee recognised that in most organisations promotion opportunities normally involve increased management responsibilities. However, some people with excellent technical skills do not have (or do not want to develop) the necessary 'people skills' to line manage. The Committee noted that these people may benefit from alternative promotion and development opportunities.

4.11 The Committee recognised that line managers, like the employees they manage, may experience life crisis events such as grief or bereavement, relationship problems or financial difficulties. The Committee noted that at such times line managers will seek and receive staff support services that are available to all employees. Furthermore, the Committee noted that line managers could also seek support for themselves with any mental health or physical health issues they are experiencing.

4.12 The legal obligations of employers were also acknowledged, such as health and safety responsibilities, sight tests, supporting those who are visually impaired or otherwise disabled and providing safety equipment. Employers may find it useful to use Health and Safety Executive and Equality and Human Rights Commission Codes of Practice and guidance.

4.13 The Committee noted the important work of the Advisory Conciliation and Arbitration Service (ACAS) in helping prevent and resolve workplace problems.

Members agreed that employers may find it useful to use ACAS Codes of practice and guidance.

4.14 Most of the studies identified in the evidence reviews report short-term outcomes. The Committee felt that a long-term focus is also needed when commissioning and planning further research. There is a need for more longitudinal studies to investigate sustainable effects over longer follow-up periods.

4.15 The Committee recognised the there was a need for a national database on the effect of new activities, policies and organisational change on health and wellbeing. National recommendations of this kind are outside the scope of this guideline. However, the Committee discussed that it would be useful for employers if such a database included productivity and business outcomes, cost information and the general and economic benefits of providing a healthy workplace. It also noted that there was a need for qualitative data and evidence on what works for whom and when. The Committee also discussed the fact that employers, practitioners and researchers on workplace health may provide a useful contribution this nationwide database.

Economic evaluation

4.16 Some key benefits of improving the health of employees through improved workplace practices are hard to measure quantitatively. These benefits include a feeling of increased safety and satisfaction, greater loyalty, and improved societal reputation for employers, and are associated with increased productivity of workers. There is consistent evidence that relatively small investment in line manager training (and its effects on their attitudes and those of their employees) can lead to worthwhile improvements in worker satisfaction, which in turn are linked to gains in productivity for the organisation. The modelling done for this topic shows that these productivity increases will usually be at least as large as the benefits of reducing absenteeism, presenteeism and employee turnover, and may be many times larger. However, it may take some time to recoup the initial investment.

4.17 The Committee agreed that an emphasis on employee health and wellbeing is equally important during a recession or financial crisis, as in times of economic

growth. A focus on health and wellbeing can sustain and develop a strong workforce for the future.

5 Recommendations for research

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

All the research should aim to identify differences in effectiveness among groups, based on characteristics such as socioeconomic status, age, gender, ethnicity, size and type of employer and whether workers were paid or unpaid.

5.1 How can the implementation of the recommendations made in this guideline be evaluated? This research should be developed in collaboration (or co-produced) with those likely to use or be offered the interventions studied, that is, line managers and employees. More UK intervention studies are needed with line managers in a range of organisations to answer the following questions:

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

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

5.2 How can outcome measures relating to workplace health and wellbeing be measured? Research funding bodies such as for example the National Institute for Health Research or Economic and Social Research Council should ensure clear outcome measures relating to workplace wellbeing, work retention, workplace absence, workplace performance and productivity, return to work and work retention are included in all the research they fund. This will ensure that all intervention research examines the effect on people's working lives and their health and wellbeing.

5.3 How can the effectiveness of workplace health policies and programmes be measured? Further research studies need at least 3 measurement points:

- before the intervention takes place
- after the intervention has finished, to measure immediate effect
- a later point, such as 12–18 months from the start, to measure longer-term effect.

The design of studies should also consider the effects of staged interventions (such as training line managers in new practices, assessing uptake and implementation, and its effect on the workplace). How effective are methods for synthesising such evidence, including relevant equalities characteristics? Finally, there is a need to fund more longitudinal studies to identify cause and effect relationships.

5.4 How can the design and reporting of the outcomes used in intervention studies be improved, so researchers can identify 'active ingredients'? Which validated tools are effective at consistently measuring success, especially in relation to health and wellbeing, performance, productivity and in economic terms? Research studies should collect both subjective and objective measureable outcomes of wellbeing. This will help organisations to make a business case to invest in policies and measures to improve the health and wellbeing of their employees.

More detail identified during development of this guideline is provided in gaps in the evidence.

6 Related NICE guidance

Published

- Behaviour change: individual approaches (2014) NICE guideline PH49
- Promoting mental wellbeing at work (2009) NICE guideline PH22
- Managing long-term sickness and incapacity for work (2009) NICE guideline PH19
- Promoting physical activity in the workplace (2008) NICE guideline PH13
- Behaviour change (2007) NICE guideline PH6
- Workplace interventions to promote smoking cessation (2007) NICE guideline PH5
- Obesity (2006) NICE guideline CG43

Under development

- Workplace policies and approaches to promote and protect the health of older employees. NICE guideline. Publication expected February 2016.
- Workplace health: policies and approaches to support employees with disabilities and long-term conditions. NICE guideline. Publication expected February 2017.

7 Glossary

Health and wellbeing

Health relates to a person's physical or mental condition. Wellbeing is the subjective state of being healthy, happy, contented, comfortable and satisfied with one's quality of life.

Leadership

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

Line manager

A person with direct managerial responsibility for an employee.

Micro-organisation

An organisation employing fewer than 10 people.

Occupational health service

A service established either in-house or externally to:

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

Presenteeism

Being at work when you should be at home because you are ill.

Vocational rehabilitation

Helping people who are finding it difficult to obtain, stay in or return to work because of a physical or mental impairment.

8 References

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

Robertson IT, Leach D, Doerner N et al. (2012) Poor health but not absent: Prevalence, predictors and outcomes of presenteeism. Journal of Occupational and Environmental Medicine 54: 1344–9

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

9 Summary of the methods used to develop this guideline

Introduction

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

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

Guideline development

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

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

Key questions

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

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

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

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

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

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

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

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

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

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

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

These questions were made more specific for each review.

Reviewing the evidence

Effectiveness reviews

Three reviews of effectiveness were conducted:

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

Identifying the evidence

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

The following additional searches were also carried out:

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

The following tasks were completed to identify additional evidence:

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

Selection criteria

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

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

Reviews 1 and 2 included experimental and observational quantitative studies, and economic studies (cost-benefit and cost-effectiveness analyses). Review 3 included qualitative studies.

Studies were excluded if they covered:

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

Inclusion and exclusion criteria for each review varied and details can be found in reviews 1, 2 and 3.

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the public health methods manual. Each study was graded (++, +, −) to reflect the risk of potential bias arising from its design and execution.

Study quality

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

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

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

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

Summarising the evidence and making evidence statements

The review data were summarised in evidence tables (see the reviews in supporting evidence).

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

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

Cost effectiveness

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

Review of economic evaluations

The review of economic evaluations was conducted as part of the effectiveness reviews 1 and 2. See identifying the evidence and selection criteria for details of the databases searches and the inclusion and exclusion criteria.

See reviews 1 and 2.

Economic modelling

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

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

The 'ready reckoner' is available in modelling report: economic analysis of workplace policy and management practices to improve the health of employees.

How the PHAC formulated the recommendations

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

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

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

- Strength (type, quality, quantity and consistency) of the evidence.
- The applicability of the evidence to the populations/settings referred to in the scope.

- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of harms and benefits.
- Ease of implementation and any anticipated changes in practice.

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

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

10 The evidence

Introduction

The evidence statements from 3 reviews are provided by external contractors.

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

How the evidence and expert papers link to the recommendations

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

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

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

Recommendation 1: evidence statements 1.1, 1.3, 3.2d; EP1, EP4; IDE; modelling report: economic analysis of workplace policy and management practices to improve the health of employees.

Recommendation 2: 3.2d; EP2, EP4; EP5, IDE

Recommendation 3: evidence statements 1.1, 3.1c, 2.1, 3.2b, 3.2c, 3.4; EP1, EP4; EP5, IDE

Recommendation 4: evidence statements 3.3; EP4; EP5, IDE

Recommendation 5: evidence statements 2.4, 3.1d, 3.2c, 3.3; EP2, EP4; IDE

Recommendation 6: evidence statements 3.1a, 3.2a, 3.1e, 3.2b, 3.2c; 3.2e, 3.2f, EP1, EP2, EP4, EP5; IDE

Recommendation 7: evidence statements 1.1, 2.4, 3.1a, 3.1d; EP4, EP5; IDE

Recommendation 8: evidence statements 2.4, 3.2a, 3.2b, 3.2c, 3.2e, 3.2f, 3.5; EP2, EP4; IDE

Recommendation 9: evidence statements 1.1, 2.1, 3.1c; EP5, IDE

Recommendation 10: evidence statements 3.1c, 3.1d, 3.2c, 3.4; EP1, EP2, EP4, EP5; IDE

Recommendation 11: evidence statements EP1, EP3; IDE

Economic modelling

No cost effectiveness studies were found that could be used in the modelling report, despite an extensive literature search. So a 'ready reckoner' was developed for organisations to use instead. Average costs of absenteeism and staff turnover were found by searching the UK literature. By inputting the expected cost per head of training courses designed to improve absenteeism and turnover into the ready reckoner, users can determine what reductions are needed to pay for the training costs. The ready reckoner can also be used to estimate, the extent of improvement in staff satisfaction and productivity needed to pay for the training.

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

11 Gaps in the evidence

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

1. There were only 5 UK studies reported in the 3 evidence reviews undertaken for this guideline. There is therefore a need for more research in the UK. Furthermore, no cost-effectiveness studies were found that could answer the research questions. So there is also a need for more economic and cost-effectiveness data. More research is needed on how much training, and what kind of training, line managers should have to reduce worker absence and staff turnover cost effectively. There is also a need to identify the extent to which interventions designed to improve the wellbeing of employees can cost effectively increase productivity.

(Source: evidence reviews 1, 2, 3 and cost effectiveness review)

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

(Source: evidence reviews 1, 2 and 3)

3. No studies were found on the line management of unpaid workers such as volunteers and interns.

(Source: evidence reviews 1, 2 and 3)

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.

(Source: evidence reviews 1, 2 and 3)

5. There is need for more accurate and detailed reporting of study methods to encourage transparency, ensure studies can be replicated and assess long-term impact. Studies need to report what does not work as well as what works. There is also a need for journals to have editorial policies that invite and publish reports of negative, inconclusive or positive effects. The suppression of negative results can bias study effectiveness.

(Source: evidence reviews 1, 2 and 3)

The Committee made 4 recommendations for research into areas that it believes will be a priority for developing future guidelines. These are listed in recommendations for research.

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

Public Health Advisory Committee E

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

Chair

Paul Lincoln
Chief Executive, UK Health Forum

Core members

Ralph Bagge
Community member

Ruth Hall
Independent Public Health Consultant, Cheshire

Jane Royle
Consultant in Public Health, Cornwall Council

Matthew Taylor
Director, York Health Economics Consortium

Jeremy Wight
Director of Public Health, SheffieldCity Council

Topic members

Mark Gabbay
Professor of General Practice, University of Liverpool; Academic Associate GP, Liverpool

Elaine Harris
Healthy Workplace Manager, Somerset County Council

Diana Kloss
Chair, Council for Work and Health

D'Arcy Myers
Community topic member

Ivan Robertson
Director, Robertson Cooper; Emeritus Professor of Work and Organisational Psychology, University of Manchester; Visiting Professor of Organisational Psychology, University of Leeds

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

Expert co-optees to PHAC

Maria Karanika-Murray
Senior Lecturer in Psychology, Nottingham Trent University

Expert testimony to PHAC

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

Jenifer Lord
JeniferLord.com

Maria Karanika-Murray
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Sarah Page
Health and Safety Officer, Prospect

Richard Preece
Medical Director, Saga

Paul Winter
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Declarations of interests

The following members of the Public Health Advisory Committee made declarations of interest. All other members of the Committee stated that they had no interests to declare.

About this guideline

What does this guideline cover?

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

How was this guideline developed?

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

Members of the PHAC are listed in membership of the Public Health Advisory Committee and the NICE project team.

For information on how NICE public health guidelines are developed, see the NICE public health guideline process and methods guides.

What evidence is the guideline based on?

The evidence that the PHAC considered included:

- Evidence reviews 1, 2 and 3: 'Workplace policy and management practices to improve the health of employees'. All the reviews were carried out jointly by The Institute for Employment Studies, The Work Foundation and Lancaster University. The principal authors were: Jim Hillage, Jenny Holmes, Catherine Rickard and Rosa Marvell (Institute for Employment Studies), Tyna Taskila, Zofia Bajorek and Stephen Bevan (The Work Foundation) and Jenny Brine (Lancaster University).
- Economic modelling: 'Modelling report: Economic analysis of workplace policy and management practices to improve the health of employees' was carried out by the Work Foundation and the Institute for Employment Studies. The principal authors were: Charles Levy and Stephen Bevan (The Work Foundation) and Jim Hillage (Institute for Employment Studies).
- Expert papers:

- Expert paper 1 'NICE workplace health expert testimony' by Paul Winter, Chief Executive, Ipswich Building Society.
- Expert paper 2 'People matter' by Jayne Hayward, Pulse Training Partnership and Jenifer Lord, JeniferLord.com.
- Expert paper 3 'NICE testimony: workplace practices to improve health' by Richard Preece, Saga.
- Expert paper 4 'Some additional evidence from work psychology' by Maria Karanika-Murray, Nottingham Trent University.
- Expert paper 5 'Workplace policy and management practices to improve employee health and wellbeing' by Sarah Page, Prospect Union.

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

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

Status of this guideline

The draft guideline, including the recommendations, was released for consultation in September to November 2014. At its meeting in December 2014 the PHAC amended the guideline in light of comments from stakeholders and experts and the fieldwork. The guideline was signed off by the NICE Guidance Executive in May 2015.

The guideline complements but does not replace NICE guidelines on: promoting mental wellbeing at work, managing long-term sickness and incapacity for work, promoting physical activity in the workplace and workplace interventions to promote smoking cessation. (For further details, see related NICE guidance.)

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

The guideline is available on NICE's website. The recommendations are also available in a pathway for professionals whose remit includes public health and for interested members of the public.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Implementation

NICE guidelines can help:

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

NICE has developed tools to help organisations put this guideline into practice.

Updating the recommendations

This guideline will be reviewed 3 years after publication to determine whether all or part of it should be updated. Information on the progress of any update will be posted on the NICE website.

Your responsibility

This guideline represents the views of the Institute and was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

Implementation of this guideline is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guideline, in their local context, in light of their duties to have due regard to the need to eliminate

unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guideline should be interpreted in a way which would be inconsistent with compliance with those duties.

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