NICE National Institute for Health and Care Excellence

NICE guideline

Workplace health: management practices

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline is the basis of QS147.

This guideline should be read in conjunction with NG146.

Overview

This guideline covers how to improve the health and wellbeing of employees, with a focus on organisational culture and the role of line managers.

In March 2016, NICE added recommendations about older employees, aged over 50 in paid or unpaid work.

Who is it for?

- Employers, senior leadership and managers (including line managers), human resource teams and all those with a remit for workplace health
- Employees, people who are self-employed, and other members of the public

Recommendations

This guideline was first published in June 2015. A new committee considered evidence relating specifically to older employees and added new recommendations in March 2016 – it did not review or amend the original recommendations. New recommendations were made if explicit evidence was found for older people. However, the original recommendations remain applicable to employees of all ages. Recommendations are marked as:

- **[new 2016]** for new recommendations added about older employees (aged over 50 in paid or unpaid work)
- **[2015]** for original recommendations.

These recommendations support compliance with equality legislation under the Equality Act (2010). This protects employees from discrimination in employment, training and education.

Using NICE guidelines to make decisions explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Organisational commitment

These recommendations are for employers, senior leadership and managers, human resource teams and all those with a remit for workplace health.

1.1.1 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. **[2015]**

1.1.2 Establish the business case for ensuring employees' health and wellbeing. Make clear the link between employees' health and wellbeing and improved productivity. **[2015]**

1.1.3 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. [2015]

1.1.4 Incorporate health and wellbeing in all relevant corporate policies and communications. For example, by ensuring employees work reasonable hours and have regular breaks. [2015]

1.1.5 Make communication clear to ensure that employees have realistic expectations of what's possible, practical and affordable. [2015]

1.1.6 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. [2015]

1.1.7 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. [2015]

1.1.8 Ensure health and wellbeing policies are included in any induction, training and development programmes for new staff. [2015]

1.1.9 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. [2015]

1.2 Physical work environment

These recommendations are for employers, senior leadership and managers, human resource teams and all those with a remit for workplace health.

1.2.1 Develop and implement workplace policies and procedures to reflect statutory requirements and existing best practice (for example, manual handling and display screen equipment). [2015]

1.2.2 Ensure all facilities and equipment are clean, safe, well maintained and of a good standard. [2015]

1.3 Mental wellbeing at work

These recommendations are for employers, senior leadership and managers, human resource teams and all those with a remit for workplace health.

1.3.1 Create a supportive environment that enables employees to be proactive when and if possible to protect and enhance their own health and wellbeing. [2015]

1.3.2 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). [2015]

1.4 Fairness and justice

These recommendations are for employers, senior leadership and managers, human resource teams and all those with a remit for workplace health.

1.4.1 Ensure any unfair treatment of employees is addressed as a matter of priority. [2015]

1.4.2 Ensure line managers know how to direct employees to support if the employee feels that they are being treated unfairly. [2015]

1.4.3 Offer older employees the same opportunities (including those identified in

NICE's guideline on mental wellbeing at work) as younger employees. [new 2016]

1.4.4 Treat each employee as an individual and avoid making stereotypical assumptions. For example, don't assume that an older employee may find learning new tasks difficult or that younger employees are less dependable. [new 2016]

1.5 Participation and trust

These recommendations are for employers, senior leadership and managers, human resource teams and all those with a remit for the workplace.

1.5.1 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. [2015]

1.5.2 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. [2015]

1.5.3 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. [2015]

1.5.4 Encourage employees to engage with trade unions, professional bodies and employee organisations whenever possible. [2015]

1.6 Senior leadership

These recommendations are for senior managers, employers and those with a leadership responsibility in workplace health.

1.6.1 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. [2015]

1.6.2 Consider helping employees to access screening and other health services to which they are entitled. This could include providing information about services such as cervical screening and eye tests and allowing time off to attend appointments. [new 2016]

1.6.3 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. [2015]

1.6.4 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. [2015]

1.6.5 Display the positive leadership behaviours that are asked of line managers, such as spending time with people at all levels in the organisation and talking with employees. [2015]

1.6.6 Act as a role model for leadership and proactively challenge behaviour and actions that may adversely affect employee health and wellbeing. [2015]

1.7 Role of line managers

These recommendations are for employers, senior leadership and managers, human resource teams, and all those with a remit for workplace health.

1.7.1 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. [2015]

1.7.2 Acknowledge that line managers have an important role in protecting and improving the health and wellbeing of 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 employees. [2015]

1.8 Leadership style of line managers

1.8.1 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 which can be explained and made 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. [2015]

1.8.2 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. [2015]

1.8.3 Avoid negative behaviour such as:

- detachment from colleagues and ignoring employees' suggestions
- failure to monitor and manage 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. **[2015]**

1.9 Training

These recommendations are for employers, senior leadership and managers, executive teams, human resource teams, and all those with a remit for training.

1.9.1 Ensure line managers receive training in:

- effective leadership (see section 1.8)
- 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
- keeping 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 workplace health: long-term sickness absence and incapacity to work. [2015]

1.9.2 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. [2015]

1.9.3 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. [2015]

1.9.4 Line managers should offer older employees the same training and development opportunities as other employees. [new 2016]

1.9.5 Offer or support older employees, in the same way as other employees, to undertake training if their job role changes. [new 2016]

1.9.6 Tailor training programmes to meet employees' individual needs, learning style and ability. This could include providing:

- a training needs analysis
- work-based, practical on-the-job training
- mentoring or one-to-one sessions
- opportunities for reflection. [new 2016]

1.9.7 Encourage and help employees, including older employees, who have few qualifications, or who may have received education and training some years ago, to make the most of learning and development opportunities. This includes giving them the necessary time off for training. [new 2016]

1.10 Job design

These recommendations are for line managers.

1.10.1 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. **[2015]**

1.10.2 If possible, and within the needs of the organisation, be flexible about work scheduling, giving employees control and flexibility over their own time. **[2015]**

1.10.3 When implementing flexible working, balance the needs of the business with the workloads and needs of other employees. **[2015]**

1.10.4 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 physical activity in the workplace. **[2015]**

1.10.5 Address the needs of older employees as part of a broad diversity policy to support retention of older employees. This should include recognising key life stages and life events and taking into account that caring responsibilities may change as people age. This policy could include:

- providing timely and appropriate support, for example, flexible working policies or carer's leave
- communicating working time options and eligibility clearly and without jargon, and providing information on the financial implications of flexible working if relevant
- planning and resourcing the policy effectively, including early liaison between HR and pensions fund staff if appropriate. **[new 2016]**

1.10.6 For each employee, identify and address issues affecting their health, wellbeing and ability to do their job. This includes the impact of shift work, and in particular of night working. **[new 2016]**

1.10.7 Consider delivering a workplace health promotion programme incorporating both physical activity and diet. See NICE's pathways on physical activity and diet. **[new 2016]**

1.11 Monitoring and evaluation

These recommendations are for employers, senior leadership and managers, human resource teams, and all those with a remit for workplace health.

1.11.1 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. **[2015]**

1.11.2 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. **[2015]**

1.11.3 Identify and use reliable and validated tools to monitor impact. **[2015]**

1.11.4 Give line managers a role in monitoring impact. **[2015]**

Putting this guideline into practice

NICE has produced tools and resources to help you put this guideline into practice.

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find whether there are gaps in current service provision.

4. **Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see: Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

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 2013/14 Health and Safety Executive). Work-related illness and workplace injury led to the loss of an estimated 28.2 million working days in 2013/14. 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.[1]).

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 (Working while ill as a risk factor for serious coronary events: the Whitehall II study 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[2]. 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.

Older employees

The number of employed people aged 65 or over in the UK has more than doubled over the past 2 decades, from 425,000 in 1994 to almost 1.17 million in 2015. Furthermore, nearly 8.2 million people aged 50–64 were also in employment in 2015 (Labour Market Statistics, June 2015 Office for National Statistics). The proportion of older employees is similar across all sectors (HSE horizon scanning intelligence group demographic study Health and Safety Executive).

By 2020, it is predicted that older people will account for almost a third (32%) of the working-age population and half of the adult population (National Population Projections, 2012-based projections Office for National Statistics). Increases in the state pension age may mean the proportion of this group continuing in employment increases further.

Older people who earn less tend to retire earlier than their middle-income peers, due to ill health and disability (Living in the 21st century: older people in England ELSA 2006 [Wave 3] Institute for Fiscal Studies). They are more likely to have long-term health problems, some of which are attributable to lifestyle behaviours. They also have higher rates of non-work related stress and mental health problems.

If people in this group are to work until 68, action is needed to raise their general level of health, reduce health inequalities ('Fair society, healthy lives') and offer a broader range of employment opportunities.

Over the next 10 years it is predicted that there will not be enough young people to fill the jobs

available. So employers will become more reliant on older people (Managing a healthy ageing workforce: a national business imperative Chartered Institute of Personnel and Development).

More information

You can also see this guideline in the NICE pathway on workplace health: policy and management practices.

To find out what NICE has said on topics related to this guideline, see our web page on workplaces.

See also the evidence reviews and information about how the guideline was developed, including details of the committee.

[1] 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.

[2] 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.

Committee discussion

For an explanation of the evidence statement numbering, see the evidence reviews section.

The committee (Public Health Advisory Committee E) 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 where appropriate.

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.

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.

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.

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.

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.

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'.

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.

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.

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.

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.

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 codes of practice and Equality and Human Rights Commission codes of practice and technical guidance.

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.

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.

The committee recognised that 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 to this nationwide database.

Economic evaluation

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.

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.

Committee discussion about older employees

The committee (Public Health Advisory Committee D) agreed that recommendations covering older employees should be considered as part of a wider approach to promoting all employees' health and wellbeing. They were therefore incorporated into the existing public health guideline on this topic. This would simplify and support the process of implementing both sets of recommendations.

The committee noted that workplace policies and practices could also affect other groups such as people with disabilities or minority ethnic groups. Although actions could be taken to address the needs of these groups, the aim of extending this guideline was to incorporate recommendations on older employees in line with the referral from the Department of Health.

The committee noted that older people are more likely to be unemployed or economically inactive than younger people, and tend to find getting back into work after absence more difficult.

Unpaid workers are included in the recommendations because the committee was aware of the many benefits (to volunteers, organisations and wider society) gained from older people's participation in unpaid work. The committee's view was that much of the evidence is likely to be applicable to these volunteers.

Changes to workplace health and safety and other relevant legislation are not part of the guideline scope. The committee had hoped to make recommendations to help increase employers' awareness of the legislation and support its implementation, in particular related to the needs of older employees. Although this is out of scope, members recognised and reflected on its importance in their discussions.

Committee members noted that NICE's guideline on alcohol-use disorders: prevention makes only limited reference to the workplace. This was because there was only limited evidence about alcohol interventions at work at the time it was published. The committee noted that the workplace is now recognised as an important setting for delivering brief advice on alcohol. Making general health promotion recommendations is outside the scope of this work, but the committee wanted to recognise its importance here.

Issues for older employees

The committee agreed that the benefits of working can extend beyond financial remuneration. Actively participating and making a worthwhile contribution at work can improve health and wellbeing. Working (including volunteering) can also be an important way of socialising and making friends.

But members also agreed that not everyone benefits from work. For example, work that makes excessive physical and mental demands on a person can be detrimental to their health and wellbeing. The committee recognised this by recommending offering re-training opportunities (recommendation 1.9.5) to enable them to continue working if their job role changes.

The committee discussed changes to the state pension age and the abolition of the default retirement age, including the potential health implications of a later retirement. But the effects of these changes have not yet been reported in the published literature. Lack of evidence meant that interventions on planning and preparation for retirement could not be included. They also noted that self-employment and the use of zero-hours contracts (in which the employer is not obliged to provide any minimum working hours, and the worker is not obliged to accept any work offered) were not considered by the published literature.

The committee noted that as people age their caring responsibilities change, and this is likely to become more common as more people survive into older age. Some employees may be caring for their children and their parents at the same time, while others may have caring responsibilities for their grandchildren. Bereavement also has a significant impact, particularly if it involves loss of a partner. As the working age extends it may become more likely that people will experience bereavement while they are still working.

The committee reflected this need in recommendation 1.10.5. The evidence for this recommendation included 13 studies [1 high quality (++), 9 moderate quality (+) and 3 poor quality (−), ES6.1a] including surveys and qualitative studies on older workers, which covered attachment to work, and factors that help and hinder flexible working for older employees. There was also evidence from a range of other studies [ES6.4a, ES6.4b and ES6.4c] from surveys, qualitative data and mixed methods approaches on flexible working and on retirement decisions and financial planning [ES6.8c]. The committee recognised the limitations of the study types in terms of bias. But it agreed that the results were in line with its own experience and expert consensus. It also agreed that making recommendations about these issues was important to support older employees in the workplace.

Stereotypical assumptions about older employees

The committee discussed the need to avoid stereotypical assumptions about older employees, such as assuming that they are unwilling to change or unwilling to learn (recommendations 1.4.3 and 1.4.4; [ES6.2a, ES6.2c, EP9, EP11]). That is because such assumptions risk marginalising this group, and could prevent employers from making the best use of their potential.

This is the case even when the assumptions are positive (for example, that older people may be more reliable and loyal). Making such assumptions may imply, for example, that younger employees are less reliable and less loyal.

Workplace health interventions for older employees

The committee noted that poor health can have a direct impact on a person's ability to work. Other factors related to poor health, such as the time needed for health appointments, and the need to take medication at work or to manage any adverse effects of treatment, will also have an impact. The committee agreed by consensus that providing health interventions at work, such as flu vaccinations for the over-65s, may be helpful for employees who find it difficult to attend health appointments during the day, although this would only cover a small proportion of the workforce. However, the committee decided that offering a general workplace health promotion service may not increase uptake of these services in older employees.

The committee agreed on the need to raise awareness of health-related issues and recommend signposting to relevant services (as in recommendation 1.6.2), such as free eye tests for people over 60. However, it noted that some services are also available to younger age groups and it would be important to ensure that all employees are helped to access appropriate services.

The committee considered comments on the importance of communication issues relating to sight and hearing loss. These can have a significant impact on people, both at work and in other areas of their lives. However, no evidence was found relating specifically to sight or hearing issues. The committee noted that equalities legislation requires employers to make reasonable adjustments to the workplace to accommodate the needs of people with visual impairments. However, the committee felt it was not necessary to recommend compliance with a legal requirement.

The committee looked at recovery from shift work and the role of physical activity and diet programmes in supporting recovery. The evidence base identified by NICE's commissioned review was limited. Evidence supported the committee's view of the potential impact of shift working on health [ES6.1a, ES6.1b]. Weak evidence from 1 poor quality (−) before-and-after study was found on rotation of shift and its impact on older employees [ES4.1]. The committee felt that considering the impact of shift work in the recommendations was warranted (recommendation 1.10.6), although the evidence did not allow a recommendation to be made about the type or frequency of shift patterns specific to the needs of older workers. Evidence from 1 moderate quality (+) randomised controlled trial (RCT) showed positive outcomes in mental health and decreased daily work strain from a physical activity intervention. Another moderate quality (+) RCT of a worksite vitality intervention (comprising exercise and yoga sessions, free fruit and visits from a coach) had a beneficial effect on recovery after work in employees aged over 45 years [ES4.6]. The committee recognised the limitations of this evidence but considered it plausible that physical activity and improved nutrition could have a beneficial effect on recovery, and may also have other broader health outcomes (recommendation 1.10.7).

The evidence for older employees

The reviews examined evidence relating to employees aged over 50. Two reviews looked at the effectiveness of interventions and were limited to evidence published since 2005, and to evidence from OECD (Organisation for Economic Co-operation and Development) countries. They excluded older employees with pre-existing health conditions. Studies were included that were aimed at employees aged over 50 or addressed entire workforces where at least 51% of employees were aged over 50.

Full details of inclusion and exclusion criteria are in the evidence reviews.

Little evidence was found on the effectiveness and cost effectiveness of interventions for older employees that aim to:

- improve their health and wellbeing
- extend their working lives
- help them prepare and plan for retirement.

A third review (of qualitative research) was restricted to the UK, Australia and New Zealand.

Evidence about the general workforce is likely to be more extensive, but the referral from the Department of Health was specific to older employees and the literature search reflected this.

The evidence identified focused on older employees. It did not identify any head-to-head comparisons between the needs of older and younger employees so the committee couldn't determine whether different interventions are needed for older and younger employees. The committee recognised that the evidence identified may apply equally to younger age groups, and have developed the recommendations to recognise this where possible.

Economic modelling

Economic modelling was carried out from an employer's perspective because they will be paying for the interventions to maintain and improve older employees' health and wellbeing. Because every organisation is different, the committee wanted the modelling to take the form of a cost calculator that could be used by individual organisations.

The cost calculator assumes that employers are concerned only with profits. This is not necessarily the case, so it is likely to underestimate the range of potential benefits to the organisation (such as loyalty and active participation in reaching organisational goals).

To estimate whether an intervention is worthwhile, the organisation inputs its details, including number of employees, annual staff turnover, absentee rate and the gross cost of the intervention. The assumptions made can be modified to model 'what if' scenarios. The calculator then estimates the net cost of the intervention.

The basic cost calculator does not include healthcare costs, but users may add this aspect. The model assumes the intervention will reduce the sickness absence rate.

Employers will need to use their own judgement about how well the assumptions in the model reflect their own circumstances.

In addition, the cost calculator does not take account of any positive or negative effects on third parties. For example, it does not calculate any potential reduction in road collisions, third party injuries or hospital care needed as a result of interventions to improve the performance of older employees who drive as part of their work. **[new 2016]**

Evidence reviews

Details of the evidence discussed are in the evidence reviews.

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

Evidence statement (ES) number 1.1 indicates that the linked statement is numbered 1 in review 1. **ES 2.1** indicates that the linked statement is numbered 1 in review 2. **ES 2.1 (1)** indicates that the linked statement is numbered 1 in review 2 and relates to key question 1. **EP1** indicates that expert paper 'Ipswich Building Society' is linked to a recommendation. **EP2** indicates that expert paper 'People matter' is linked. **EP3** indicates that expert paper 'Workplace practices to improve health' is linked. **EP4** indicates that expert paper 'Expert testimony: Dr Maria Karanika-Murray' is linked. **EP5** indicates that expert paper 'Expert testimony: Sarah Page, Prospect Union' is linked. **EP6** indicates that expert paper 'Health in older workers: an introduction' is linked. **EP7** indicates that expert paper 'Some evidence on impact of Age Management and Work Ability Programmes' is linked. **EP8** indicates that expert paper 'Extending working life, pensions & retirement planning' is linked. **EP9** indicates that expert paper 'Employers' attitudes and practices towards older workers. Policies and approaches to combat barriers for older employees and support extended working lives: an international perspective' is linked. **EP10** indicates that expert paper 'Work Ability model and index' is linked. **EP11** indicates that expert paper 'Extended and extending working lives: your experience of the health and care sector. An international perspective' is linked. **EP12** indicates that expert paper 'Healthy workplaces group (Age Action Alliance) and your work with the Employers Network for Equality and Inclusion'.

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).

The evidence statements from 6 reviews are provided by external contractors.

Section 1.1: ES1.1, ES1.3, ES3.2d; EP1, EP4; IDE; modelling report: economic analysis of workplace policy and management practices to improve the health of employees. **[2015]**

Section 1.2: ES3.2d; EP2, EP4, EP5; IDE **[2015]**

Section 1.3: ES1.1, ES2.1, ES3.1c, ES3.2b, ES3.2c, ES3.4; EP1, EP4, EP5; IDE **[2015]**

Section 1.4: ES3.3; EP4, EP5; IDE **[2015]**

Section 1.4: ES6.2a, ES6.2c; EP9, EP11; IDE **[new 2016]**

Section 1.5: ES2.4, ES3.1d, ES3.2c, ES3.3; EP2, EP4; IDE **[2015]**

Section 1.6: ES3.1a, ES3.1e, ES3.2a, ES3.2b, ES3.2c, ES3.2e, ES3.2f; EP1, EP2, EP4, EP5; IDE **[2015]**

Section 1.6: IDE **[new 2016]**

Section 1.7: ES1.1, ES2.4, ES3.1a, ES3.1d; EP4, EP5; IDE **[2015]**

Section 1.8: ES2.4, ES3.2a, ES3.2b, ES3.2c, ES3.2e, ES3.2f, 3.5; EP2, EP4; IDE **[2015]**

Section 1.9: ES1.1, ES2.1, ES3.1c; EP5; IDE **[2015]**

Section 1.9: ES6.2a, ES6.2c, ES6.3; EP11; IDE **[new 2016]**

Section 1.10: ES3.1c, ES3.1d, ES3.2c, ES3.4; EP1, EP2, EP4, EP5; IDE **[2015]**

Section 1.10: ES4.1, ES4.2, ES4.6, ES6.1a, ES6.1b, ES6.2a, ES6.2c, ES6.3, ES6.4a, ES6.4b, ES6.4c, ES6.8c; EP10; IDE **[new 2016]**

Section 1.11: EP1, EP3; IDE **[2015]**

Gaps in the evidence

Both committees identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence and stakeholder comments. The gaps relating to the original workplace guideline are set out below numbered 1–5, followed by the gaps relating to older employees numbered 6–15.

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 a 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)

6. There is a need for evidence on how different work conditions affect perceived workplace equity for older employees compared with the whole workforce.

(Source: evidence review 6)

7. There is a need for evidence on how workplace interventions for older employees affect health

inequalities.

(Source: evidence reviews 4, 5 and 6)

8. There is a need for evidence on the effectiveness and cost effectiveness of interventions aiming to improve and maintain the health and wellbeing of older employees.

(Source: evidence review 4)

9. There is a need for evidence on the effectiveness and cost effectiveness of interventions to help older employees remain in work. For example, the impact of a change in job specification on retention.

(Source: evidence review 4)

10. There is a need for evidence on the effectiveness and cost effectiveness of interventions to help older employees plan and prepare for retirement.

(Source: evidence reviews 4, 5 and 6)

11. There is a need for evidence on the options for work, retirement and pensions on offer and the impact of these options on a person's decision whether or not to stay on at work. This includes providing flexible and part-time work, or a change in job role.

(Source: evidence reviews 4, 5 and 6)

12. There is a need for evidence on the effectiveness and cost effectiveness of interventions to challenge stereotypes and change employer and general workforce attitudes to older employees.

(Source: evidence reviews 4 and 6, expert testimony 12)

13. There is a need for evidence on the transferability of interventions to support older employees across employment sectors.

(Source: evidence review 6)

14. There is a need for evidence on knowledge about and uptake of newer technologies by older employees.

(Source: evidence review 6)

15. There is a need for evidence on the health benefits and risks of extending working life and how these may vary according to the nature of the work.

(Source: evidence reviews 5 and 6)

Both committees made recommendations for research that they believe will be a priority for developing future guidelines. These are listed in recommendations for research.

Recommendations for research

The guideline committees made the following recommendations for research.

The Public Health Advisory Committee E 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.

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?

2. How can outcome measures relating to workplace health and wellbeing be measured? Research funding bodies such as 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.

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.

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.

Recommendations for research: older employees

The Public Health Advisory Committee D recommends that the following research questions

should be addressed.

1 Maintaining and improving the health and wellbeing of older employees

What are the most effective and cost-effective interventions to maintain and improve the health and wellbeing of older employees?

Why this is important

Demographic changes, and changes to the state pension age, mean the proportion of older employees in the workforce is likely to continue to increase. Productivity depends on the workforce being in good health, and a person's health will affect their ability to stay in work and continue earning an income. However, older employees may wish to remain in work for a variety for reasons other than financial. Continuing to work can have both social and health benefits for older people. So there is a need to further understand what can help to maintain and improve outcomes in this group from a health and wellbeing perspective.

2 Helping older employees stay in work

What are the most effective and cost-effective interventions to help older employees stay in or re-enter work? For example, to overcome the problems of a change in job specification?

Why this is important

Older people are more likely to be unemployed or economically inactive than younger people and tend to find getting back into work after an absence more difficult. It is important to ensure they can stay economically active if possible as changes in the state pension age mean many people will need to work in their later years.

3 Helping older employees plan and prepare for retirement

What are the most effective and cost-effective interventions to help older employees plan and prepare for retirement?

Why this is important

It is important that older employees leave the workforce at the time and in the way that suits them, because a lack of control (this could be perceived or real) over these decisions may have an impact on their wellbeing.

4 Challenging stereotypes and changing attitudes towards older employees

What are the most effective and cost-effective interventions to challenge stereotypes and change employers' and workforce attitudes towards older employees?

Why this is important

Negative attitudes and stereotyping have led to some older people retiring before they wanted to. Changing attitudes and reducing stereotyping may result in people working for longer, with all the associated benefits for them and society. Reducing negative attitudes may also improve mental health and wellbeing and reduce distress arising from exposure to negative stereotyping.

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

Inappropriately continuing to go to work despite health problems. It also describes someone's attendance at work without performing all of their usual tasks (regardless of the reason). When employees feel the need to attend work although they are not functioning fully it can result in losses in productivity. Presenteeism can also make health problems worse.

Vocational rehabilitation

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

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