Project OSCAR: Occupational Stress Consultation and Research

Report 3 Barriers and enablers to effectively manage work-related stress

Health and Safety Executive

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The purpose of this research was to build the evidence base on how work-related stress (WRS) is understood, identified and managed in practice across workplaces. This will be used to help support developments in preventing and reducing the effects of psychosocial hazards in the workplace.

Affinity Health at Work and partners, the Institute of Employment Studies and the Institute of Occupational Medicine, used a multi-method research approach combining evidence reviews, interviews, and stakeholder engagement.

The findings are published in an overarching summary report and three thematic reports addressing the programme's key research questions:

- Overarching summary report: brings together key findings from across the programme
- Report 1: How is WRS defined and labelled by organisations and medical professionals?
- Report 2: What interventions are effective for preventing and managing WRS?
- Report 3: What are the enablers and barriers to organisations effectively reducing the risks of WRS?

The reports will be of interest to employers, practitioners, policymakers, academics and researchers working to improve the prevention and management of psychosocial risks.

In summary, the research found that:

- there is no shared understanding of how work-related stress is defined and labelled

- organisational responses to work-related stress are often reactive rather than preventative
- effective prevention depends on linking interventions to identified psychosocial risks and involving workers in developing solutions
- stronger evaluation and sharing of learning would improve understanding of what works in practice
- the key challenge is how existing knowledge is translated into coordinated prevention activity

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Project OSCAR (Occupational Stress Consultation and Research)

Report 3 Barriers and enablers to effectively managing work-related stress

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Research ethics statement

This study was reviewed by Reading Independent Ethics Committee (Reference: Occupational Stress Consultation and Research; 29.07.2024).

All research for HSE is expected to be carried out with rigour, responsibility and respect following the principles within the Universal Ethical Code for Scientists and, where applicable, the International Code of Ethics for Occupational Health Professionals. This programme of stress research implements these principles and also adheres to the British Psychological Society's code of conduct, Government Social Research professional guidance framework and Market Research Society code of conduct:

Abbreviations

Abbreviation	Definition
AP	Advisory Professional
BMA	British Medical Association
BRC	British Retail Consortium
CFIR	Consolidated Framework for Implementation Research
CIPD	Chartered Institute of Personnel and Development
EAP	Employee Assistance Program
GB	Great Britain
H&S	Health and Safety
HR	Human Resources
HSE	Health and Safety Executive
IES	Institute for Employment Studies
ILO	International Labour Organization
IOM	Institute of Occupational Medicine
MHPP	Mental Health and Productivity Pilot
NI	Not Included
NICE	National Institute for Health and Care Excellence
OH	Occupational Health
OL	Organisational Leader
OSCAR	Occupational Stress Consultation and Research

PAG	Project Advisory Group
PSG	Project Steering Group
RA	Risk Assessment
SIT	Stress Indicator Tool
SME	Small and Medium-sized Enterprise
SOM	Society of Occupational Medicine
WHO	World Health Organization
WRS	Work-Related Stress

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Key messages

Why the work was done

Work-related stress (WRS) is one of the most common causes of work-related ill health in Great Britain (GB). Despite legal duties to assess and control psychosocial risks, action to identify and reduce the risk of WRS remains inconsistent across employers. This research informs HSE's understanding of what contributes to a good management of WRS risk looks like and what gets in the way or helps.

What we did

- Reviewed UK and international research published between 2014 and 2024.
- Interviewed 20 organisational leaders and 10 stakeholders from advisory and professional bodies.
- Ran workshops with stakeholders to check and explore findings.

What we found

- **Organisational culture can enable and block progress**. Visible openness, communication, and support enable uptake of stress management initiatives and help combat stigma. Rigid or toxic practices are incompatible with good WRS management.
- **Operational and resource pressures push WRS down the agenda**, leading to reactive rather than preventative action.
- **Data and measurement are weak or inconsistent.** Gaps in collection, ownership and use of data prevent employers from identifying and managing risk.
- **Management capability is critical.** Managers need competence, confidence, and organisational support to embed WRS management into routine practice.
- **Participation helps, but time is constrained**, with workload pressures and operational constraints limiting opportunities for engagement.
- **Use of HSE tools is patchy**. Reported barriers to adoption include perceptions of complexity, lack of sector specificity, and limited adaptation to hybrid/remote work.
- **Perceived enforcement gap reduces urgency.** Lack of parity with physical risks and limited visibility of enforcement reduce urgency and prioritisation of WRS.

What this means

Making WRS prevention a visible organisational priority despite operational pressures, and taking a systemic approach to address barriers, is needed.

Executive summary

Introduction

Work-related stress (WRS) is a major occupational health challenge in the UK, accounting for nearly half of all cases of work-related ill health and lost working days. Prolonged exposure to WRS is strongly linked to mental health conditions such as depression, anxiety, and burnout, with significant impacts on individuals, organisations, and the wider economy. Despite a robust evidence base linking psychosocial hazards (e.g., job demands, low control, poor leadership, and job insecurity) to poor health outcomes, many organisations struggle to identify and manage WRS risks effectively. To address this, HSE commissioned Project OSCAR to build an evidence base on barriers and enablers to effective WRS management, informing policy development and practical guidance for employers.

Methods

A mixed-methods approach was adopted, combining a systematic literature review, stakeholder interviews, roundtable discussions, and consultation with project steering and advisory groups. This multi-phase process enabled triangulation of evidence from research, practice, and policy perspectives. The analysis focused on barriers and enablers to managing WRS risks, organisational use of HSE guidance and tools, and contextual factors such as sector, size, and leadership engagement.

Key findings

Organisational culture can enable and block progress

The findings show that organisational culture is both a barrier and an enabler to managing WRS. Supportive, inclusive, and open cultures act as enablers by fostering psychological safety, reducing stigma, and encouraging early disclosure, which improves uptake of interventions. In contrast, negative or blame cultures, stigma around stress, and fears of career repercussions act as barriers, particularly in sectors such as public sector, manufacturing, and rail.

Operational and resource pressures push WRS down the agenda, leading to reactive rather than preventative action

Resource pressures, including high workloads, financial constraints, and staff shortages, also create barriers by forcing organisations to adopt reactive rather than proactive approaches.

Data and measurement are weak or inconsistent

Gaps in collection, ownership and use of data prevent employers from identifying and managing risk.

Management capability is critical

Leadership and management capability emerged as enablers. Trained, confident leaders who role model supportive behaviours enable cultures of trust and embed WRS management into routine practice. However, lack of time, skills, or confidence among managers was identified as a barrier that can exacerbate stress, especially where overwork is normalised.

Participation helps, but time is constrained

Participatory approaches, which involve employees in designing and implementing interventions, were found to be strong enablers of engagement and sustainability, though workload pressures and operational constraints frequently acted as barriers to participation.

Use of HSE tools is patchy

Reported barriers to adoption include perceptions of complexity, lack of sector specificity, and limited adaptation to hybrid/remote work. The use of HSE's Management Standards was enabled when there was leadership commitment, worker involvement, and structured frameworks, but barriers included limited awareness, perceived complexity, and a lack of sector specific tailoring.

Perceived enforcement gap reduces urgency

The perceived lack of visible enforcement mechanisms reduces prioritisation of WRS compared with physical health and safety.

Conclusions

Effective control of work-related stress hinges on visible, supportive leadership and managers with the skills and time to act. Stigma and day-to-day pressures (high workload, tight budgets) push prevention aside, so a clear business case and proper resourcing matter. Perceived low enforcement and lower status than physical risks reduce urgency; duties and proportionate compliance should be made clear. Uptake of HSE tools is limited by perceived complexity and poor fit to hybrid work-updating and tailoring them, defining simple core measures to show costs/benefits, and building staff participation into routine processes will lift uptake and impact.

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1 Introduction

1.1 Background to Project OSCAR

Stress is one of the most significant occupational health challenges in Great Britain (GB). It accounts for almost half of all cases of work-related ill health and the number of working days lost due to illness (HSE, 2024). Prolonged exposure to work-related stress (WRS) is strongly linked to poor mental health outcomes, such as depression (e.g., Madsen et al., 2017), and can contribute to serious mood disorders, burnout, and suicide (Khamisa et al., 2015; Howard et al., 2021; Dunning et al., 2022; Teoh et al., 2024).

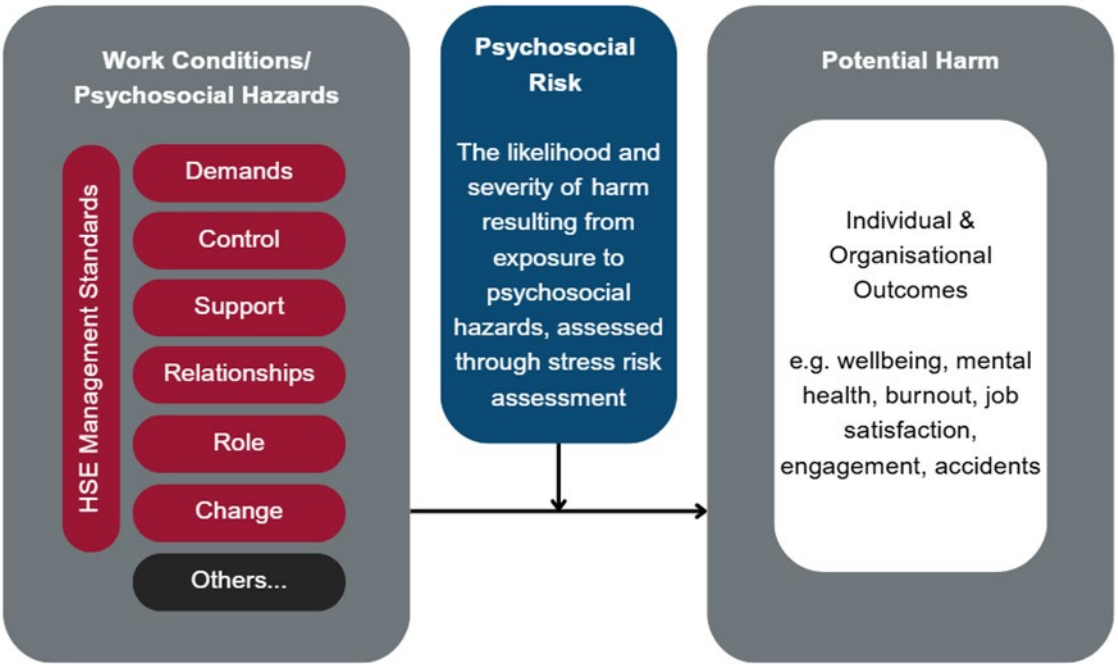
The impact of WRS goes beyond the individual. For employers, it means more sickness absence, presenteeism (coming to work while unwell), reduced performance, reduced productivity, job turnover and early retirement, and the associated costs (e.g., Knapp and Wong, 2020; Hassard et al., 2018; Kinman, 2019). At a national level, it is associated with increased healthcare costs (BMA, 2016) and lowers workforce participation (HSE, 2023).

A strong and consistent body of research shows that specific working conditions (also called psychosocial hazards) are linked to WRS and poor health. These psychosocial hazards can include job demands, long working hours, poor leadership, low job control, low social support, poor work relationships, low work recognition, and high job insecurity as reflected in Figure 1 (Burman et al., 2018; van der Molen, 2020; Teoh et al., 2023). Many of these psychosocial hazards are reflected in HSE's Management Standards for WRS. The likelihood of these hazards causing harm and the severity of this potential outcome is referred to as psychosocial risk. It is this risk of psychosocial hazards potentially leading to harm which organisational and individual stress risk assessments seek to understand in order to put in place mitigations to reduce this risk.

Despite this evidence, many employers are not taking action to identify and reduce the risk of WRS. According to the CIPD Health and Wellbeing Report (2023) only 40% of the 726 organisations surveyed were taking steps to identify causes of stress using surveys, interviews or stress risk assessments/stress audits.

There is a perception that managing WRS is more complex than managing physical risks. The causes and impacts of stress are shaped by a mix of personal, organisational, and wider system factors. Unlike physical hazards – where the relationship between the hazard and outcome is directly measurable and where controls are more commonly used (such as reducing the risk of falling from height with barriers and safety equipment) – WRS is generally perceived to be harder to identify, manage, and mitigate. Some organisations are also likely to have implemented measures such as good work design or management practices, which they do not recognise as mitigations for WRS and so underestimate the action they have already taken.

Figure 1. Evidence on psychosocial hazards, risk, and their links to outcomes



It is important to recognise that many factors involved in managing WRS can sit outside the traditional scope of how organisations comply with health and safety legislation. For example, in sectors like education and healthcare, working conditions are often shaped by staffing levels, unpredictable/external work demands, funding models, trade union negotiations, professional regulation, and national policy. These factors may limit what individual employers are able to change. While the employing organisation is ultimately responsible for managing work-related stress under health and safety law, the actions taken often sit with human resource or occupational health teams. These teams may be less familiar with health and safety duties or may not work closely with those responsible for legal compliance within their organisation. HSE can take enforcement action, where appropriate, but identifying where and how poor management of stress and psychosocial hazards has created a risk of harm may be unclear.

At the same time, public and workplace conversations have changed. Terms such as “stress,” “mental health,” and “wellbeing” are used frequently and interchangeably. There has been a rapid growth of initiatives such as Mental Health First Aid and the Thrive at Work Standards. While these efforts have raised important awareness of and engagement with mental health, they can sometimes create ambiguity between individual-level wellbeing and systemic management of psychosocial risk. This may lead to confusion around roles, responsibilities, expectations, and what counts as an employer’s duty.

To address these issues, the HSE commissioned Affinity Health at Work, the Institute of Occupational Medicine, the Institute for Employment Studies, and the Society of Occupational Medicine through a competitive tender process to lead the Occupational Stress Consultation and Research Programme - Project OSCAR.

Project OSCAR is designed to provide HSE with robust evidence to inform policy development and practical guidance for employers on preventing and managing work-related stress. The research addresses three priority questions identified by the HSE:

1. How is work-related stress (WRS) assigned and/or labelled by (a) an organisation and (b) medical professionals?
2. What are the enablers and barriers to organisations effectively reducing the risks of work-related stress?
3. What interventions are effective for preventing and reducing work-related stress?

This report summarises study activity and findings related to the third research question. Study activity and findings related to first and second research questions have been reported separately (see report 1 and report 2)

1.2 Background to research question three

Recognising the role implementation plays in determining the success and efficacy of interventions, there is a growing body of research on implementation issues. Prior reviews on implementing workplace mental health initiatives (Daniels et al., 2021; Yarker et al., 2022; Nielsen et al., 2023) point to common success factors: visible senior commitment, alignment with business goals, and resourcing; capable line managers with time and clear roles; and approaches that fit the local context and involve employees. They also emphasise the importance of understanding the process of intervention delivery (reach, dose, fidelity, mechanisms) as well as outcomes, and embedding activity into “business as usual” rather than bolt-on programmes. Much of this evidence comes from large public-sector settings, with Small and Medium-sized Enterprises (SMEs) and several sectors under-represented.

While offering valuable insights, existing reviews are focused on the full spectrum of workplace mental health interventions and do not focus specifically on the organisational level barriers and enablers specific to reducing WRS risks. Furthermore, there is very limited analysis of the adoption of the HSE Management Standards, risk assessment templates or the Stress Indicator tool, and therefore much of our understanding about implementation barriers and enablers is inferred. They rarely map findings to specific psychosocial risks or describe the practical steps organisations take to scope hazards, gather data, agree controls and review impact. Comparisons by size, sector and resources are thin.

There is a need for focused research to identify the enablers and barriers to organisations in managing WRS, and specifically in using HSE guidance and tools in

real-world settings. These findings could help us to understand what tailoring, support and processes would increase adoption and effectiveness.

1.3 Research aims

HSE needs to have a clear and robust understanding of what contributes to good management of WRS risk and what barriers to reducing the risk may exist. This is key to helping ensure that HSE can support and guide duty holders, as well as provide appropriate guidance to inspectors. Detail on barriers and possible enablers to managing WRS risk had not been robustly collated, and had remained superficial, rather than addressing the deeper root causes/contributory factors.

This research aims to answer the question '**What are the barriers and enablers to organisations effectively reducing the risks of WRS?'** Sub-questions, agreed through a process of consultation with the HSE and the Project Advisory Group and Project Steering Group, helped to guide the research focus:

1. What are the enablers and barriers from an organisation's perspective? (e.g., attitudes, resources, knowledge/awareness, responsibilities, trusted sources).
2. What are the enablers and barriers to the use of current HSE guidance and tools?
3. What are the enablers and barriers in terms of understanding and developing a WRS risk assessment?
4. How do influencing factors impact WRS management?

2 Methodology

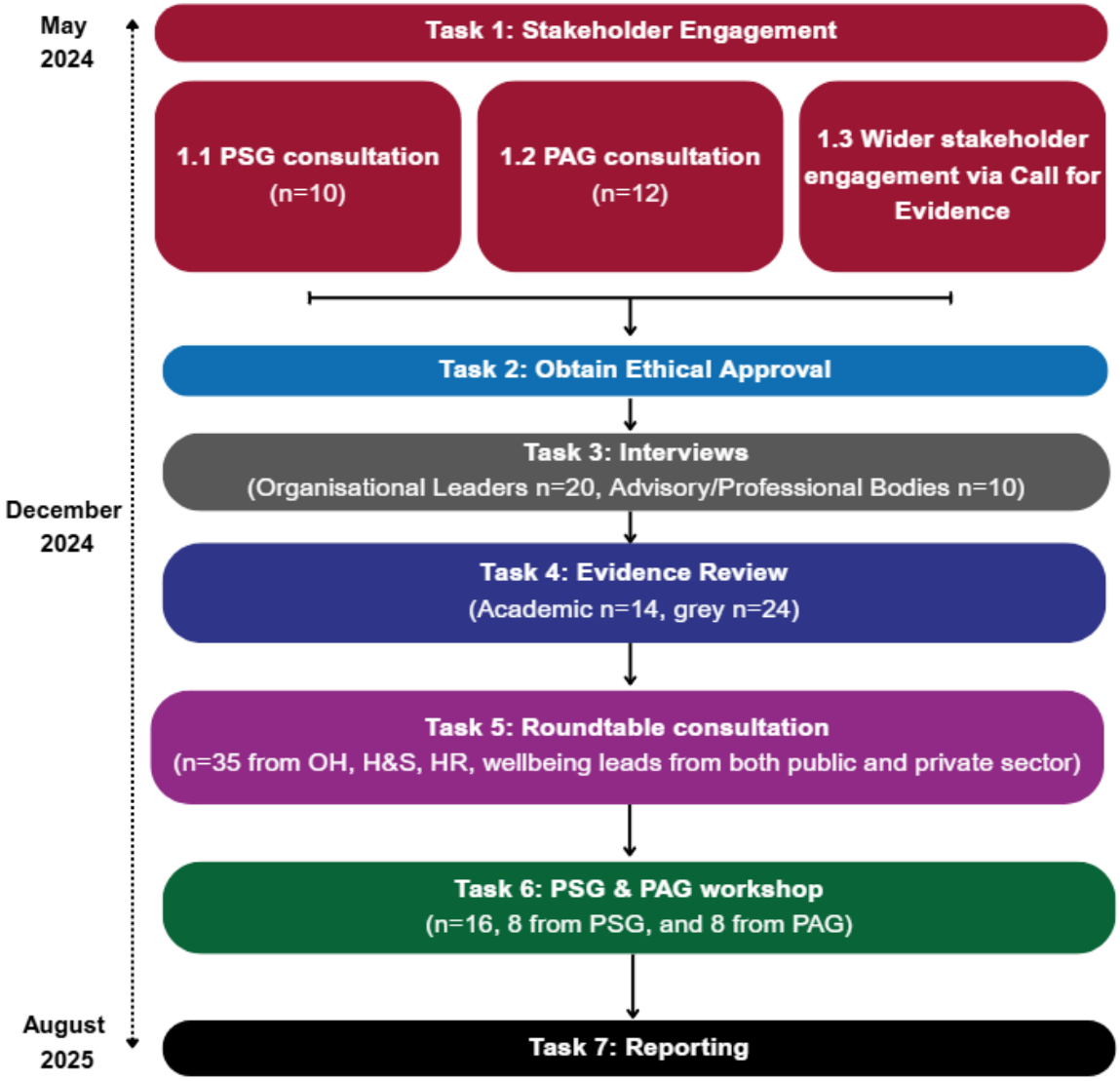
A multi-phase, mixed methods approach combined findings from: stakeholder engagement, a systematic literature review, stakeholder interviews, roundtable discussions and consultation with Project Steering Group (PSG) and Project Advisory Group (PAG). This was carried out as shown in the flow chart in Figure 2 below.

This mixed-methods approach was selected to make sure that findings were both evidence-informed and grounded in the realities of practice. Each phase of the research was designed and delivered in line with scientific best practices. Full details of the methods used and supporting materials are provided in Appendix 1 on page 45.

Data from each phase was integrated using a narrative synthesis to address the research questions. A formal quality assessment was applied to the academic literature review which included studies predominantly of low to moderate quality. The wider project prioritised the engagement of diverse stakeholders to gather new insight and identify implications for practice. As such no overall rating of the quality of the evidence is provided.

The findings presented are intended to inform future work and discussion rather than provide definitive conclusions. The strengths and limitations of the methodologies used in this research should be kept in mind when considering the findings and implications of this research. Further details of the strengths and limitations of this study can be found in Appendix 5 - Strengths and limitations on page 119.

Figure 2. Flow chart showing methodology of research undertaken



3 Findings

The following section summarises findings from across all sources of evidence relative to the four sub-questions of interest (detailed within section 1.2) segmented by common findings evident across data sources; insights drawn from the literature; and insights drawn from interview data. Detailed findings from each research phase are available in Appendices 2-3, starting on page 78. Appendix 6 – Mapping of evidence sources, summarises how each theme contributes to each research question and relevant data sources contributed.

A note on terminology - The practitioner literature frequently employs *wellbeing* as a lay term, reflecting a tendency to present discussions of WRS in a manner perceived as more accessible or acceptable to employers and non-specialist audiences. Where authors have adopted 'wellbeing' as descriptor that is replicated here: note that the term 'wellbeing initiatives' may describe activities intended to address WRS, while also encompassing broader workplace health themes (as detailed in section 1.1).

This study encompassed a rapid evidence review of 14 academic papers of variable quality (n=2 high quality, n=6 moderate quality, n=6 low quality as detailed in Table 3, based on author or researcher judgement) and 24 items of grey literature. Diverse industry representatives were also consulted through semi-structured interviews and roundtable discussion using a purposive sampling approach. The combination of evidence types provides a more holistic view than would be possible through a single method alone. However, the focus on qualitative synthesis and stakeholder engagement means that conclusions should be interpreted with caution and within the context of the data sources included. Therefore, the findings cannot be generalised across whole populations or sectors but rather provide an indication of what is happening "on the ground" and/or expert perceptions of this.

3.1 Enablers and barriers from an organisation's perspective

3.1.1 Common findings across data sources

Organisational culture and stigma surrounding stress and mental health was commonly cited as a barrier, or conversely an enabler, within the empirical data and identified literature.

Positive organisational culture, is generally referred in the literature as one that promotes:

- openness
- trust
- inclusivity

A ‘just culture’ was viewed as a key enabler for WRS management (Cambridgeshire Constabulary, 2024; Bagnall et al., 2016; Pandey et al., 2022; Donohue et al., 2024; National Institute for Health and Care Excellence [NICE], 2022). In workplaces where employees felt safe to disclose mental health challenges, without fear of stigma or negative repercussions, there was greater uptake and success in wellbeing interventions (World Health Organization [WHO], 2022; Bagnall et al., 2016; Daniels et al., 2022; Pandey et al., 2022; British Retail Consortium [BRC] Response, 2024; Donohue et al., 2024).

Enabling cultures were exemplified during Organisational Leaders (OLs) interviews as having supportive management, strong team dynamics, and open discussions about workload pressures (noted particularly in emergency services).

Negative organisational culture, was characterised by OLs as:

- limited communication.
- minimal staff interaction.
- blame-culture when problems arose.

OLs interviewed described this type of environment as a barrier to effective identification and management of WRS. Advisory Professionals (APs) also discussed the role of organisational culture when managing WRS, expressing concern that many organisations are focussed on delivering high workloads in fast-paced, high-pressure environments often creating emotionally demanding conditions for employees.

‘Toxic’ work environments referred to within the literature and by interview participants were characterised by rigid management practices and resistance from leadership and other stakeholders acting as major obstacles to effectively managing WRS risks (BRC Response, 2024; CIPD, 2023; Julings and Cowen, 2023).

Stigma, the negative judgement and disadvantage people face because of a particular issue, in this case stress, was highlighted by both the literature and interview data (OLs and APs) as a major barrier to managing WRS. Employees often feared negative repercussions, which discouraged them from engaging with support interventions (Bernard et al., 2022; Stevenson and Farmer, 2017; Julings and Cowen, 2023; WHO, 2022; Virtanen et al., 2024; Pandey et al., 2022; World Health Organization and International Labour Organization [WHO/ILO], 2022).

- Some sources cited stigma as the primary barrier to participation in WRS interventions (Fallon et al., 2023).
- Others highlight stigma to be more acute where confidentiality concerns arise (Kinman, Teoh, and Harriss, 2020).
- Several OLs reported that employees worried about the career impact of admitting stress.

This stigma was especially strong in certain industries/sectors:

- Public sector: A belief that admitting stress signals weakness or lack of resilience.
- Manufacturing and rail: Employees feared that reporting stress would harm promotion opportunities.

With respect to overcoming stigma, some APs noted that their clients had begun to acknowledge stressful environments, but stigma was still considered to prohibit engagement with support offerings and many organisations still failed to recognise the impact of WRS on wellbeing.

Within the literature, factors said to enable a psychologically safe culture included:

- Mental health awareness campaigns (Pandey et al., 2022).
- Senior leaders normalising conversations around mental health and demonstrating personal vulnerability (Brassey et al., 2022; Pandey et al., 2022).
- A broader "culture of health", where mental health is embedded in values and business goals, was linked to highly effective WRS management (Nicholson, 2022).

Costs, demands, and resources were frequently described as interconnected barriers that limit organisations' ability to prioritise work-related stress (WRS) and take proactive, preventative measures.

Key Resource and financial limitations, such as lack of time to deliver or access workplace interventions and staff shortages (Aust et al., 2023; Nicholson, 2022; WHO, 2022; Yarker et al., 2022; Mental Health and Productivity Pilot [MHPP], 2024; Stevenson and Farmer, 2017; von Thiele Schwarz et al., 2020), alongside financial constraints (CIPD, 2023; Wilson et al., 2019; BRC Response, 2024; ILO, 2016), were found to hinder the implementation of interventions, particularly in SMEs. In contrast, when time, resources, and financial investment were available, these same factors were seen as enablers of success (Fallon et al., 2023; von Thiele Schwarz et al., 2020; Paterson et al., 2024; Yarker et al., 2022).

Nicholson (2022) and NICE (2022) highlight the importance of presenting a data-driven business case to secure management commitment and subsequent investment in WRS interventions, though difficulties in linking interventions directly to worker outcomes or cost effectiveness can weaken the argument for investment. Waddell (2023) highlighted challenges to implementing mental wellbeing interventions in the workplace, including understanding which intervention has the highest quality evidence underpinning it and deciding which will present the best return on investment. Referring to NHS investment in health and wellbeing services, "times of austerity" were said to impact public spending within healthcare trusts and restrict investment in staff wellbeing services (NICE, 2022).

Some OLs, particularly in local authority and healthcare settings, described the cost of using a more preventative approach (co-ordinating a stress survey and taking preventative action) as a barrier to using WRS tools, such as the HSE's Stress

Indicator Tool, preferring instead to adopt more reactive approaches for WRS management. In some instances, OLs acknowledged the importance of proper risk assessments and stress support, however emphasised that their budgets were too constrained to implement them.

Workload pressures and having **competing priorities** were also commonly cited in the literature (Kinman, 2021; Julings and Cowen, 2023; MHPP, 2024). Feelings of guilt when needing to take time away from work to access support and/or prioritise personal wellbeing needs were also noted (Julings and Cowen, 2023). These concerns were echoed during interviews with OLs. Some OLs expressed a willingness to adjust workloads or allocate time to stress prevention activities (e.g., protected time with managers to raise WRS issues; personal resilience training scheduled on inset days to enable attendance; and allowing modification of timetables to enable additional planning time when needed). The financial burden of bringing in relief staff to support during periods of high WRS or in exceptional circumstances was highlighted in the education sector.

A number of OLs highlighted that work demands were not easily reduced due to financial or operational limitations (e.g., client demands or external pressures). This sentiment of continuous busy and pressurised environments was echoed by multiple OLs across different sectors, said by some to overshadow employer efforts to manage WRS, with client demands and service delivery often reportedly prioritised over the wellbeing of those delivering the service. In such environments, time constraints on engaging with interventions were often cited in the literature as resulting from staff burnout or fatigue (Kinman, 2021; Teoh et al., 2023; Julings and Cowen, 2023) with workers subsequently less receptive to wellbeing initiatives offered (NICE, 2022). Relative to organisation directed interventions, De Simone, Vargas, and Servillo (2019) also highlight "*enhancing job resources (e.g., social support, autonomy, performance feedback and opportunities for development) that can moderate the influence of workload on burnout*" as an opportunity for management.

In a housing sector organisation, an OL interviewee described how continuous tenant needs made it seem impossible to pause normal operations and conduct a stress survey for staff. Health and care sector leaders reported that staff shortages and rising patient needs created practical barriers to implementing proactive measures. Those in education noted that heavy workloads, and tight marking deadlines, coupled with staff turnover, left little space for wellbeing initiatives. Although a few leaders managed to incorporate wellbeing checks into routine meetings, the consensus suggests that cost, demands and resource challenges combined create a perpetuating cycle in which WRS can remain unaddressed until it reaches a critical point.

APs reported that in organisations in which WRS was not seen as a priority there was little investment, and on some occasions, no will to invest in resources (both time and financially). Such organisations were seen by respondents to be more 'finance

focused rather than people focused', often taking a short-term approach to the management of WRS, instead of considering the long-term implications (e.g., sickness absence and staff retention). APs speculated that some organisations simply did not have the means to fully implement any changes.

The importance of **data gathering** was noted in the literature and by interview participants. Advocated by the HSE's 'five steps of risk assessment'[1] (cited within NICE, 2022), data collection from diverse sources and in different forms can support organisations management of WRS, from identification of risk factors to target, through to assessing effectiveness of interventions provided. OLs interviewed reported limited data collection through which to understand and measure WRS within their organisation. Reliance on basic metrics, such as absence rates, were commonplace yet fail to provide a comprehensive understanding of WRS causes and contributors within an organisation. Some OLs reported having no formal measures of identifying and classifying WRS and therefore relying upon self-report (e.g., through ad hoc, individual conversations) and generic staff satisfaction surveys.

The CIPD (2023) found that many organisations, particularly SMEs, can struggle to collect and interpret data to help identify interventions that would deliver the required WRS support. **Poor or inconsistent data collectio**n included low levels of disclosure by employees (CIPD, 2023), inadequate sickness absence records lacking detail to be of use (BRC Response, 2024, MHPP, 2024), and the lack of analytical expertise limiting the ability to monitor staff wellbeing outcomes and adjust measures accordingly (MHPP, 2024). In one study, over one third of organisations (36%) did not feel they had the expertise to analyse data and form recommendations and 27% did not use data to inform their wellbeing plans (MHPP, 2024). This may help to explain the limited data collection and measurement of WRS reported by OLs, with incomplete sickness absence data also highlighted by some OLs, as employees do not always disclose the reason for their absence.

While **impact measurement** was highlighted as a priority among interview participants and in the literature, OLs acknowledged challenges in measuring the effectiveness of WRS initiatives. These included: low case numbers of WRS (known by the business), confidentiality limiting measuring the impact of certain initiatives and data limitations, lack of robust evaluation, reliance on self-report and inconsistent application of initiatives/interventions. Some OLs stated that their organisation did not measure the impact of WRS initiatives at all or that they only become aware of WRS when an employee goes off sick with 'stress, anxiety and depression' (as can be stipulated on a fit note), at which point the problem has reached crisis level. Bernard et al., (2022) highlights the importance and value of collecting data to enable comprehensive and ongoing evaluations thereby enabling such insights to inform future implementation, with interventions cited to do so reported as more effective.

[1] Superseded by Managing for health and safety (HSG65)

The potential for data to inform and evaluate WRS appears to be challenging for organisations to achieve in practice, creating further barriers to justifying the business case for investment and proactive prioritisation of WRS amongst senior management (another common organisational barrier already cited above). It may therefore be beneficial to provide senior leaders in organisations with the support to navigate the measurement of mental health and the impact of WRS interventions, and how to translate this knowledge into organisational best practice (MHPP, 2024).

3.1.2 Insights drawn from the literature

No standalone findings emerged from the literature review with respect to enablers and barriers from an organisation's perspective.

3.1.3 Insights drawn from interview data

Though not identified within the literature, a theme raised in the interviews with OLs and APs was a **perceived lack of strong enforcement** mechanisms for stress management. Despite high self-reported knowledge of the legal requirement to undertake risk assessments amongst OLs interviewed, many organisations stated that they did not routinely do so, with APs observing the absence of such actions amongst their members/followers. Some participants speculated that this could be due to there being few repercussions for not undertaking risk assessments, and because WRS and wellbeing were perceived not to have the same parity as physical health and safety within organisations. Furthermore, this was described as diminishing the sense of urgency for organisations to comply with relevant legislation and prioritise stress management.

Implications for research

- The business case for WRS management could be supported through provision of diverse case study examples set in context with resource (staff, time money) and impact to nudge stress Risk Assessment (RA) and data collection as a minimum. Consider communicating the business benefits to safer workplaces e.g., reduced sickness absence.

Implications for practice

- Encourage cultivation of psychologically safe workplace cultures through leadership modelling, anti-stigma campaigns, and embedding mental health into organisational values.

- Clarify organisational duties and consequences (e.g., enforcement) to ensure stress management is treated with the same rigour and proactive consideration as physical risks. Enhance organisations understanding of the importance and means through which to assess WRS and evaluate the impact of interventions implemented, thereby enabling proactive understanding and management of risk.

3.2 Enablers and barriers to using current HSE guidance

3.2.1 Common findings across data sources

No prominent convergent themes were evident across both literature and consultation data.

3.2.2 Insights drawn from the literature

NICE (2022) was the only included peer reviewed literature source to explicitly reference barriers and enablers to the use of HSE guidance and tools. Included within this review paper two qualitative studies (Mellor et al., 2011; Mellor et al., 2013) specifically explored implementation of the HSE Management Standards within workplace settings. One such study (Mellor et al., 2013) explored application of the Management Standard approach, through case studies undertaken in five large organisations.

Documented enablers to the management of WRS amongst those large organisations implementing the Management Standards approach included: worker involvement in exploring problems and developing solutions; line manager commitment and training related to stress risk assessment; support from the senior management team to monitor and review action plans to assess effectiveness.

Barriers reported were manager ‘unavailability’ following risk assessments, along with a culture fixated on operational targets and frequent organisational change. It should be emphasised that such findings are evident within the academic and grey literature more generally and echo other areas of H&S management. They are not isolated challenges pertaining to specific use of the HSE Management Standards approach.

NICE (2022) reports that “*Incorporating 'HSE management standards' into organizational policy allowed causes (work/non-work) to be discerned”,* though this reported finding is acknowledged to be unsubstantiated with participant quotes within the source paper. Furthermore, the authors highlight assumptions of both management commitment and worker involvement to deliver an intervention relevant to address worker needs. Additional guidance from HSE is called for by the authors to support more rigorous evaluation of the HSE management standards.

3.2.3 Insights from interview data

Interviews with APs specifically identified a small number of enablers to the use of current HSE guidance and tools. **Detailed and comprehensive guidance** that

accompanies the HSE Stress Indicator Tool was considered supportive towards organisational assessment. At an individual level, some suggested that Talking Toolkit questions could help line managers guide discussions around WRS and support the development of a more formal approach to improving employees' experiences of stress at work. However, if done effectively this may take a long time to work through.

With respect to barriers to the use of HSE stress tools and resources (such as the Stress Indicator Tool and the Talking Toolkit), interviews with OLs and ABs expressed the **perceived need for HSE resources to be updated** given the change in workplaces over the last few years, to reflect the now commonplace flexible working, and to advocate for more focus on preventative approaches as opposed to reactive approaches to identify and manage WRS. OLs reported a **lack of consistent understanding and application of HSE tools**, (e.g., Management Standards), finding them challenging to apply and not user-friendly, as well as lacking specificity to support practical application in different sectors/organisational context. Language barriers and complex methodologies were also said to make it challenging to apply existing tools effectively. APs also questioned whether the Management Standards sufficiently cover issues such a job design and task allocation in relation to WRS.

APs highlighted further barriers to industry use of HSE stress resources. There was **varying organisational and managerial awareness of the HSE Management Standards,** which in turn affected if and when they were used. Organisations often default to generic wellbeing initiatives such as Employee Assistance Programmes (EAPs) or occupational health services rather than using the HSE Stress Indicator Tool to identify and manage specific WRS risks. APs reported lack of clarity among employers regarding whether use of the HSE Stress Indicator Tool is mandatory**.** Interviewees stated that the language regarding use of such tools could be strengthened to encourage use, although some APs questioned the adequacy of HSE resources/tools to monitor and act on WRS issues. Line managers not being trained to use the HSE tools properly was flagged by APs. When trained, line managers may still lack the time needed and/or confidence to effectively address all the questions and apply the Standards. Finally, concern was expressed that use of the HSE tools may become a tick box exercise, rather than a tool through which to highlight opportunities to manage WRS.

With respect to undertaking stress risk assessments, some OLs acknowledged that the use of HSE Management Standards enables a structured framework for stress risk assessments. A small number of OLs reported that stress risk assessments are reviewed within their organisation (e.g., by the health and safety team or the occupational health team). In some instances, APs acknowledged that the HSE stress risk assessment tools and resources were well developed and provided a framework through which organisations can review what is occurring and where gaps in their management of WRS lie. However, for many APs they believed there was a

knowledge and implementation gap, and that **further education around stress risk assessments, the nature of psychosocial hazards, and how risk assessments should be undertaken and applied in organisations was needed**.

Implications for Practice

Bridge the gap between research and industry practice - provide further guidance to apply and evaluate interventions applied within organisations.

Promote awareness and understanding of quantitative and qualitative WRS data sources amongst organisational leaders and managers to reduce knowledge gaps that limit their use and to help identify issues.

3.3 Influencing factors impacting WRS management

3.3.1 Common findings across data sources

The **Impact of leaders and managers** on WRS management was a common factor reported across interview data and literature sources. The literature highlighted how inadequate accountability at a senior leadership level (Stevenson and Farmer, 2017); a lack of prioritisation by senior managers (CIPD, 2023; Pandey et al., 2022) or line managers (MHPP, 2024); or waning leadership interest in wellbeing and/or WRS can hinder the effectiveness of wellbeing interventions (NICE, 2022). Other sources (Paterson et al., 2024) cite leadership and management as an enabler to effective implementation of workplace interventions when proactive leadership buy-in and support are evident. Paterson et al., (2024) and WHO (2022) also advocate for leaders, and workers, to have an awareness of mental health issues, thereby reducing stigmatising attitudes and enabling self help and support provision for others.

Interviews with OL and APs commonly identified managers as critical in supporting conversations about mental health, encouraging openness and fostering supportive work environments that enable preventative rather than reactive approaches to WRS management. Within this, AP members specifically highlighted the importance of ‘good management practices’, such as senior and line managers placing mental health and wellbeing on organisational agendas and visibly promoting a supportive environment. They also noted that poor line management could be compounded by organisational cultures (further explored within section 3.1) that do not approach mental health as stringently as health and safety, and where employees may be rewarded for overwork and burnout.

Positive leadership involvement and endorsement was often cited as a critical enabler to the success of workplace wellbeing interventions (CIPD, 2023; BRC Response, 2024; Pandey et al., 2022; Daniels et al., 2022; Brassey et al., 2022; Teoh et al., 2023). The evidence suggested that when senior leaders prioritise mental

health, role model supportive behaviours and openly share relevant personal experiences, this set the tone for a more psychologically safe and inclusive work environment to enable discussions. Their influence then ensured greater strategic alignment, resource allocation and sustainability of interventions (Daniels et al., 2022; Brassey et al., 2022; Pandey et al., 2022; BRC Response, 2024; Teoh et al., 2023).

Some OLs acknowledged that even when internal guidelines were available within their organisation, translating them into concrete daily actions remained challenging. Specific examples cited included: varying support from local level management, local level management overlooking legislation; being perceived as interfering when championing internal guidelines and a lack of understanding amongst managers and access to relevant training. These challenges were not confined to large or small organisations, with examples from both facing difficulties in embedding proactive stress management into their operations. Both OLs and APs noted that mental health concerns often receive less attention than physical health issues, leading to a reactive rather than preventive approach. Pandey et al., (2022) found that senior managers, line managers and HR need to be empowered to effect change to manage WRS risks.

Having the relevant knowledge and skills is a way to empower managers, however evidence from the grey literature suggests they lack the confidence, knowledge and skills to manage and address WRS risks (CIPD, 2023; Kinman et al., 2020; Pandey et al., 2022; ILO, 2016). The CIPD (2023) reported that just three in 10 organisations provide the relevant guidance and training for line managers.

When managers have access to sufficient and continuous management support (Leka and Jain, 2024) were skilled in responding empathetically (Bagnall et al., 2016; Nicholson, 2022; Daniels et al., 2022; Pandey et al., 2022) the reported effectiveness of wellbeing intervention increased. APs emphasised that line management training was key to helping managers develop awareness of the link between health, stress and performance, and the skills to provide employees with the ‘right’ support. The role of developing a culture in which employees trusted senior managers and line managers and felt safe to disclose WRS and mental ill health was often mentioned. In many cases however, managers were reported to be under intense pressures themselves, not having the time or the resources to manage WRS effectively, and very rarely having been trained and confident to have sensitive conversations.

The **absence of clear roles and defined responsibilities** were highlighted as a barrier to managing WRS. Both OLs and APs reported difficulties within their organisation or amongst their members, in defining roles and responsibilities with respect to supporting WRS management. Furthermore, employees were said often to find it hard to determine who to approach with WRS-related concerns, leading to scenarios where actions to reduce stress generally occurred only after problems had intensified. Workplace champions and dedicated health and wellbeing roles were highlighted as key facilitators in coordinated and embedded activities within NICE (2022). Within SME’s there were specific barriers linked to the lack of an HR

department or established teams alongside the lack of time and resources to effectively support the implementation of WRS interventions (Virtanen et al., 2024).

APs perceived an **awareness gap** amongst their members, with some organisations believed to be unclear of 'what works' with respect to managing WRS. The literature emphasises the importance of ensuring employee awareness of what support is available and how to access it, with evidence suggesting this can otherwise hinder the success of interventions (Kinman, 2021; Deloitte, 2022; Julings and Cowen, 2023; MHPP, 2024).

3.3.2 Insights drawn from the literature

The literature highlighted the **importance of participatory approaches** and workforce engagement when developing and implementing any wellbeing intervention, including those to manage WRS (Bernard et al., 2022; Fox, 2022; Kuster, 2017; Paterson et al., 2024). Employee participation from the planning phase through to intervention implementation was seen in the literature to lead to a better understanding of wellbeing needs and potential solutions (Teoh et al., 2023), ownership of interventions, and employees' engagement with them (Teoh et al., 2023; Bagnall et al., 2016; Cambridgeshire Constabulary, 2024; Leka and Jain, 2024; WHO/ILO, 2022).

Grey literature sources specifically referred to the need to enlist specialist expertise and knowledge to support effective management of WRS, or alternatively upskill staff with specialist knowledge, e.g., specialised training for facilitators of mental health interventions (MHPP, 2024) to ensure management of potential risks. This is especially the case in micro-organisations (10 employees or less) (Gov UK, n.d), where managers have reported lower levels of confidence and capability in addressing mental health problems (MHPP, 2024), and the opportunity or feasibility for management training is more challenging due to a lack of resources (WHO, 2022). Another source reported that OH services can sometimes lack the expertise required to support mental ill health problems experienced by healthcare professionals (Kinman et al., 2020).

Practical challenges to accessing secondary and tertiary interventions and support were documented within the grey literature only. These included having the physical space for workers to engage with an intervention (e.g., availability of rooms for quiet spaces or to have confidential conversations) (Wilson et al., 2019; Julings and Cowen, 2023); the wellbeing services being in an inconvenient location (Kinman et al., 2020); technical access issues and IT services (Kinman, 2021; Teoh et al., 2024); or long waiting lists (Kinman, 2021). Similarly, having too many options for employee support, is said to potentially reduce an employee's engagement and uptake of wellbeing interventions (Kinman, 2021).

3.3.3 Insights drawn from interview data

No standalone themes emerged from the interview data with respect to influencing factors impacting WRS management.

Implications for practice

Ensure leaders and managers are competent and confident to lead and support matters of WRS, with emphasis placed on role modelling desired practices and how to foster a psychologically safe workplace.

Encourage organisations to co-design WRS interventions/support with members of their workforce to maximise relevance and value and minimise barriers to participation/engagement.

Advocate that organisations consider the parameters of expertise within their own workforce and therefore whether specialist training provision or whether enlisting external support (e.g., OH expertise) would support recognition and management of WRS at a preventative level (e.g., WRS risk assessments) interventions.

Ensure roles and responsibilities for identifying and managing WRS are clearly defined through the workforce (e.g., managers, leaders, specialist roles and employees).

3.4 Key findings specific to WRS management

3.4.1 Stigma and organisational culture impacting early identification of WRS

Organisational culture plays a critical role in the management of work-related stress (WRS). Negative cultures, where stress is perceived as a weakness and employees fear career repercussions, discourage early disclosure and reduce engagement with interventions. In contrast, cultures that foster psychological safety, openness, and trust are associated with more proactive measures along with higher uptake and greater effectiveness of WRS initiatives. Sectoral differences are also evident; in industries such as government, manufacturing, and rail, prevailing beliefs about resilience often lead staff to delay reporting stress until issues have escalated.

3.4.2 Operational pressures and resource constraints challenging participation with secondary/tertiary interventions

High workloads, staff shortages, and competing operational priorities often lead to the deprioritisation of WRS prevention, with organisations focusing instead on immediate service delivery. As a result, WRS is frequently addressed reactively, once it has escalated to crisis point, rather than through proactive and systematic hazard control. Burnout, fatigue, and other workload pressures further reduce employees' capacity and willingness to engage with interventions, limiting their overall effectiveness.

3.4.3 Limited visibility of enforcement appears to reduce prioritisation of WRS management

The absence of meaningful consequences for non-compliance appears to contribute to low reported levels of stress risk assessment and proactive action. WRS often lacks parity with physical health and safety in organisational priorities.

3.4.4 Data gaps hinder feedback and progress of WRS management

Many organisations lack consistent and standardised data collection on the causes, prevalence, and impacts of WRS. Reliance on absence rates, broad staff surveys, or informal feedback provides only limited insight into underlying drivers. Without more detailed data, it becomes difficult to evaluate the effectiveness of interventions or demonstrate return on investment, thereby weakening the case for proactive investment in WRS prevention.

3.4.5 Barriers to effective use of HSE management standards

HSE's Management Standards framework and associated tools (e.g., the Stress Indicator Tool (SIT), guidance document, talking toolkit, etc…) are often considered complex and overly generalised, lacking specificity to sector-related WRS hazards and not fully accounting for new ways of working (e.g., remote/hybrid). Limited awareness, inconsistent application, and uncertainty regarding their mandatory nature are reported by industry to further contribute to low uptake. Consequently, many organisations default to generic wellbeing measures rather than using the HSE Management Standards framework to identify and manage WRS risks.

3.4.6 Management confidence and capability are critical to assessing and addressing WRS risks

Even where WRS policies and processes are in place, managers may lack the confidence, capability, or time to discuss stress hazards and implement appropriate controls. Inadequate line management capability can exacerbate WRS, particularly in organisational cultures that normalise overwork and burnout. Manager competence in recognising, assessing and addressing WRS risks appears to be a key determinant of whether prevention is embedded.

3.4.7 Participatory approaches improve WRS identification and action

Involving workers in the development, planning, and implementation of WRS interventions enhances hazard identification, fosters stronger ownership, and increases engagement. However, practical barriers such as heavy workloads, limited physical space for activities, and restricted IT access can constrain participation in WRS initiatives.

4 Conclusions

Our findings are consistent with earlier reviews, highlighting the importance of visible leadership, capable line managers, participation and local fit. The findings further extend this knowledge by focusing specifically on preventing WRS, exploring: barriers and enablers from organisations perspective; how HSE guidance and tools are actually used; implementation of stress risk assessment; and identifying influential factors to WRS management.

No study is without strengths and limitations (Summarised in Appendix 5 - Strengths and limitations) and these should be considered when reflecting on the conclusions from this report. Our mixed methods approach enabled a rounded synthesis of different types of evidence to be undertaken and captured perspectives from a wide range of stakeholders, including insights from academic and practitioner authors, as well as 'on the ground' experience of OLs from key sectors of interest and diverse APs. This provided a means of:

- Capturing barriers and enablers as experienced by practitioners when working with diverse organisations as well as the first-hand experiences of employers themselves in sectors of interest.
- Drawing from published evidence sources where barriers and enablers are described in the context of implementing effective approaches to the management of WRS, i.e., in the context of practical application.
- Iteratively validating and refining the findings through the input of the PAG and PSG.

The study approach also has several limitations that must be considered when interpreting the conclusions:

- The quality of the available academic evidence base is limited.
- The practitioner literature tends to describe barriers and enablers generically: i.e. unspecific to particular WRS interventions or organisational contexts.
- The interview samples may be more informed and engaged than the general population.
- Formal evaluation of the prevalence or impact of the described barriers and enablers was beyond the scope of this research.

The following themes were evident across all data sources, indicating consistency and convergence in the findings:

Positive leadership culture has a central role in enabling effective management of WRS. Visible openness, communication, and support from leaders are strongly associated with greater uptake of interventions and stronger embedding of good practice. Conversely, rigid management practices or toxic working environments are fundamentally incompatible with effective WRS management. Across all contexts, management buy-in emerges as the most consistent enabler of effective action.

Stigma around mental health remains a widespread barrier to addressing WRS, although this varies across sectors. Where stress is perceived as weakness early disclosure is discouraged and this delays intervention until problems escalate. In contrast, cultures that foster psychological safety, openness, and trust are linked to proactive measures and more effective uptake of WRS initiatives. Anti-stigma campaigns, combined with openness from senior leaders, are enablers that can counter negative perceptions and potentially cultivate psychologically safe workplace cultures.

Costs and resources are critical factors: financial and time investment are key enablers of success. Where resources are lacking, preventive approaches are often sidelined, signalling the importance of demonstrating the business case for WRS management, SMEs are particularly vulnerable, lacking the specialist knowledge or capacity needed for effective risk management, highlighting the guidance and information needs of this group. Related to this, high workloads, staff shortages, and **competing priorities** can push management of WRS down the agenda. Organisations may deprioritise stress management in favour of immediate service delivery, addressing stress reactively once it reaches crisis point. Burnout, fatigue and workload pressures further limit employees' capacity or willingness to engage with available interventions, reducing their effectiveness. Embedding processes in 'business as usual' is therefore important.

Another organisational barrier to progress is poor or **inconsistent data collection.** Many organisations rely on absence rates, broad staff surveys, or informal feedback, which offer only partial insight into the causes and impacts of WRS. Without detailed or targeted data, it is difficult to identify specific psychosocial hazards, evaluate interventions, or make a robust business case for prevention. It is apparent that organisations require guidance on core data to collect to inform their approach to management of WRS such as staff absence data and success of WRS interventions. There is also potential to help employers understand how data collection can demonstrate the business case for action; for example, via online tools which allow employers to calculate the financial cost of stress-related absence and turnover.

The **impact of leaders and managers** within organisations also emerges as a critical enabler. Competence and confidence among line managers to identify, assess and address WRS hazards is an essential element of good practice. This cannot be resolved through training alone: managers need time and organisational support to prioritise wellbeing alongside operational demands.

The absence of **clear roles and defined responsibilities** within organisations to support WRS emerged as a common theme across data sources. This is said to hinder stress management, resulting in reactive approaches to WRS management. Dedicated wellbeing roles requisite skills and expertise is documented as an enabler within the literature, however acknowledged to be more challenging within SME's who may lack specific departments, time and resources to implement such roles.

The following themes were evident in discrete data sources (See Appendix 6 for mapping of themes to data sources):

A lack of in-house metrics also means organisations struggle to understand “what works” in their own context and therefore challenge **impact measurement**. This is a particular challenge for SMEs, who often lack the expertise or capacity to collect and analyse data effectively. This is an area where there is scope to bridge the gap between research and industry practice, to better equip employers with the knowledge of interventions that have worked in organisations similar to theirs.

Awareness challenges were evident to organisational understanding of ‘what works’ with respect to managing WRS, and amongst employees to know what support is available and how to access it. These knowledge gaps are detrimental to selection and uptake of effective interventions. Awareness of the employer duty to assess and manage WRS is reported by APs and organisations themselves to be lacking; also the **perception that enforcement action is unlikely** was said to weaken prioritisation. This, combined with a lack of parity between psychosocial and physical health risks, contributes to a reduced sense of urgency. As a result, stress management is often not given equal weight to other health and safety hazards.

Uptake of HSE’s tools is limited by perceptions that they are complex, overly generic, and not adapted to newer working models such as hybrid or remote working. As a result, organisations often default to generic wellbeing initiatives such as Employee Assistance Programmes (EAPs) or occupational health services rather than using the HSE SIT to identify and manage specific WRS risks. While such interventions have value, they tend to be secondary or tertiary, rather than addressing the root causes of stress. This underscores the value of **increasing awareness of HSE’s tools** and support offered to industry.

Using participatory approaches to involve staff directly in planning and implementing WRS initiatives was identified as an enabler which can significantly improve hazard identification, ownership, and engagement. Evidence shows participatory approaches are associated with better uptake and outcomes. However, practical barriers such as heavy workloads, lack of physical space, or limited IT access can restrict participation. This signals a need to embed participatory planning in organisational processes ensuring channels of engagement are fully inclusive and accessible.

Involving staff directly in planning and implementing WRS initiatives is an enabler which can significantly improve hazard identification, ownership, and engagement. Evidence shows participatory approaches are associated with better uptake and outcomes. However, practical barriers such as heavy workloads, lack of physical space, or limited IT access can restrict participation. This signals a need to embed participatory planning in organisational processes ensuring channels of engagement are fully inclusive and accessible.

5 Considerations

5.1 For research

Real-world case studies, illustrative of different sectors and enterprise sizes could help build organisational commitment and practical insights, especially if clearly linked to resource requirements (e.g., staff, time, money), and measurable impacts on WRS is evident through data collection. Publication of such evidence in peer reviewed manuscripts and disseminated in a format accessible to practitioners and employers, could help to justify investment and encourage adoption of stress risk assessments and systematic data collection through which to evaluate and improve practices.

To maintain credibility and uptake, HSE could refresh their WRS tools and resources and test their acceptability with different stakeholder groups. Study insights suggest that these could be updated to better reflect evolving patterns of work, such as hybrid and flexible arrangements, the growing diversity of the workforce, and shifts in the physical and psychosocial work environment. Aligning tools with these realities and examining their accessibility, relevance, and impact for organisations could accelerate reach and uptake.

Clear, accessible communication could help to ensure that employers not only know what resources exist but also understand how to use them effectively. Embedding mental health into organisational values through leadership modelling, anti-stigma initiatives, and open dialogue could help to foster psychologically safe workplaces where early reporting and intervention are encouraged. To reinforce this, stress management, and an understanding of psychosocial risk, could be positioned alongside physical health risks, with legal duties explicitly articulated and backed by robust enforcement mechanisms to emphasise WRS as a mandatory requirement rather than an optional wellbeing measure. There is need to better understand how parity between physical and psychological risk can be achieved.

Building competence and confidence among leaders and managers could help to ensure effective prevention and position management of WRS as a core responsibility. Training could highlight role modelling, clarify responsibilities, and provide guidance on when to access internal expertise or external specialist support. Having awareness of both quantitative and qualitative data to close knowledge gaps and enable timely action could help organisations to have the capability to assess risks and evaluate interventions. In Report 2, findings showed current training typically increases knowledge but does not translate to changes among team members. Further research should focus on how benefits of leader training are transferred to team members.

Bridging the gap between academic research and practical application requires translation of robust findings into accessible, practice focused guidance, while co-designing interventions with employees ensures relevance, buy in, and sustainability. This collaborative and evidence informed approach could help to enhance trust, improve implementation consistency, and embed solutions that reflect the realities of the workforce.

5.2 For employers/ duty holders

The findings point to **specific, practical processes** that duty holders should be encouraged to embed to manage barriers and make the best use of enablers, many of which are already incorporated into guidance but could be made more explicit. These processes could be designed around the existing health and safety (H&S) systems (Plan–Do–Check–Act), with feasibility for SMEs as well as larger organisations being borne in mind. Our findings suggest the key processes are:

- **Governance and ownership:** Appoint a WRS risk owner; define roles with a simple RACI; add WRS to the risk register; report to the H&S/Board cycle with clear decision and review points.
- **Proportionate WRS risk assessment:** Follow a staged workflow: (1) scope hazards; (2) collect targeted data; (3) agree controls with workers; (4) implement with named owners and timelines; (5) review impact and iterate. Keep a short-written record.
- **Manager routines (beyond training):** Embed WRS into day-to-day management: regular 1:1s with workload/role clarity checks, early temporary adjustments, clear referral routes, and protected time to do these.
- **Data and cadence:** Set a minimal dataset (e.g., sickness/turnover, simple pulse items on demands/control/support, incident/near-miss for WRS). Assign data ownership and review monthly/quarterly; use findings to adjust controls.
- **Participation by design:** Provide low-burden routes (toolbox talks, short co-design huddles, digital suggestion forms) that reach shift, remote and site staff; record how input shaped management approach.
- **Compliance and assurance:** Apply the same principles to psychosocial hazards as physical hazards: define “what good looks like” for your sector/size, keep audit trails, run internal checks, and brief leaders on legal duties.

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7 Appendix 1 – Methodology

7.1 Approach

The overall approach took a multi-phase, mixed methods approach, combining findings from:

- A supplementary Rapid Evidence review.
- Stakeholder interviews, knowledge exchange workshops and qualitative analysis of these.
- Consultation with the Project Steering group and Project Advisory Group.

7.2 Project governance

7.2.1 Project steering group

The Project Steering Group (PSG), set up by the HSE, consisted of 10 members, including representation from the science division, the policy team, and senior leadership within the HSE, the Department of Work and Pensions, and members of the project team. Chaired by Professor Andrew Curran, Chief Scientific Adviser and Director of Research at HSE, the PSG met approximately every 3 months throughout the project to review deliverables and obtain early insights.

7.2.2 Project advisory group

The Project Advisory Group (PAG), set up by the research team, consisted of 12 experts in the field of WRS, including representation from advisory agencies, industry representatives, academics and members of the project team. Chaired by Professor Jo Yarker, the PAG met throughout the project with the aim to:

- Gain advice on emerging policy, practice and research that is relevant to the research questions.
- Share learnings from the research with those who are advocating, researching and consulting in the area of work-related stress to promote a coordinated approach.
- Gain a critical eye and sense-check approach to ensure the most robust and appropriate approaches available were used, optimizing the contribution of the work.
- Identify avenues for dissemination of learnings for research, policy and practice.

PAG members were offered various ways to engage as their expertise, preference and time allowed. The following arrangements were made:

- Meetings were held quarterly for 1 hour via Teams.
- Relevant material was shared ahead of meetings; meeting notes and actions circulated following.

- Specific documents relating to review protocols and draft outputs were circulated for comment.
- Members were invited to complete the calls for evidence and attend roundtable events run throughout the project to share experiences and recommendations along with other multidisciplinary work and health professionals.

7.2.3 HSE project team

Members of the HSE Science Division and Engagement and Policy Division met with Professor Jo Yarker and Nathan Palmer monthly to review research materials and deliverables, discuss early findings, seek clarification on HSE policy on WRS and provide oversight of contracting arrangements.

7.2.4 Consortium project team

The main project team undertaking the research for the HSE was Affinity Health at Work in conjunction with its partners, the Institute of Occupational Medicine (IOM), the Institute for Employment Studies (IES), and the Society of Occupational Medicine (SOM). The Consortium Project Team met at regular intervals to discuss project activities, report on progress, and identify and mitigate risks to delivery. The team also used Teams channel to maintain regular communication.

7.3 Initial stakeholder engagement

In the early stages of the Project OSCAR research, a wide consultation and stakeholder engagement phase was conducted to help clarify the research approach and questions and identify ongoing activities in research and practice. This consultation was carried out between May – October 2024 and consisted of:

- An online call for evidence via the OSCAR webpage where members of the community could upload files, share evidence, thoughts, references and documents pertaining to the three research questions (of which this current report addresses one).
- Initial meeting with the PSG to further develop and understand project context and aims.
- Initial meeting with the newly formed PAG to further refine and define research questions and protocol for the evidence reviews.

Evidence submitted through the call for evidence were tagged to be considered in the evidence review.

7.4 Wider stakeholder engagement

A Knowledge Exchange Workshop (KEW) was facilitated virtually to engage stakeholders. Attendees included academics, researchers, consultants, health professionals and practitioners, and experts in the field of WRS. The KEW enabled experts to share their knowledge and insights on WRS across the three RQs of interest and signpost the study

team to relevant information sources for inclusion in the evidence reviews. The input provided during this session was helpful to refine and further target our approach to reviewing the evidence base and data collection methods to consult with relevant stakeholders as part of research for this question and more widely across Project OSCAR on the topic of WRS.

7.5 Evidence reviews

7.5.1 Identification of relevant literature

An umbrella review was conducted in response to the question "What interventions are effective for preventing and reducing work-related stress?" (the third research question addressed in Project OSCAR). The protocol was designed following wide collaboration with HSE, the PSG and PAG and provided in report 2.

Literature included in this review was 'tagged' during data extraction if it contained relevant insights into barriers and enablers to organisations management of WRS (in response to the research questions answered in this report, RQ3). This included literature was however focused on a list of priority interventions agreed with HSE (illustrated in Table 1) as either primary/preventative; or commonly used in practice.

Those papers (including grey and academic literature) 'tagged' as relevant from the review were subsequently re-examined and data extraction completed for barriers and enablers. Additional academic publications were then identified by the study team as having general relevance to barriers and enablers in managing WRS (not intervention specific). A total of 14 academic papers were reviewed and extracted to address the barriers and enablers, encompassing seven relevant review papers drawn from the umbrella review and a further seven generic papers identified for inclusion. The spread of papers relative to intervention categories examined as part of Project OSCAR (and summarised in report 2) is illustrated in Table 1 and Table 2.

Table 1: Mapping of RQ2 papers by intervention category

Intervention Category	No of academic sources identified
Awareness	0
Work design	4
Leadership training	1
Occupational health and external support	0
Interpersonal interventions	6
Additional generic papers	7

A total of 24 grey sources were reviewed and extracted to address RQ2. The nature of the grey literature included in both the review and the extraction processes was reflective of a tendency for practitioner guidance to describe a range of WRS interventions and highlight generic enablers and barriers to implementation. The spread of papers relative to RQ2 intervention categories is illustrated in category. Table.

Table 2: Mapping of grey literature sources by intervention category.

Intervention Category	No of grey sources identified
Awareness	0
Work design	1
Leadership training	2
Occupational health and external support	1
Interpersonal interventions	3
>3 intervention categories described	18

7.5.2 Screening, appraisal and data extraction

This review of relevant literature for RQ2 upon the inclusion and exclusion criteria stipulated for the RQ3 review (see full protocol in report 2), notably:

- Participants/populations of interest being workers/employees.
- Encompassing literature with an outcome focus on stress as, wellbeing, mental health (used interchangeably).
- Containing relevant insights concerning barriers and enablers to managing work-related stress – relative to a specific type of intervention or more generally.
- Published within the last 10 years. Reviews of reviews were prioritized, though more recent, discursive papers were included only included if they were considered to add value generally, as opposed to in the context of an applied intervention.

Title, abstract and full text screening was conducted, using a phased approach, with screening and extraction decisions independently validated by a second researcher.

7.6 Included literature

7.6.1 Summaries of academic and grey evidence

Table 3: Summary of academic evidence

Reference	Intervention/ strategy	Psychosocial hazard targeted	Number and type of studies included in review	Outcome measure and how	Evaluation framework	Quality Appraisal (AJ: Author Judgement where provided; RJ: Researcher Judgement with rationale where not provided by author)
Aust et al., (2023)	Participatory interventions	Multiple, predominantly Demands, Control, Support	52 reviews (957 primary studies)	Stress, burnout, employee wellbeing and retention at work.	Quality rating based on rating system developed for study, inspired by the rating systems used by Joyce et al., and the Navigation Guide.	RJ: Moderate
Bernard et al., (2022)	Computer-based education	Not specified	28 journal articles, 2 book chapters and a doctoral dissertation	Stress- related disorders and symptoms, mental health problems e.g., burnout, anxiety disorders, and substance-related disorders	NA	RJ: Low

Daniels et al., (2021)	Work re-design	Not specified	74 studies	Psychological wellbeing	Snape et al., (2016) quality grading for reviews of complex interventions targeted at wellbeing.	RJ: Moderate
De Simone, Vargas, and Servillo (2021)	Workload	Demand, control and support inferred	20 RCTs	Burnout	Cochrane risk of bias tool	AJ: Low
Fallon et al., (2023)	Social/peer support	Support	13 (9 cross-sectional studies, 1 case study, 1 cluster RCT and 2 participatory action research studies	Distress	NA	RJ: Low
Fox et al., (2021)	Participatory interventions	Demand, control and support	83 studies	Psychological distress, resilience, general wellbeing, burnout	NA	AJ: Moderate
Kuster et al., (2017)	Computer-based education	Not specified	2 RCT's	Stress	Grade approach	AJ: Low
NICE (2022)	Mixed including Implementation of the Management	Job demands, control, support, relationships,	9 studies	Stress and mental wellbeing	ROBIS tool, Mixed Methods Appraisal Tool, CEBM	RJ: Moderate

	Standards approach, Well-being strategy, workplace health promotion (WHP), EAPs.	organizational change.			checklist and CASP qualitative checklist.	
Paterson et al., (2024)	Worker directed interventions and approaches	Demands	43 studies	Mental health or mental wellbeing	The Mixed Methods Appraisal Tool supplemented by an 8-item process evaluation tool.	RJ: Moderate
von Thiele Schwarz et al., (2020)	Non-specific	Support	Discussion paper	Non-specific	Sigtuna Principles	RJ: Low
Tamminga et al., (2023)	Social/ peer Support, Mental Health Awareness Training/Literacy and MHFA	Demands	41 studies	Work-related stress and burnout	Cochrane risk of bias tool	AJ: Moderate
Waddell et al., (2023)	Mental Health Awareness Training/Liter	Not specified	80 reviews	Stress, fatigue, mental illness, mental wellbeing	NA	RJ: High

	acy and MHFA					
WHO (2022)	Flexible working and job re-design	Demand and control inferred	3 reviews	Mental health symptoms	AMSTAR II (Assessing the Methodological Quality of Systematic Reviews tool (Shea et al)	RJ: High
Yarker et al., (2022)	Individual, manager or organisational level interventions	Not specified	33 studies	Positive mental health, reduced symptom severity, work-related absence and return, quality of life and functioning	CASP and CERQual	RJ: Low

Table 4: Summary of grey evidence

The grey literature differed from the academic literature in several important respects, drawing on a wider variety of evidence sources. In many cases, barriers and enablers were discussed in relation to multiple-or unspecified-interventions. As a result, it was not always possible or practical to extract detailed information for each of the categories outlined below.

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
Bagnall et al. (2016)	Job design	Burnout and WRS	Evidence review	1	Psychological distress and emotional exhaustion	N/A	Moderate
Brassey et al., (2022)	N/A – no relevant interventions included	Not specified	Survey report	0	N/A	N/A	Low
BRC Response (2024)	Various including Mental Health Awareness Training/Literacy Job design, Manager training	Not specified	Guidance	6	N/A	N/A	Low
Cambridgeshire Constabulary (2024)	Social/peer support	Not specified	Longitudinal evaluation	1	Long-term absence due to work-related trauma	N/A	Moderate

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
CIPD (2023)	Work adjustments/ flex working/ home working Line manager training – Employee mental health	Not specified	Survey report	5	N/A	N/A	Low
Daniels et al., (2022)	Social/ peer support Job design Physical work environment	Not specified	Rapid Evidence Review (REA) and Economic Analysis	5	Psychological distress Burnout and stress Anxiety	N/A	Moderate
Donohue et al., (2024)	Various Mental Health Awareness Training/Literacy Mental Health first aid Job design Breaks Physical work environment	Not specified	Scoping literature review Desk research of grey literature Semi-structured interviews	15	N/A	N/A	Moderate

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
	Work adjustments/flex working/ home working Line manager training – Employee mental health Social/peer support						
Hesketh, Strang, Pollitt, and Wilkinson (2020)	Mental Health Awareness Training/Literacy Mental health first aid Job design Participatory interventions Work adjustments/flex working/home working Social/peer support Anti -bullying and incivility	Not specified	Rapid Evidence Assessment (REA)	8	N/A	N/A	Low

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
	Coaching						
International Labour Organization (ILO) (2016)	Mental Health Awareness Training/Literacy Job design Physical work environment Social/peer support	Not specified	Guidance	16	N/A	N/A	Low
Julings and Cowen (2023)	Social/peer support	Not specified	Document review Analysis of programme data - including Management Information, Pre and post surveys. Qualitative fieldwork with Delivery staff, Sector stakeholders	1	Wellbeing, stress and anxiety	Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)	Moderate

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
			, Participants.				
Kinman (2021)	Line manager training – Employee mental health	Not specified	Guidance	1	N/A	N/A	Moderate
Kinman, Teoh, and Harriss (2020)	Mental Health Awareness Training/Literacy Job Design Breaks Physical work environment Participatory interventions Work adjustments/flex working/home working Line manager training – Employee mental health	Not specified	Systematic review	12	Mental health and wellbeing	N/A	Moderate

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
	Social/ peer support						
Leka and Jain (2024)	Mental Health Awareness Training/Literacy Job design Breaks Physical work environment Participatory interventions Work adjustments/flex working/home working Leadership Training Interventions – To support others mental health Line manager training – Employee mental health	Not specified	Evidence review	30	N/A	N/A	Moderate

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
	Teamwork (interprofessional) Social/peer support Anti-bullying and incivility						
MHPP (2024)	Mental Health Awareness Training/ Literacy Mental Health first aid MH champions Line manager training – Employee mental health Social/ peer support Coaching	Not specified	Reviews Feasibility study RCT Natural experiment	6	Psychological distress Psychological wellbeing Stress Depression Anxiety	N/A	Moderate
Nicholson (2022)	Occupational health provision	Not specified	Guidance	1	N/A	N/A	Low

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
Pandey et al., (2022)	Mental Health Awareness Training/Literacy MH champions Job design Work adjustments/flex working/home working Leadership Training interventions to support others mental health Line manager training - Employee mental health Social/ peer support	Not specified	Survey report Qualitative interviews	13	N/A	N/A	Moderate
Stevenson and Farmer (2017)	Mental Health Awareness Training/Literacy MH champions Job design	Not specified	Evidence review	13	N/A	N/A	Moderate

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
	Participatory interventions Work adjustments/flex working/home working Line manager training - Employee mental health Social/ peer support						
Teoh et al., (2023)	Job design Breaks Work adjustments/flex working/home working Teamwork (interprofessional)	Not specified	Evidence review	7	N/A	N/A	Moderate
Teoh et al., (2024)	Mental Health Awareness	Not specified	Qualitative interviews	13	Burnout	N/A	Moderate

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
	Training/Literacy Mental Health first aid MH champions Job design Participatory interventions Work adjustments/flex working/home working Line manager training Employee mental health Teamwork (interprofessional) Social/ peer support		and analysis, including case studies.				
Virtanen et al., (2024)	Mental Health Awareness Training/Literacy Mental health first aid Job design	Not specified	Evidence review	24	Burnout Stress	N/A	Low

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
	Physical work environment Work adjustments/flex working/home working Leadership Training interventions - To support others mental health Line manager training - Employee mental health Social/ peer support Coaching						
WHO (2022)	Mental Health Awareness Training/Literacy Job design Breaks Physical work environment	Not specified	Guidance	18	N/A	N/A	Low

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
	Participatory interventions Work adjustments/flex working/home working Leadership Training interventions - To support others mental health Line manager training Employee mental health Teamwork (interprofessional) Contact-based workplace education						
WHO/ILO (2022)	Mental Health Awareness Training/Literacy Job design	Not specified	Guidance	15	Emotional distress Stress	N/A	Low

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
	Breaks Physical work environment Participatory interventions Work adjustments/flex working/home working Leadership Training interventions - To support others mental health Social/ peer support				Mental health literacy		
Wilson et al., (2019)	Line manager training – Employee mental health	Not specified	Longitudinal survey RCT	1	Stress Distress	N/A	Moderate
Wilson, Martin and Spiegelhalter, (2018)	Mental Health Awareness Training/Literacy	Not specified	Evidence Review	21	Stress Distress	N/A	Moderate

Reference	Intervention/ strategy	Psychosocial hazard targeted	Type of source	Number of relevant interventions included in source	Outcome measure	Evaluation framework	Researcher judgement of quality
	Mental Health first aid Leadership Training interventions - Manager training - Own mental health Leadership Training interventions - To support others mental health Line manager training - Employee mental health						

7.6.2 Grey literature

To identify relevant grey literature, a search protocol was developed which incorporated three complementary strategies to capture the relevant evidence:

1. A search of targeted websites of prominent public, private and third sector institutions, including governmental and intergovernmental organisations[2].
2. Searches of grey literature databases relevant to the review.

7.7 Interviews

7.7.1 Participants

To explore how work-related stress (WRS) is labelled and assigned we interviewed 20 Organisational leaders and 10 advisory professionals.

- **Organisational leaders (OLs)** – The participants from this group were leaders from a variety of sectors, including public sector (5), healthcare (3), construction (3), emergency (3) education (2), care (2), transport (1), and one classified as 'other'. During their one-hour virtual interview, participants were asked to reflect on work-related stress laws and rules; identification, classification and labelling; causes and risks of work-related stress; information sharing and trusted sources; resources, support, and interventions; enablers and barriers to managing work-related stress; responsibilities for workplace stress and future improvements and knowledge gaps.
- **Advisory professionals (APs):** The participants from this group were representatives of organisations with external influence on stress management and wellbeing practices within other organisations. These participants represented a range of professions, including HR practitioners, teachers, the NHS workforce, the construction industry, and those working in the occupational health and safety profession, as well as trade union bodies and a self-employed work and stress consultant. Interviewees held a variety of positions, including policy leads, leading on health, wellbeing and employee relations, supporting mental health at work and informing employee action, stakeholder management and work-related stress leads.

7.7.2 Sampling strategy

The primary sampling strategy was opportunity sampling, as the recruitment methods lead to a voluntary approach to participants offering to take part in the study. Pre-screening was used to identify the coverage of relevant factors, as well as gathering further information from participants during interviews to describe the sample and compare their experiences. The project was not aiming to reach saturation for each participant group, due to the individual nature of WRS and contextual factors that impact this (e.g., size of enterprise, sector/industry, geographic location, demographic characteristics, etc....). Therefore, the sample group size is appropriate to provide initial insight into the experience of each group rather that drawing firm or transferable conclusions at this stage. Pre-screening questions included:

[2] Consensus on authoritative sources as recommended by experts across the consortium and the PAG.

- **Demographic information:** Participant's demographics including age, gender and ethnicity were captured prior to interview, to allow for accurate description of the sample and to identify potential bias in the results. We did not propose to conduct purposive sampling on a demographic basis given the small size of the sample.

- **Industrial sector:** Interviews with organisational leaders were prioritised to provide a range of representation from various sectors.

7.7.3 Recruitment

Interview participants were recruited for RQ1 and RQ2 at the same time using a variety of methods such as:

- **Expert Input:** Affinity, IOM and IES drew upon our respective connections to generate interest amongst wider stakeholders (in the form of independent experts or representatives with relevant organisations) to register with the study webpage and contribute their professional expertise.
- **Intermediaries:** Collaboration with professional bodies, unions and member organisations such as SOM, as well as support from our PAG and professional networks raised awareness of the study. Promotion materials and email templates with QR codes for individuals to register their interest were shared and PAG and collaborating members who were encouraged to share with their networks.
- **Social media:** The project team leveraged their respective social media platforms, to create and repost materials with encouragement for intermediaries to share/repost these where possible.
- **Direct Outreach to Organisations:** Potential participants and relevant organisations were approached via email.

7.7.4 Interview conduct and coverage

Semi-structured interviews were conducted virtually via Teams. Informed consent was obtained prior to commencement, with each interview lasting between 30 minutes and 1 hour. Interviews were recorded (with expressed permission) for quality and transcription purposes.

An interview proforma was developed with a set of different questions for each stakeholder group for consultation (see Table 5 and Table 6). Proformas were iterated though PAG consultation and agreed with the PSG.

Table 5: Organisational leaders interview proforma

Section and timing	Content questions and prompts
Introduction and Rapport Building	Brief introduction, explanation of the interview purpose, and confirming consent.

Roles and Responsibilities	Can you provide an overview of your role and your involvement in managing or preventing work-related stress (WRS)?
Understanding of WRS Laws and Requirements	How well do you know the laws and rules with respect to managing WRS in your sector/industry? What steps do you take to ensure your organisation follows them? How do you monitor and review this, how regularly and does this integrate with your health and safety system? *Possible probes - What does this mean in practice? How do you monitor and review this, how regularly and does this integrate with your health and safety system?*
Identification, Classification, and Labelling of WRS	How do you identify and classify cases of WRS in your organisation, and are there any frameworks that influence these decisions? *(e.g., staff survey, line managers, sickness absence).* What factors *(e.g., work environment, sector, industry)* influence these decisions and their outcomes? If an employee shares that they are WRS, what is the response to this information within your organisation? *(e.g., across different teams, from the interviewee)*
Causes and Risks of WRS	What are the main causes of work-related stress in your experience, and how do you monitor these risks? *Possible probes – how do you use risk assessments for monitoring and how do you do this (level/regularity)?*
Information Sharing and Trusted Sources	What sources of guidance, information, and support do you trust to help manage WRS within your organisation?
Resources, Support, and Interventions	What resources and support does your organisation provide to prevent and manage WRS (e.g., Clinical/Therapeutic intervention, Time off work, Work adjustments, risk assessments, training)? How do you measure their effectiveness? What advice do you provide to individuals suffering from WRS, and how is information shared between different stakeholders (e.g., employees, HR, health professionals, line managers)? Are there any common misunderstandings or misapplications of WRS measures?
Enablers and Barriers to Managing WRS	What are the main enablers and barriers for your organisation in effectively preventing and managing WRS? *What effects do these have? How have they impacted your approach?*

	(If participant does not touch on relationships/support) Have you noticed any enablers and barriers in terms of enablers and barriers in terms of relationships or support Are you aware of particular barriers and enablers specific to the use of current HSE guidance and tools to manage WRS? *Do you use them? If not, why not?*
Responsibilities for Workplace Stress	Who should be responsible/accountable for stress in the workplace, and why? Which aspects should people be responsible/accountable for? Does this reflect current practice in your organisation (explore)?
Future Improvements and Knowledge Gaps	What could be done differently in the way that work-related stress is currently: A) identified/ labelled? B) prevented/managed? Where are your knowledge gaps in preventing and managing WRS within your organisation? *Are you aware of evidence on the effectiveness of different approaches?*
Conclusion and Wrap-Up	Is there anything I didn't ask that you would like to share? Thank the interviewee, offer to share the final report, and provide any final clarifications or answer their questions. End of interview

Table 6: Advisory agencies interview proforma

Section and timing	Content questions and prompts
Introduction and Rapport Building	Brief introduction, explanation of the interview purpose, and confirming consent.
General understanding of preventing and managing WRS	Can you provide an overview of your role and involvement in preventing and managing WRS? How well do you know the legal requirements with respect to preventing and managing WRS in your sector/industry? What does this mean in practice? How well do you think this is understood by the clients you advise?
Tools and resources to prevent and manage WRS	What resources does your organisation publish or endorse to manage WRS? Prompts for specific tools/guidance, training programmes, mental health first aiders, measurement. How do you evaluate the effectiveness of these resources? (Prompts: metrics used, feedback

	mechanisms, success stories, evidence available, strength of evidence)
Enablers and barriers to preventing and managing WRS	What are the main enablers for organisations to effectively prevent and manage WRS? Prompts: training, culture, management support/leadership, business reputation, financial benefits) What are the main barriers for organisations preventing and managing WRS? Prompts: lack of awareness, resource/financial constraints, complexity of guidance, lack of management support/buy in, knowing what to do. Are you aware of particular barriers and enablers specific to the use of the current HSE guidance and tools to prevent and manage WRS?
Advice on WRS management	What advice is your organisation currently providing to its members regarding the prevention and management of WRS? Prompts: intervention/management strategies, awareness of psychosocial risks, evaluation. Can you provide examples of organisations that have successfully implemented WRS management strategies? What made them successful? Is this advice tailored and if so, how? Prompts: enterprise size, sector, industry, industry feedback on advice. Are there any areas where you have noticed organisations have difficulties in preventing and managing WRS? Prompts: risk assessment, providing support, evaluation, lack of focus on prevention, use of data, consultation, what information/advice do you think organisations need etc.
Trends and influential factors	How have changes in the wider world and new ways of working impacted the effectiveness of interventions targeting prevention and management of WRS? Prompts: changes in prevalence, macro context, economic conditions, regulatory conditions, remote/hybrid work, contractual arrangements. What characteristics show trends in the effective management of WRS? Prompts: sector, industry, enterprise size, link with organisational purpose, evidence, strength of evidence. What factors do you think are most influential in inducing or exacerbating WRS withing organisations? Prompts: job roles, work environment, work tasks, supervision arrangements, organisational changes, relationships, support.
Close interview and thanks	Is there anything else you feel you would like to add that has not been covered by this interview?

7.7.5 Analysis

Interview transcripts were qualitatively analysed using framework analysis (Goldsmith, 2021). A deductive approach pre-defined matrix aligned with the key research questions was used to organise and interpret data helping to identify and interpret patterns within the data set within and across cases and themes. An inductive analytical approach was also employed to capture emergent patterns within the dataset, allowing for the identification of organic insights, generating added value to the research topic.

7.8 Stakeholder consultation: joint workshop

After initial synthesis of the project findings, a PSG and PAG joint workshop was held to present and discuss planned outputs. This session aimed to help ensure project outputs achieve intended impact with respect to:

- Justifying strategic planning and informing policy decisions
- Shaping HSE guidance on WRS to support duty holders to implement suitable controls and interventions to prevent and mitigate WRS amongst their workforces
- Informing and supporting HSE inspectors to perform compliance audits and inspections of duty holders to constructively improve their management of WRS
- Ensuring findings are fit for purpose, accessible and valued across different stakeholder groups directly (HSE inspectors) and indirectly (e.g., duty holders, policy experts, support organisations) utilising them

In order to ensure time in the session was used for feedback, a pre-watch was recorded covering findings and initial synthesis of stress and the process of labelling.

The session took place on Wednesday 11th June 2025**,** at 9:30 – 11:00 and the main questions which were asked of the group for each section were:

- What are the key implications for these research findings?
- How can we best convey these findings to practitioners in relevant fields?
- Are there any specific implications for professional body/ policy stakeholders that we should be mindful of as we convey findings? (see Figure 3)
- What challenges could be raised about the findings / what limitations of the research should we proactively raise and explain (over and above typical limitations of specific methodologies)?

8 members from the PAG and PSG attended respectively, totalling 16 participants.

Feedback provided by attendees was used during the report writing phase to iterate and co-design the final format and structure of project outputs to maximise impact for all relevant stakeholders. Written feedback was encouraged from members from the PAG and PSG who were unable to attend.

Figure 3: Key stakeholders for consideration



7.9 Participant consent form

Health and safety executive programme of research on work-related stress

Participant consent form

Please complete, sign and return this consent form to our project team at oscar@affinityhealthatwork.com in advance of your interview. We will also provide you with a copy of the signed consent form. Alternatively, your interviewer will need to talk through this consent form with you prior to your interview starting, extending your interview time by approximately 5 minutes.

Activities:

1. I confirm that I have read the attached Participant Information Sheet for this research, I have had the opportunity to consider the information, ask questions, and had these answered satisfactorily.
2. I understand that my participation in the study is voluntary and that I am free to withdraw up to two weeks following my interview completion without giving a reason and without detriment to myself. I understand that it will not be possible to remove my data from the project any later than 2 weeks following completion of my interview, once this forms part of the data set for analysis.
3. I agree to the interview being recorded for quality assurance purposes. I understand that I can choose between audio recording or having a scribe present to take notes.

Please inform interview in advance if you do not wish to have audio recording so that we can arrange a scribe to make notes during your discussion.

4. I agree that any data collected may be published in anonymous form in academic books, reports or journals. It will not be possible to identify me personally or my company from any published study material.
5. I understand that data collected during the study may be looked at by individuals from Affinity Health at Work, the Institute of Occupational Medicine and the Institute for Employment Studies, where it is relevant to my taking part in this research. I give permission for these parties to have access to my data.

I agree to take part in this study.

Study findings will be made publicly available on the study webpage www.affinityhealthatwork.com/oscar

Participant name: _____ Participant electronic signature:

The personal information we collect and use to conduct this research will be processed in accordance with data protection law as explained in the Participant Information Sheet and the IOM Privacy Notice for Research Participants

7.10 Topic guide - Organisational leaders

Thank you for your time today.

Introduction: I will be asking you some questions about managing and controlling WRS, guidance provided to your managers and staff, measures preventing WRS and WRS accountability.

Before we begin, can I confirm that you have read the information sheet giving the background to this study? I can confirm that you have completed your consent form and returned this to us.

Sharing information: In our discussions today, please bear in mind that you do not need to share or talk about anything that you feel uncomfortable about. We can pause or stop at any time. You will also have the option to withdraw from the study without any consequences or to rearrange the interview. In the participant information and debrief you are signposted to support services you may wish to contact.

What will happen now and at the end of this session: This interview will be recorded and after this session will be transcribed and anonymized. Your data will be held securely in compliance with UK Data Protection Laws. You are able to pause or withdraw from this interview at any time.

Recording: (If participant consented to being recorded within consent form) I just wanted to check that you are still happy to be recorded? Great, I will begin the recording and then I'll give you a brief introduction before we begin. Is that OK? [START RECORDING]. (If participant did not consent to being recorded within consent form) I can see on your consent form you did not want to be recorded, that is not a problem, my colleague [insert name] will be present on the call to make detailed notes whilst I conduct the interview with you.

Questions: Before we begin, did you have any questions from the information you were sent?

1. Introduction and Rapport Building (3 minutes)
    - Brief introduction, explanation of the interview purpose, and confirming consent.

2. Role and Responsibilities (5 minutes)
    - Can you provide an overview of your role and your involvement in managing or preventing work-related stress (WRS)?

Note: Combines role overview and specific involvement in WRS, setting the context for the interview.

3. Understanding of WRS Laws and Rules (5 minutes)
    - How well do you know the laws and rules with respect to managing WRS in your sector/industry?

- What steps do you take to ensure your organisation follows them?
- How do you monitor and review this, how regularly and does this integrate with your health and safety system?

  (Possible probes - What does this mean in practice? How do you monitor and review this, how regularly and does this integrate with your health and safety system?)

4. Identification, Classification, and Labelling of WRS (5 minutes)
   - How do you identify and classify cases of WRS in your organisation, and are there any frameworks that influence these decisions? (e.g., staff survey, line managers, sickness absence).
   - What factors (e.g., work environment, sector, industry) influence these decisions and their outcomes?
   - If an employee shares that they are experiencing work-related stress, what is the response to this information within your organisation? (across different teams, from the interviewee).
5. Causes and Risks of WRS (5 minutes)
   - What are the main causes of work-related stress in your experience, and how do you monitor these risks?

     (Possible probes – how do you use risk assessments for monitoring and how do you do this (level/regularity)?)
6. Information Sharing and Trusted Sources (5 minutes)
   - What sources of guidance, information, and support do you trust to help manage WRS within your organisation?
7. Resources, Support, and Interventions (10 minutes)
   - What resources and support does your organisation provide to prevent and manage WRS (e.g., Clinical/Therapeutic intervention, Time off work, Work adjustments, risk assessments, training)?
   - How do you measure their effectiveness?
   - What advice do you provide to individuals suffering from WRS, and how is information shared between different stakeholders (e.g., employees, HR, health professionals, line managers)?
   - Are there any common misunderstandings or misapplications of WRS measures?
8. Enablers and Barriers to Managing WRS (10 minutes)
   - What are the main enablers and barriers for your organisation in effectively preventing and managing WRS? What effects do these have? How have they impacted your approach?
   - (If participant does not touch on relationships/support) Have you noticed any enablers and barriers in terms of enablers and barriers in terms of relationships or support
   - Are you aware of particular barriers and enablers specific to the use of current HSE guidance and tools to manage WRS? Do you use them? If not, why not?

9. Responsibilities for Workplace Stress (5 minutes)

- Who should be responsible/accountable for stress in the workplace, and why? Which aspects should people be responsible/accountable for? Does this reflect current practice in your organisation (explore)?

10. Future Improvements and Knowledge Gaps (5 minutes)
    - What could be done differently in the way that work-related stress is currently:
    - A) identified/ labelled?
    - B) prevented/managed?
    - Where are your knowledge gaps in preventing and managing WRS within your organisation? Are you aware of evidence on the effectiveness of different approaches?

11. Conclusion and Wrap-Up (2 minutes)
    - Is there anything I didn't ask that you would like to share?
    - Thank the interviewee, offer to share the final report, and provide any final clarifications or answer their questions.

End of interview

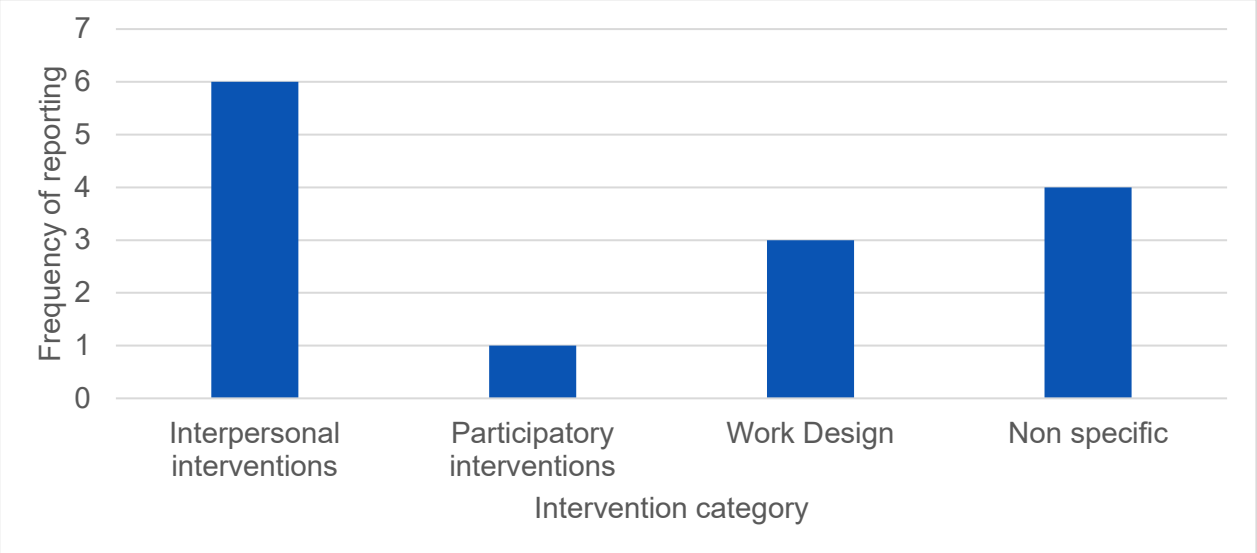
Outro text:

Thank you for volunteering your time today to participate in an interview today, your insight has been really valuable. Once we have finished running the interviews we will be analysing the data and writing up the findings. Once we have a final report, we can send this to you if you are interested in reading about the findings?

8 Appendix 2 - Academic literature review findings

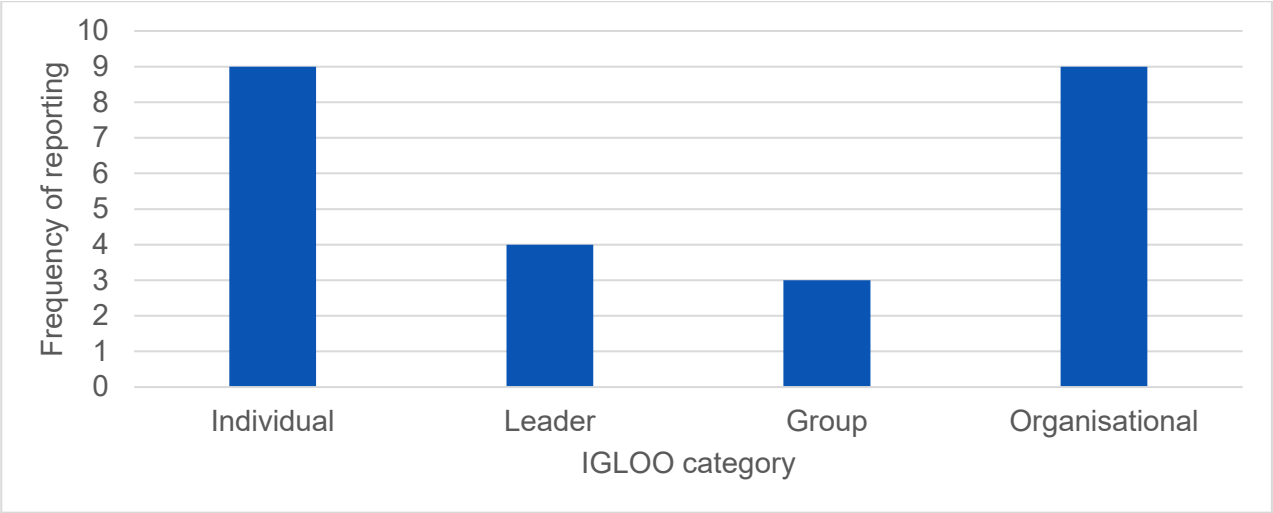
Across the 14 review papers included studies from 30 different countries were identified. The majority of studies referenced within these papers were most commonly from the US (69), UK (45), Canada (20), Sweden (20), Germany (16), Australia (15), and Denmark (14). Additionally, across the 14 papers, various workplaces were covered these have been grouped into 12 sectors. 374 references were identified of these 62% examined health and social care, 13% examined public services (including policing and defence), and 10% examined multiple or various sectors, or did not provide specific data regarding the sector being reviewed. The remaining 15% covered professional, scientific, and technical services, information and communication services, industrial services (including construction, labour, and manufacturing), education services, arts, entertainment, and recreation, agriculture, forestry, and fishing, finance and insurance services, and retail services. The breakdown of intervention categories for the 14 academic papers can be seen in Figure 4 below.

Figure 4: Intervention categories



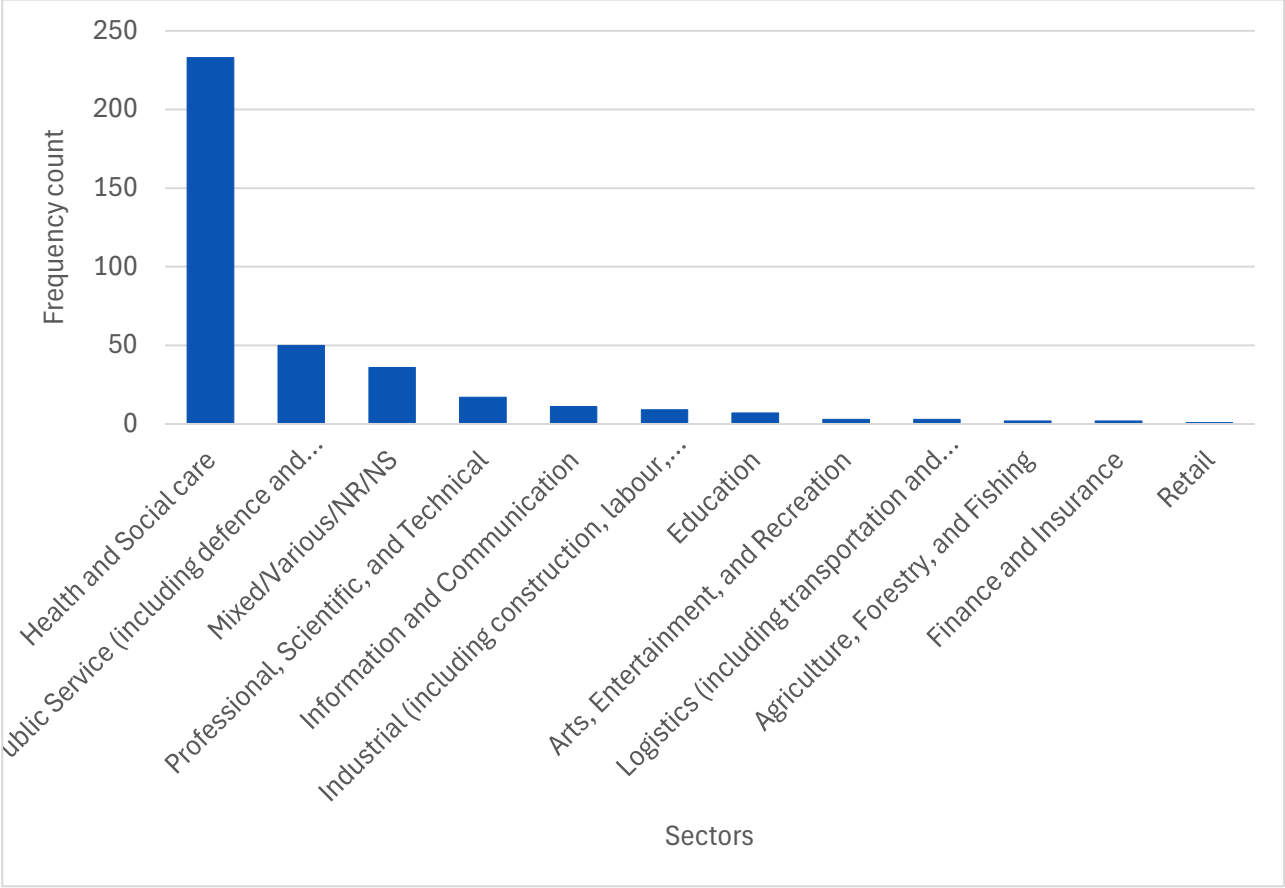
A breakdown of the 14 academic papers mapped onto the IGLOO model (Nielsen et al., 2018), where studies looked at individual, group, leadership, organisational and outside interventions can be seen in Figure 5. In some cases, interventions addressed multiple of the IGLOO categories and were therefore dual coded.

Figure 5: Mapping of literature to IGLOO model



Academic papers covered a variety of sectors, most commonly health and social care, as illustrated in Figure 6 below.

Figure 6: Mapping of literature to sectors



In many instances, barriers and enablers identified in the literature and discussed during interviews were direct opposites of one another (e.g., sufficient resources being an enabler to management of WRS, with insufficient resources identified as a barrier). Consequently, they are presented together in relation to the emergent themes within the project findings, with examples showing how some factors could act as either a barrier or an enabler to the management of work-related stress.

The detailed findings from each research phase are available in Appendices 2 to 4. A map summarising how each data source contributed to the findings can be found in Appendix 5.

Table 7 presents data extraction from each included academic paper, mapped to the Consolidated Framework for Implementation Research (CFIR) indicating where components of the CFIR were Not Included (NI) across the studies.

Table 7: Tabulation of academic study extraction mapped to the CFIR.

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
Aust et al., 2023	How effective are organizational-level interventions in improving the psychosocial work environment, health, and retention of workers? A systematic overview of systematic reviews	**Barriers** •Employee motivation and interest 'active' involvement of employees cited as possible factor in success "... employees and their leaders need to agree on changes and implement them so that enough employees are exposed to them..."	**Barriers** •Available Resource "... success... may depend on... sufficient and continuous management support..." "... workplace interventions of the psychosocial work environment require more complex and time-consuming implementation activities..."	**Barriers** •Organisational challenges "... unforeseeable contextual changes such as restructuring, downsizing, high turnover among leaders and/or employees, competing projects, and similar incidents that disturb or limit the focus needed to develop and implement workplace improvements, may impact the chances for positive outcomes..."	**Barriers** NI	**Barriers** NI

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
Aust et al., 2023 continued		**Enablers** •Employee motivation and interest Implied: converse of above-mentioned barriers	**Enablers** •Available Resource Implied: converse of above-mentioned barriers	**Enablers** •Organisational support Implied: structural stability improves intervention outcome	**Enablers** NI	**Enablers** NI
Bernard et al., 2022	Strategies for Implementing Occupational Mental Health Interventions: Scoping Review	**Barriers** •Stigma Possible perceived stigma associated with intervention adoption was cited as a barrier to intervention •Employee motivation and interest A general lack of motivation and interest in using the intervention was cited as a barrier	**Barriers** •Accessibility / Technology Poor computer literacy and digital skills are cited as barriers to intervention uptake/success Low workability of the intervention was cited as a barrier	**Barriers** •Organisational Challenges The perception of low organizational commitment to addressing issues was cited as a barrier to employee uptake •Stigma Possible perceived stigma associated	**Barriers** NI	**Barriers** •Employee challenges "...a lack of privacy (e.g., sharing information disclosed within the intervention with employers) ..." "...no opportunities to interact with others during the intervention..." Relatability of content: presenting information highly

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
		•Employee health "...reduction in engagement and adoption (of the intervention) due to symptoms associated with medical condition..."		with intervention adoption was cited as a barrier to intervention		relevant to employees.
Bernard et al., 2022 continued		**Enablers** NI	**Enablers** •Accessibility Including comprehensive engagement measures, presenting interventions based on credible information highly relevant to target employees, and providing evidence from similar interventions that demonstrate effectiveness was cited as important for intervention uptake	**Enablers** NI	**Enablers** NI	**Enablers** •Communication Interventions that collect and utilise comparable demographic data from a diverse sample of industries and occupations to conduct a comprehensive and ongoing process of evaluations to inform implementation were cited as being more effective

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
Daniels et al., 2021	Implementing practices focused on workplace health and psychological wellbeing: A systematic review	**Barriers** •Employee health Employee health was cited as a barrier to 'tertiary interventions'	**Barriers** NI	**Barriers** •Line managers Paper identified that negative line/middle manager dispositions can undermine the effectiveness of changes that are made	**Barriers** NI	**Barriers** NI
Daniels et al., 2021 continued		**Enablers**	**Enablers** •Clear delivery structures "... clear delivery structures appear to be a necessary but not sufficient condition to facilitate WHWP implementation."	**Enablers** •Organisational support "Functional governance structures may promote functional learning structures, in turn facilitating adaptation of interventions during implementation."	**Enablers**	**Enablers**

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
De Simone, Vargas, and Servillo, 2021	Organizational strategies to reduce physician burnout: a systematic review and meta-analysis	**Barriers** NI	**Barriers** NI	**Barriers** NI	**Barriers** NI	**Barriers** NI
De Simone, Vargas, and Servillo, 2021 continued		**Enablers** NI	**Enablers** •Available resource Enhancing job resources was cited as an important enabler of implementation. "…enhancing job resources (e.g., social support, autonomy, performance feedback, and opportunities for development) that can moderate the influence of workload on burnout."	**Enablers** •Organisational challenges Creating a safe space to allow staff to acknowledge and decrease stress was cited as an enabler	**Enablers** NI	**Enablers** NI
Fallon et al., 2023	Peer Support Programs to Reduce Organizational Stress and Trauma for Public Safety Workers	**Barriers** •Stigma Authors cite stigma as the primary barrier to participation.	**Barriers** NI	**Barriers** •Stigma Authors cite stigma as the primary barrier to participation.	**Barriers** NI	**Barriers** Establishing and embedding policy and practice.

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
Fallon et al., 2023 continued		**Enablers** NI	**Enablers** •Training Authors cite training as a key factor to develop and sustain PSPs •Resources Authors cite funding as a key factor to develop and sustain PSPs	**Enablers** •Management / Organisational support Organizational support from administration and managers, along with policies were identified as key factors to develop and sustain PSPs. The authors cite that policies that formalize PSPs by providing written guidelines validate the program as essential to the organization.	**Enablers** NI	**Enablers** NI
Fox et al., 2021	Organisational- and group-level workplace	**Barriers** •Employee challenges	**Barriers** NI	**Barriers** •Organisational challenges	**Barriers** NI	**Barriers** NI

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
	interventions and their effect on multiple domains of worker well-being: A systematic review	Authors cite that poor employee engagement as a barrier.		Authors cite that a failure to engage employees in decision making process can result in poorly designed interventions. Authors cite that failure to improve well-being or actual harms were more often evident when management prioritised increased productivity or higher quality standards rather than well-being.		
Fox et al., 2021 continued		**Enablers** •Employee challenges	**Enablers** NI	**Enablers** NI	**Enablers** NI	**Enablers** NI

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
		Authors cite that enhancing employee engagement through a formal participatory process or by incorporating employee feedback and encouraging engagement is an enabler.				
Kuster et al., 2017	Computer-based versus in-person interventions for preventing and reducing stress in workers (Review)	**Barriers** NI	**Barriers** •Technology Computer-based interventions were cited as being more prone to a mismatch between the goals of the intervention and the goals of the participants, and as being less flexible in adjusting to situations and user characteristics, which has been associated with higher attrition.	**Barriers** NI	**Barriers** NI	**Barriers** NI

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
Kuster et al., 2017 continued		**Enablers** •Employee challenges Authors cited employee engagement and participation as a key factor in the effectiveness of stress management interventions.	**Enablers** •Intervention enablers Authors cited that guided interventions were shown to be more effective at symptom reduction and increased intervention completion.	**Enablers** NI	**Enablers** NI	**Enablers** NI
Nice 2022	Mental wellbeing at work Evidence review F: Barriers and facilitators to the implementation and delivery of interventions to improve and protect mental wellbeing at work	**Barriers** •Employee challenges Report cites survey fatigue as a barrier to effective implementation.	**Barriers** •Available resource Report cites time and costs as barriers to effective implementation.	**Barriers** •Line managers “... Manager 'unavailability' following risk assessments outlined as a 'significant barrier' to effective implementation, Line manager training on stress risk assessment was vital to enhance their skills but	**Barriers** NI	**Barriers** Integration with policy, process and practice: Establishing and embedding 'stress policy' (preventative and remedial action, detailed, manager guidance or risk assessment and focus groups) into corporate plans, internal systems and procedures demonstrated 'stress' as a priority.

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
				ensuring that all line managers received this training was challenging due to their unavailability, a target driven culture and constant organizational changes were barriers to line manager availability." •Organisational challenges The report cites several factors as barriers to implementation of HWB interventions: • current state of the NHS and "times of austerity"		To have dedicated HWB staff roles with the relevant skills and expertise - clearly outlined HWB job role with well-defined expectations, being a protected role with post holder having relevant skills and expertise

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
				• Busy and pressurized environments caused by staff shortages • Financial barriers to implementation of HWB services • A perception that the money available in the NHS should be prioritised for patient care rather than staff HWB • Logistical barriers due to the nature of NHS work • Dependence on the existence of a receptive audience		

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
Nice 2022 continued		**Enablers** NI	**Enablers** • Resources Being creative and innovative with resources was cited as an enabler of HWB intervention: • Fostering and using external partner relations - respondents with successful HWB implementation described how they had fostered good relationships with external partners such as workplace wellbeing organizations, local councils, local gyms, and businesses • Sharing knowledge and expertise with external partners was perceived as a catalyst for change • Intervention Enablers Report cites that intervention efficacy and use needs to be analysed and evaluated.	**Enablers** • Management An organisational structure that supports staff HWB is cited as an important factor, authors stated that support was required at all levels of the organisation; from the Executive Board to the front-line HWB practitioners. Authors identified that an organizational culture that supports staff HWB was an important enabler.	**Enablers** • Resources Government schemes and funding were cited as incentives to implementing HWB interventions.	**Enablers** • Communication Communication and advertisement of intervention was cited as an important enabler.

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
				Authors cited taking a preventative approach to workplace HWB requires a change in the whole NHS organizational culture, and that change would involve “trying to change that culture to make people understand the importance of staff health and wellbeing”. Coherent, strategic approach to implementation were cited as an important facilitator.		

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
				Steering groups- Permanent steering groups with mixed representation stakeholders to co-ordinate initiatives and address risk assessment process.		
Paterson et al., 2024	**Barriers** and facilitators to implementing workplace interventions to promote mental health: qualitative evidence synthesis	**Barriers** • Stigma Stigma issues were cited as overall barriers to intervention implementation	**Barriers** NI	**Barriers** • Stigma Stigma issues were cited as overall barriers to intervention implementation	**Barriers** NI	**Barriers** • Employee challenges Confidentiality issues were reported as a barrier to intervention engagement.
Paterson et al., 2024 continued		**Enablers** NI	**Enablers** • Credibility Authors indicate relevant and tailored content was a key enabler.	**Enablers** • Management / Organisational support Authors cite continuous and	**Enablers** NI	**Enablers** • Organisational support Paper cites internal or external agents/champions,

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
			Perception of the intervention as being useful was cited as an enabler. • Resources Paper cites easy accessibility to the intervention and time provision to engage with the intervention were cited as enablers.	pro-active leadership buy-in and support a being an enabler. Senior-level experience and awareness of mental health issues was cited as an intervention enabler.		and assistance from managers and peers as key enablers. • Communication Fostering relationships and clear communication was cited as an enabler of interventions.
Tamminga et al., 2023	Individual-level interventions for reducing occupational stress in healthcare workers (Review)	**Barriers** NI	**Barriers** NI	**Barriers** NI	**Barriers** • Country specific legislation “Country-specific policies and legislation can influence what types of interventions are implemented. In most countries, there is some legislation on health and safety at	**Barriers** NI

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
					work, but the extent and quality vary between countries according to a report by the World Health Organization. The minimum variant is protecting workers from injuries or illness, but more refined legislation is in place in many countries requiring aspects such as a risk assessment, and the implementation and monitoring of measures.”	
Tamminga et al., 2023 continued		**Enablers** NI	**Enablers** NI	**Enablers** NI	**Enablers** NI	**Enablers** NI

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
von Thiele Schwarz et al., 2020	How to design, implement and evaluate organizational interventions for maximum impact: the Sigtuna Principles	**Barriers** NI	**Barriers** • Available resource Insufficient resource was cited as a possible barrier.	**Barriers** • Organisational challenges “Aligning the intervention with organisational objectives means that the intervention is placed in the landscape of (perceived or real) contradictory and competing organisational objectives, such as those between safety and production. This may amplify tensions between stakeholder-groups which, in turn, may pose a barrier to the implementation	**Barriers** NI	**Barriers** NI

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
				of the intervention." Authors cite staff turnover as a possible barrier to intervention implementation.		
von Thiele Schwarz et al., 2020 continued		**Enablers** NI	**Enablers** • Resource Sufficient resource availability was cited as an enabler.	**Enablers** NI	**Enablers** NI	**Enablers** NI
Waddell et al., 2023	How effective are interventions in optimizing workplace mental health and well-being? A scoping review of reviews and evidence map	**Barriers** NI	**Barriers** NI	**Barriers** NI	**Barriers** • External challenges "Research suggests there is a gap between knowledge and practice, that is, research takes many years to be implemented in practice. This gap presents several	**Barriers** NI

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
					challenges to implementing mental well-being interventions in the workplace, including understanding which intervention has the highest quality evidence underpinning it and deciding which will present the best return on investment.	
Waddell et al., 2023 continued		**Enablers** NI	**Enablers** NI	**Enablers** NI	**Enablers** NI	**Enablers** NI
WHO 2021	WHO guidelines on mental health at work	**Barriers** • Stigma Stigma and fear were cited as barriers to intervention.	**Barriers** • Resources of small organisation Smaller sized organisations were cited as having less available	**Barriers** • Stigma Stigma and fear were cited as barriers to intervention.	**Barriers** NI	**Barriers** NI

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
			resources to allocate to interventions.	• Organisational challenges Workplace knowledge and attitudes were cited as a barrier.		
WHO 2021 continued		**Enablers** NI	**Enablers** • Training Report indicated that providing training to staff that adequately addresses stigmatising knowledge/attitudes is an important enabler. “Training of workers in mental health literacy and awareness is designed to improve knowledge about mental health, reduce stigmatizing attitudes in recipients of the training, and enable workers to support themselves or colleagues appropriately (e.g., through identifying the signs of	**Enablers** NI	**Enablers** NI	**Enablers** NI

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
			emotional distress and taking appropriate action such as seeking or facilitating help from formal or informal sources). • Line manager training "Manager training for mental health is designed to enable managers to identify and respond to workers who require support related to mental health, to give managers the confidence to recognize, engage with and support team members with mental health problems and to adjust job stressors in working conditions."			
Yarker et al., 2022	Meta-synthesis of qualitative research on the barriers and facilitators to	**Barriers** NI	**Barriers** • Available resource Workload issues and staff shortages were cited as barriers.	**Barriers** • Line managers / Organisational challenges	**Barriers** NI	**Barriers** NI

Paper ID	Title	Individual-	Intervention	Inner Setting	Outer Setting	Process
	implementing workplace mental health interventions		High workloads and difficulties in leaving work unattended for those in client-facing roles can affect access to training during working hours unless protected time or staff coverage is provided at the organisational level. Credibility of individual delivering the intervention.	Authors cite managers not prioritising interventions, lack of suitable training of facilitators, and competing priorities as barriers.		
Yarker et al., 2022 continued		**Enablers** NI	**Enablers** • Resource Authors cited that provision of worktime for completion of intervention and scheduling flexibility as a facilitator. • Credibility Trainer credibility was cited as an enabler on interventions.	**Enablers** • Management Positive disclosure by line management was cited as a facilitator.	**Enablers** NI	**Enablers** NI

9 Appendix 3 - Grey literature review findings

9.1 Barriers to organisations effectively managing WRS risk

9.1.1 Employee engagement

Effective managment of WRS risk requires employees to engage fully with the WRS measure or intervention (Julings and Cowen, 2023; CIPD, 2023). The barriers to employee engagement with such interventions typically include:

- workload pressures and competing priorities (Kinman, 2021; Julings and Cowen, 2023; MHPP, 2024).
- feelings of guilt linked to taking time out to access support and/or prioritisation of own wellbeing needs (Julings and Cowen, 2023).
- general denial that support is personally needed (Kinman, 2021).
- access issues, for example, with accessing the physical space to engage with an intervention (e.g., availability of rooms etc) (Wilson et al., 2019; Julings and Cowen, 2023); or services being in an inconvenient location (Kinman, Teoh, and Harriss, 2020) or technical access issues (IT) (Kinman, 2021; Teoh et al., 2024) or long waiting lists (Kinman, Teoh, and Harriss, 2020).
- workplace interventions designed for one employee group that may be unsuitable for others (Kinman, 2021).

Stigma surrounding mental health also remains a pervasive barrier to engagement with interventions (Stevenson and Farmer, 2017; Julings and Cowen, 2023; WHO, 2022; Virtanen et al., 2024; Pandey et al., 2022; WHO/ILO, 2022). Employees can fear negative career repercussions which deter them from engaging with support interventions (Kinman, 2021; WHO, 2022: WHO/ILO, 2022). This lack of psychological safety is particularly acute in environments where confidentiality is not guaranteed or where self-referral is not possible (Kinman, Teoh, and Harriss, 2020) and may be a particular barrier within some specific subgroups (e.g., those from religious or minority ethnic backgrounds) (Julings and Cowen, 2023).

9.1.2 Understanding and awareness of WRS support

Low awareness of the availability (Kinman, 2021; Pandey et al., 2022; Kinman, Teoh, and Harriss, 2020), purpose and benefits of mental health support can hinder the success of interventions (Julings and Cowen, 2023). Employees may not know that support exists or how to access it (Kinman, 2021; Deloitte, 2022; MHPP, 2024).

Equally, an abundance of options can overwhelm employees, reducing engagement and uptake (Kinman, 2021).

9.1.3 Organisational culture

Organisational culture plays a critical role. In some cases, toxic work environments, rigid management practices, and resistance from leadership and other stakeholders act as major obstacles to effectively managing WRS risks (BRC Response, 2024; CIPD, 2023; Julings and Cowen, 2023).

9.1.4 Management and leadership support

Inadequate accountability at senior leadership level (Stevenson and Farmer, 2017), waning leadership interest (CIPD, 2023) or a lack of prioritisation by line managers (MHPP, 2024) or senior managers (CIPD, 2023; Pandey et al., 2022) will hinder the effectiveness of interventions.

Managers and HR need to be empowered effectively to effect change to manage WRS risks (Pandey et al., 2022)

There can be a perception among stakeholders that workplace interventions for managing psychosocial risks are expensive or difficult to manage (ILO, 2016).

9.1.5 Skills and training

Line managers (and/or HR) often lack the knowledge, confidence or skills to manage WRS risks (CIPD, 2023; Kinman, Teoh, and Harriss, 2020; Pandey et al., 2022; ILO, 2016), with just three in 10 organisations providing relevant guidance and training for line managers (CIPD, 2023).

There are potential risks associated with handling mental health issues without sufficient expertise and therefore specialised training is required for facilitators of interventions (MHPP, 2024).

In particular, micro-organisations report lower levels of confidence and capability in addressing mental health (MHPP, 2024) and the feasibility of manager training in these organisations may be challenging due to a lack of resources (WHO, 2022). This indicates that more focus on the very smallest of employers and how to support them should be an area of priority (MHPP, 2024).

In the context of the healthcare sector, there was some evidence that occupational health services sometimes lack the expertise required to deal effectively with the particular mental health problems experienced by healthcare professionals (Kinman, Teoh, and Harriss, 2020).

9.1.6 Resource constraints

Resource limitations—whether in terms of time to implement, financial investment/budgets (CIPD, 2023; Wilson, Martin and Spiegelhalter, 2018; BRC Response, 2024; ILO, 2016), or staff shortages—can impede interventions, particularly in SMEs (Nicholson, 2022; MHPP, 2024; Stevenson and Farmer, 2017). In the context of SMEs, there may be specific barriers linked to the lack of an HR department or established teams, alongside a lack of

time and resources to support the implementation of WRS interventions (Virtanen et al., 2024).

Time constraints are especially critical in sectors like healthcare and education, where burnout and fatigue leave employees too overwhelmed to engage with interventions (Kinman, 2021; Teoh et al., 2023; Julings and Cowen, 2023).

Inadequate quality of third-party resources was also cited as a barrier to managing WRS risk (Pandey et al., 2022).

9.1.7 Data constraints

Many organisations, particularly SMEs, struggle to collect and interpret mental health data to identify interventions that would deliver the required support. Inconsistent data collection, low levels of disclosure by employees (CIPD, 2023), inadequate sickness absence records (BRC Response, 2024, MHPP, 2024), and a lack of analytical expertise limit the ability to monitor outcomes and adjust measures accordingly (MHPP, 2024). In one study, over one third of organisations (36%) did not feel they had the expertise to analyse mental health data and form recommendations and 27% did not use data to inform their wellbeing plans (MHPP, 2024).

Data-driven business cases are also often required to secure management commitment to investment in an intervention and the difficulty of attributing or quantifying direct cost-benefit outcomes to interventions can weaken the case for investment (Nicholson, 2022).

The literature highlighted that employers need significantly more support to navigate how to measure mental health and whether their interventions are having an impact, as well as how to put this insight into practice (MHPP, 2024).

9.1.8 Policy-level barriers

At a policy level, inadequate enforcement of regulations and lack of coordination between stakeholders can contribute to implementation difficulties (ILO, 2016).

In public service bodies or multinational organisations, slow and hierarchical governance frameworks serve as disablers to quick decision making and can hinder progress in managing WRS risks (MHPP, 2024).

Implementing primary interventions can be challenging in large, complex institutions that are subject to constant change, such as the NHS (Kinman, Teoh, and Harriss, 2020).

MHPP (2024) found that creating a psychologically safe workplace is often not a key priority for employers, with low investment in wellbeing and reliance on short-term fixes. The report recommends that the HSE increase awareness and provide measures to help employers address psychological safety.

9.2 Enablers to organisations effectively managing WRS risk

9.2.1 Leadership commitment and role modelling

Leadership involvement and endorsement emerged as critical enablers across multiple sources (CIPD, 2023; BRC Response, 2024; Pandey et al., 2022; Daniels et al., 2022; Brassey et al., 2022; Teoh et al., 2023). Senior leaders who prioritise mental health, openly share their own experiences, and role model supportive behaviours set the tone for a psychologically safe and inclusive work environment. Their influence ensures strategic alignment, resource allocation, and sustainability of interventions (Daniels et al., 2022; Brassey et al., 2022; Pandey et al., 2022; BRC Response, 2024; Teoh et al., 2023).

9.2.2 Organisational culture

An organisational culture that promotes openness, trust, and inclusivity is a key enabler to effectively managing WRS risks (Cambridgeshire Constabulary, 2024; Bagnall et al., 2016; Pandey et al., 2022; Donohue et al., 2024). A psychologically safe organisational culture—where employees feel safe to disclose mental health challenges without fear of stigma or repercussions—improves uptake and success of interventions (WHO, 2022; Bagnall et al., 2016; Daniels et al., 2022; Pandey et al., 2022; BRC Response, 2024; Donohue et al., 2024).

Stigma reduction can be facilitated through initiatives such as personal storytelling by leaders to normalise conversations around mental health; demonstrations of personal vulnerability (Brassey et al., 2022; Pandey et al., 2022); and mental health awareness campaigns (Pandey et al., 2022).

9.2.3 Participatory approaches

Employee participation from the planning phase through to implementation of interventions improves employee engagement and ownership of interventions (Teoh et al., 2023; Bagnall et al., 2016; Cambridgeshire Constabulary, 2024; Leka and Jain, 2024; WHO/ILO, 2022). Participation from those affected by a proposed intervention leads to better identification of issues and solutions (Teoh et al., 2023).

9.2.4 Integration into organisational strategy and values

Embedding interventions into core values, existing practices and organisational priorities such as retention, productivity, or patient safety or cost savings (Teoh et al., 2023; MHPP, 2024) can increase support and interest in interventions.

Highly effective organisations articulate a “culture of health” and emphasise the importance of employee mental health and its impact on the business in goals and values statements (Nicholson, 2022).

9.2.5 Supportive and skilled managers

Sufficient and continuous management support (Leka and Jain, 2024) and involved and empathetic line managers (Bagnall et al., 2016; Nicholson, 2022; Daniels et al., 2022; Pandey et al., 2022) increase effectiveness of mental health interventions.

Manager capability is also important to implementation success. Managers need time, training (to improve skills and credibility), and support to engage with WRS initiatives while balancing their regular work demands (Wilson et al., 2019; Kinman, Teoh, and Harriss, 2020).

WRS risks must be assessed by competent staff and the interventions must reflect identified needs (Nicholson, 2022; Leka and Jain, 2024).

In the context of small enterprises, the feasibility of manager training may be challenging due to a lack of resources. A key enabler in this context is for managers across multiple smaller enterprises to combine resources to participate in such training – such as through group occupational services (WHO, 2022).

9.2.6 Communication and transparency

Effective communication strategies foster understanding of interventions (Donohue et al., 2024), reduce resistance, and enhance transparency. Two-way communication—especially during planning stages—was found to be key to trust and engagement (Cambridgeshire Constabulary, 2024; MHPP, 2024).

Engagement and communication are key enablers and should be funded and appropriately resourced (human and digital) from the outset (MHPP, 2024).

Communicating and establishing clear action plans setting out WRS strategies are important stages in implementation of effective WRS interventions (Kinman, Teoh, and Harriss, 2020), including establishing clear pathways to appropriate support for workers at risk (Donohue et al., 2024).

9.2.7 Resourcing

Adequate resourcing—financial, staffing, and time – is a key enabler to effectively managing WRS risks (ILO, 2016; Nicholson, 2022; Daniels et al., 2022; WHO/ILO, 2022). In the context of the NHS, organisations have received funding from NHS England or from the pooling of resources across integrated care systems to run specific initiatives (Teoh et al., 2023).

Partnerships with external experts and organisations to provide resources and support (BRC Response, 2024) serve as an enabler. Large companies should use their supply chains to help share resources and influence the behaviour of smaller organisations (Stevenson and Farmer, 2017).

Effective organisations create multiple intervention leads to share the tasks across the organisation to ensure continuity and sustainability in the delivery of interventions and avoid issues of absence or departure of key personnel (MHPP, 2024; Teoh et al., 2024).

9.2.8 Monitoring, evaluation and iteration

Robust monitoring, review, and evaluation processes are critical to track progress, measure effectiveness, and adjust interventions (Teoh et al., 2023; BRC Response, 2024; Donohue et al., 2024). A continuous improvement model—the “Plan-Do-Check-Act” model—was found to underpin all NHS organisational interventions (Teoh et al., 2023)

Evaluation ensures that interventions remain relevant, evidence-based, and can be scaled to other departments or organisations (MHPP, 2024; Daniels et al., 2022; Donohue et al., 2024). However, Bagnell et al., (2016) advise that transferring interventions between contexts should be done with caution.

10 Appendix 4 – Interview findings

10.1 Who we spoke to:

To understand the enablers and barriers to managing work-related stress (WRS) risks, we conducted interviews with two participant groups, these being:

> **Organisational Leaders (OLs):** We spoke to 20 leaders from various sectors, including construction, healthcare, education, public sector, care, emergency services, transport. Most participants worked for large organisations (>500 employees) and were UK based. These individuals hold positions that influence organisational policies and practices related to employee wellbeing and stress management.
>
> **Advisory professionals (APs):** We spoke to 10 experts and representatives of organisations with external influence on stress management and wellbeing practices within other organisations. These experts represented a range of professions, including HR practitioners, teachers, the NHS workforce, the construction industry, and those working in the occupational health and safety profession. We also spoke to some trade union bodies and a self-employed work and stress consultant. Our interviewees held a variety of positions, including policy leads, leading on health, wellbeing and employee relations, supporting mental health at work and informing employee action, stakeholder management and work-related stress leads.

Prominent themes identified in the data collected across these two groups were:

- Legislation, tools and guidance.
- Competing demands and stigma.
- Responsibilities, job demands and working relationships.

Detailed findings related to these themes represented below, along with researchers' recommendations for policy and practice to support prevention and management of WRS.

10.2 Legislation, tools and guidance:

OLs often struggle to understand and apply laws, leading to inconsistent practices. APs were familiar with WRS regulations but noted varied implementation, especially in smaller organisations. Both OLs and APs highlight weak enforcement mechanisms for stress management, reducing urgency for compliance and limiting APs' influence and ability to guide clients. While APs value evidence-based tools and use HSE resources, OLs find these tools impractical and outdated. APs reported developing their own guidance and seek practical tools for WRS prevention. OLs report limited data collection and challenges in measuring WRS effectiveness, often relying on basic metrics or self-reports, which hinders comprehensive understanding and evaluation.

10.2.1 Legislation and enforcement

OLs often expressed uncertainty about their obligations under laws such as the Health and Safety at Work Act and the Equality Act and there was a **lack of consistent**

understanding and application of these legal frameworks amongst leaders. Conversely, all APs were very familiar with the legal requirements for employers concerning work-related stress, although echoed significant differences in how their clients/member organisations perceive and implement the relevant legislation, leading to inconsistent practices.

Some advisory professionals we interviewed described a relationship between readiness and effectiveness of change relating to an organisation's size. **Smaller organisations** were seen to have more difficulty in meeting requirements due to limited resources. However, it was also noted that resource availability may only be slightly better in larger organisations and that this effect may be offset by increased demands. In contrast one interviewee also described being able to deploy support quicker in smaller organisations and affect quicker change.

A perceived **lack of strong enforcement mechanisms** for stress management, was something echoed by OLs and APs with respect to their clients and membership following. This was said to diminish the sense of urgency for organisations to comply with relevant legislation and prioritise stress management, prompting some organisations to overlook WRS entirely due to a lack of perceived legal repercussions. APs also reported the lack of enforcement meant it is challenging to encourage clients/members to implement preventative measures.

10.2.2 WRS tools and guidance

Evidence based tools were seen as valuable by APs, many of whom reported using HSE resources online and when speaking to member organisations. Some APs also described actively advocating for the use of these resources, specifically various HSE resources such as the 'talking toolkit'. There was however a lack of consistent understanding and application of frameworks such as the HSE Stress Management Standards reported by OLs and perceived by APs. OLs described how such tools **lack specificity and practicality**, reporting them to be outdated, not user-friendly nor tailored to their sector/organisational context. **Language barriers and complex methodologies** were also said to make it challenging to apply existing tools effectively. APs perceived organisations often lack the confidence to use WRS tools, highlighting the need for better training and support to help with understanding, which is a role APs are currently fulfilling.

AP specific findings related to WRS tools and guidance

Analysis of interviews with APs also identified themes in the data specific to this participant group. Many of the APs reported **publishing their own stress or wellbeing guidance online**. For membership bodies, this was part of their restricted access offering to member organisations only. Membership bodies stated that they assessed the quality of resources and tools they linked or signposted to, by being **member-led** and largely in response to the issues members where facing. Some APs also described giving precedence to **evidence-based insights** and looking to experts in the field. Amongst APs there was appetite for more **practice-based tools** that are easy to implement and record. One

interviewee reported wanting to see more tools and guidance for the prevention of WRS to better understand what this looks like in practice.

10.2.3 OL specific findings related to WRS tools and guidance

OLs reported **limited data collection to measure WRS** within their organisation. For example, reliance on basic metrics like absence rates which prevents a comprehensive understanding of WRS within the organisation. Some OLs reported having no formal measures of identifying and classifying WRS and therefore relying upon self-report (e.g., ad hoc, individual conversations) and generic staff satisfaction surveys. Some OLS acknowledged **challenges in measuring the effectiveness** of WRS initiatives including low case numbers of WRS, confidentiality and data limitations, lack of robust evaluation, reliance on self-report and inconsistent application. Some OLs stated that their organisation did not measure the impact of WRS initiatives at all.

10.3 Competing demands and stigma:

Competing priorities often hinder OLs from addressing WRS prevention, with urgent demands and external pressures taking precedence. Cost barriers and a tendency towards reactive strategies were also acknowledged. Stigma also discourages open discussions and delays addressing stress until it becomes severe. Both OLs and APs note that mental health concerns often receive less attention than physical health issues, leading to a reactive rather than preventive approach.

10.3.1 Competing demands

Competing priorities emerged as a key theme. Some OLs demonstrated willingness to adjust workloads or allocate time to stress prevention activities, yet felt limited by urgent **client demands** or **external pressures**. In a housing context, for example, continuous tenant needs made it seem impossible to pause normal operations and conduct a stress survey. Health and care sector leaders mentioned that staff shortages and rising patient needs created practical **barriers to implementing proactive measures**. Those in education noted that heavy workloads, tight marking deadlines, and staff turnover left little space for wellbeing initiatives (further discussed within section 4.2). Although a few leaders managed to incorporate wellbeing checks into routine meetings, the consensus suggested that **short-term pressures** often pushed mental health concerns aside until problems became severe.

Leaders from the local authority and healthcare sector also cited **cost barriers** to the implementation of the HSE's stress indicator tool and the tendency towards using reactive rather than proactive strategies. OLs from the emergency services sector described workplaces where constant **pressure to meet targets and contain costs** often overshadows efforts to manage WRS. In some instances, OLs acknowledged the **importance of proper risk assessments and stress support** but emphasised that their **budgets were too constrained** to implement them. Others recognised their legal duty to care for employees but felt unable to invest in wellbeing measures at the current time. Smaller organisations were more likely to note that the price of using certain tools, such as

the Health and Safety Executive's Stress Indicator Tool, placed these resources out of reach. Larger organisations, while sometimes able to purchase such tools, expressed **uncertainty about demonstrating a clear return on that investment**.

10.3.2 Stigma

Stigma around stress and mental health was also highlighted by OLs and APs. Several OLs indicated that employees worry about the **career impact** of admitting to stress. In some industries e.g., government/civil service, a cultural belief persists that acknowledging stress implies a lack of toughness or resilience, making employees reluctant to speak up at early stages. Leaders in sectors such as manufacturing or rail noted that staff often **refrain from reporting** feelings of overwhelm, due to concern that it might harm their chances of promotion or advancement.

APs also highlighted how **stigma discourages open conversations** about mental health. While certain leaders try to create an environment where stress can be discussed openly, others were said to remain uncomfortable with such discussions, leading to some challenges in how to change an organisational approach to developing a more open and safe culture. Some suggested the use of line management training or coaching so that better conversations about WRS could be had with employees. In some cases, **leaders appear sceptical** about whether stress complaints are genuine or see them as excuses, which reduces the likelihood of managers providing the right support. There were also reports from APs that mental health concerns and stress do not receive the same prompt attention as physical health and safety issues, and that managers sometimes postpone addressing stress in favour of dealing with more visible hazards. One factor that contributed to the delay in prompt action was whether the stress was work-related or exacerbated by other 'environmental' or 'non-work' related factors. However, it was acknowledged that responding to work-related stress concerns it is important to address the issue promptly, to reduce the likelihood of the situation worsening in the future.

The delay in acknowledging stress often means that, by the time employees feel able to come forward, the situation has already escalated. Some OLs noted that they only become aware of stress when an employee goes off sick with anxiety or depression, at which point the problem has reached **crisis level**. APs working with trade unions confirmed that organisations frequently **wait until serious incidents** occur before reviewing policies or conducting stress assessments. This reactive stance makes early prevention more difficult.

10.4 Responsibilities, job demands and working relationship

Evidence gathered shows OLs and APs face challenges in defining roles and responsibilities for managing WRS, with line managers often lacking the training or authority to intervene effectively. Excessive workloads and high-pressure environments, common across various sectors, exacerbate WRS with financial and operational constraints making it difficult to reduce these demands. Workplace relationships and culture also play a significant role, with limited communication and a blame culture hindering stress management. While some organisations demonstrate supportive

practices, many struggle to implement proactive measures, leading to a reactive approach to stress management.

10.4.1 Roles and responsibilities

Both OLs and APs frequently highlighted **uncertainty in assigning and understanding roles** when managing WRS. For example, some OLs acknowledged that even when internal guidelines were available within their organisation, translating them into concrete daily actions remained challenging for example, varying support from local level management, local level management overlooking legislation, perception of interfering when championing internal guidelines and lack of understanding and training amongst managers regarding health and safety. APs noted that **line managers often lack training** or authority needed to intervene effectively in cases of emerging stress, leading to inconsistent support. More than one AP interviewee emphasised the need for individuals to have greater role clarity; it was suggested that job design could be reviewed regularly to identify and address emerging risks.

These challenges were not confined to large or small organisations; both types faced difficulties in embedding proactive stress management into their operations. Both OLs and APs reported that employees often found it hard to determine who to approach with WRS-related concerns. Many OLs described a scenario where actions to reduce stress generally occurred only after problems had intensified, rather than at an earlier stage when preventive measures might be more effective.

10.5 Workload and high-pressure environments

The majority of OLs and APs who commented on job demands associated WRS with **excessive workloads** and **high-pressure conditions**. Many OLs, pointed to large volumes of work, resource constraints, and tight deadlines as factors that place substantial strain on employees. APs who advised organisations in various sectors including care, emergency response, education and consultancy, reinforced these views, reporting that such pressures frequently stemmed from **staffing shortages**, reduced resources, increased work demands along with ongoing **organisational change** and other **sector-specific challenges**. APs and OLs both highlighted challenges in directly addressing workload pressures, i.e. demands were felt to be unavoidable in high-pressure sectors or the inherent stress associated with particular roles, for example the health care sector. In these contexts, while some measures might help ease stress to some degree, underlying structural issues specific to the sector need to be addressed.

Many OLs felt these demands were not easily reduced due to financial or operational limitations, a perspective that APs confirmed was common across multiple types of organisations. For example, an OL within a small school, reported considerable costs incurred to bring in relief staff to maintain classroom teaching and allow teaching staff to tackle administrative aspects of their role during periods of high workload in exceptional circumstances. The individual however acknowledged that their organisation was in a fortunate position to do so, where many schools would not be. This situation often created

environments where the expectations placed on employees outstripped the available resources, perpetuating a cycle where WRS remained unaddressed until it reached a critical point.

10.5.1 Workplace relationships and culture

A significant proportion of OLs and APs identified **workplace relationships** and **cultural factors** as crucial in shaping how WRS emerged and persisted. Several OLs described organisational cultures marked by limited communication, minimal interaction, and a tendency to assign blame when problems arose. APs echoed this, noting that in some settings employees were reluctant to voice stress-related issues due to fears of **negative repercussions** or perceptions of reduced competence. However, not all perspectives were negative. OLs from various industries including transport, social care, local authorities, emergency services cited examples where **supportive managerial approaches**, stronger team dynamics, and **open discussion** of workload pressures contributed to better WRS management. APs also observed that when organisations embraced **clear communication** and demonstrated empathy, employees were more likely to address stress before it escalated. These instances, although fewer in number, illustrate that positive relational and cultural environments can help alleviate rather than exacerbate WRS.

Data from OLs and APs indicate that while some organisations are aware of WRS, many struggle to **define responsibilities clearly**, **moderate high-pressure workloads**, and **foster supportive workplace relationships**. This often leaves employees in environments where preventive measures are limited, and stress is addressed primarily on a reactive basis.

10.6 Participant information sheet

Study Title: Occupational Stress Consultation and Research (OSCAR)

Research Team:

- Affinity Health at Work: Professor Jo Yarker, Dr Rachel Lewis, Dr Kevin Teoh, Professor Gail Kinman, Fehmidah Munir, Nathan Palmer, Sophie Walker.
- Institute of Occupational Medicine (IOM): Rebecca Canham, Katie Clabon, Emily Christopher, Dr Amanda McNamee.
- Institute for Employment Studies (IES): Dan Lucy, Dr Sally Wilson, Dr Zofia Bajorek, Arundhati Dave.

Sponsor: Health and Safety Executive (HSE)

Ethical Committee reviewing and providing approval: Reading Independent Ethics Committee

Background: Work-related stress caused the loss of 17.1 million workdays in 2023. It leads to poor mental health, mood disorders, burnout, and even suicide. Stress impacts employers through absenteeism, reduced performance, and increased turnover of staff. Despite evidence linking work conditions to stress, only 40% of organisations actively address its causes. to explore work-related stress.

Project Objective: OSCAR aims to gather evidence to help the HSE develop policies and guidelines for preventing and managing work-related stress. The study has three areas of focus:

1. Prevention and Mitigation: Effective measures to prevent and reduce work-related stress.
2. Definition and Labelling: How work-related stress is identified and classified.
3. Implementation: Barriers and enablers for organisations managing work-related stress.

Who Can Participate? We are seeking individuals from the following groups to take part in semi-structured interviews:

- Employees: Experiencing or having experienced work-related stress.
- Organisations/Employers: Leaders, business owners, HR representatives.
- Occupational Health Professionals: Physicians, nurses, vocational rehabilitation professionals, occupational therapists.
- Healthcare Representatives: GPs, psychiatrists, allied health professionals.

Participants must be over 18 and able to give informed consent.

Participation Details: You are invited to a one-time, 45-minute interview via phone or MS Teams. If interested, contact us at oscar@affinityhealthatwork.com to schedule a

convenient time for your interview and receive a consent form (which you will be given a copy of') to sign and return. You can expect questions to ask about how you recognise work-related stress, the resources and support your organisation offers, and how you measure their effectiveness. We'll discuss what makes managing stress easier or harder, and where there might be gaps in knowledge or support. This interview will be recorded and after this session will be transcribed and anonymized

Risks and Benefits to Participation:

- Risks: No anticipated risks. You may stop the interview at any time without needing to give a reason.
- Benefits: Your participation will help to shape HSE guidelines and support for businesses to prevent and manage work-related stress.

Confidentiality: Your interview answers (research data) will remain confidential and stored securely. Data will be fully anonymised with no reference made to identify you as an individual or your organisation. We acknowledge that discussing work-related stress may cause discomfort. In which case we would like to remind you that you are free to cease participation and withdraw your data.

Voluntary Participation: Participation is entirely voluntary. You can cease participation and withdraw your data within two weeks following interview conduct without penalty. After two weeks, data analysis may make withdrawal impossible.

Consent and Accessibility: If you choose to participate, you will be asked to sign a consent form (which you will be given a copy of) detailing your rights before your interview. Let us know if you need any accessibility accommodations.

Contact Information: For questions or concerns, contact our project team at oscar@affinityhealthatwork.com.

Principal Investigator: Professor Jo Yarker, Chartered Psychologist, Managing Partner, Affinity Health at Work Jo.Yarker@affinityhealthatwork.com

Further details can be found at www.affinityhealthatwork.com/oscar

Please keep this information sheet for your records.

10.7 Topic guide - Advisory professionals

Participant group – Advisory Bodies

Thank you for your time today.

Introduction: I will be asking you some questions about managing and preventing WRS, guidance provided to membership, measures preventing WRS and WRS accountability.

Before we begin, can I confirm that you have read the information sheet giving the background to this study? I can confirm that you have completed your consent form and returned this to us

Sharing information: In our discussions today, please bear in mind that you do not need to share or talk about anything that you feel uncomfortable about. We can pause or stop at any time. You will also have the option to withdraw from the study without any consequences or to rearrange the interview. In the participant information and debrief you are signposted to support services you may wish to contact.

What will happen now and at the end of this session: This interview will be recorded and after this session will be transcribed and anonymized. Your data will be held securely in compliance with UK Data Protection Laws. You are able to pause or withdraw from this interview at any time.

Recording: (If participant consented to being recorded within consent form) I just wanted to check that you are still happy to be recorded? Great, I will begin the recording and then I'll give you a brief introduction before we begin. Is that OK? [START RECORDING]. (If participant did not consent to being recorded within consent form) I can see on your consent form you did not want to be recorded, that is not a problem, my colleague [insert name] will be present on the call to make detailed notes whilst I conduct the interview with you.

Questions: Before we begin, did you have any questions from the information you were sent?

1. General understanding of preventing and managing WRS
    - Can you provide an overview of your role and involvement in preventing and managing work-related stress (WRS)?
    - How well do you know the legal requirements with respect to preventing and managing WRS in your sector/industry? What does this mean in practice?
    - How well do you think this is understood within your industry/ sector by the clients you advise?
2. Tools and resources to prevent and manage WRS
    - What resources does your organisation publish or endorse to manage WRS? (Prompts: specific tools/guidance, training programmes, mental health first aiders, measurement)

- How do you evaluate the effectiveness of these resources? (Prompts: Metrics used, feedback mechanisms, success stories, evidence available, strength of evidence).

3. Enablers and barriers to preventing and managing WRS
    - What are the main enablers for organisations to effectively prevent and manage WRS? (Prompts: Training, culture, management support /leadership, business reputation, financial benefits)
    - What are the main barriers for organisations preventing and managing WRS? (Prompts: Lack of awareness, resource/financial constraints, complexity of guidance, lack of management support/buy in, knowing what to do)
    - Are you aware of particular barriers and enablers specific to the use of current HSE guidance and tools to prevent and manage WRS?
4. Advice and misapplication of WRS management
    - What advice is your organisation currently providing to its members regarding the prevention and management of WRS? (Prompts: interventions/management strategies, awareness of psychosocial risks, evaluation).
    - Can you provide examples of organisations that have successfully implemented WRS management strategies? What made them successful?
    - Is this advice tailored and if so, how? (Prompt: enterprise size, sector, industry, Industry feedback on advice).
    - Are there any areas you have noticed organisations have difficulties in preventing and managing WRS? prompts: risk assessment, providing support, evaluation, lack of focus on prevention, use of data, consultation, what information/ advice do you think organisations need etc
5. Trends and influential factors
    - How have changes to the wider world and new ways of working impacted the effectiveness of interventions targeting prevention and management of WRS? (Prompts: changes in prevalence, macro context, economic conditions, regulatory changes, remote/hybrid work, contractual arrangements).
    - What characteristics show trends in the effective management of WRS (Prompt: Sector, industry, enterprise size, link with organisational purpose, evidence, strength of evidence).
    - What factors do you think are most influential in inducing or exacerbating WRS within organisations? (Prompts: Job roles, work environment, work tasks, supervision arrangements, organisational changes, relationships, support).

End of interview

Outro text:

Thank you for volunteering your time today to participate in an interview today, your insight has been really valuable. If there is any evidence or sources you can provide to our call for evidence you can submit this to our call for evidence. Once we have finished running the interviews we will be analysing the data and writing up the findings. Once we have a final report, we can send this to you if you are interested in reading about the findings?

11 Appendix 5 - Strengths and limitations

This research draws on multiple sources of data to explore the barriers and enablers of managing WRS. As with any study, there are several strengths and limitations of this work, and these should be borne in mind when considering our findings and conclusions.

Strengths

Multi-stakeholder perspective: Interviews with organisational leaders and those in advisory roles from policy and professional bodies, provide a rarely presented view across work and health systems.

Mixed methods approach: The integration of the evidence review (across both academic and grey sources), deep insights gathered through interviews, and the extensive consultation from diverse stakeholder groups allows a richer understanding of how WRS is defined and labelled in practice.

Cross-sector perspective: Our stakeholder engagement and sampling approach aimed to draw insights from diverse sectors to understand common challenges and capture salient points of differentiation.

Practice- and policy- oriented: The research aimed to bring together existing knowledge, and advance understanding, with a specific focus on developing practical insights to inform employers, health service provision and policy.

Limitations

Engaged sample: While we used several channels to recruit participants for this study, those who chose to take part in the interviews and workshops were likely to be more informed, engaged, or concerned about WRS than the wider professional population. This may have introduced a degree of positive bias in terms of knowledge or willingness to act.

Limited representation of some groups: While we sought input from diverse stakeholders, including key professional groups, perspectives from smaller employers, gig workers, and employers without access to occupational health services were underrepresented. The study design allowed for discussion on the barriers and enablers experienced by workers from different groups, including minority ethnic groups, neurodivergent individuals, women, and people with disabilities, and no specific issues were strongly raised by participants however research at these intersections may require further dedicated research.

Focus on professional views: The study focused on those responsible for managing or advising on WRS, rather than those experiencing it. As such, the findings may not fully capture how individuals with lived experience of WRS interpret or navigate these systems.

Lack of quantitative outcome data: While qualitative insights are strong, the study does not include quantitative analysis of the prevalence or outcomes associated with different WRS implementation issues. This limits the ability to draw conclusions about the relative effectiveness of specific approaches.

12 Appendix 6 – Mapping of evidence sources

Table 7: Mapping of evidence sources across research questions data themes.

Data theme	Q1: Enablers and barriers from an organisation's perspective	Q2 & 3: Enablers and barriers to use of HSE tools and stress risk assessment	Q3: Influencing factors impacting WRS management	Academic literature	Grey literature	OL interviews	AP interviews
*Organisational culture	Y	N	N	Y	Y	Y	Y
*Stigma	Y	N	N	Y	Y	Y	Y
*Costs, demands and resources	Y	N	N	Y	Y	Y	Y
*Workload pressures and competing priorities	Y	N	N	Y	Y	Y	Y
*Data gathering	Y	N	N	Y	Y	Y	Y
*Impact measurement	Y	N	N	Y	Y	Y	N
*Impact of leaders and managers	N	N	Y	Y	Y	Y	Y
*Clear roles and defined responsibilities	N	N	Y	Y	Y	Y	Y

*Awareness challenges	N	N	Y	N	Y	N	Y
Perceived lack of strong enforcement mechanisms	Y	N	N	N	N	Y	Y
Strengthening of HSE tools	N	Y	N	N	N	Y	Y
Lack of consistent awareness and understanding of HSE resources (including Management Standards)	N	Y	N	N	N	Y	Y
Importance of participatory approaches	N	N	Y	Y	Y	N	N

*Denotes a common theme identified across literature and interview data

The purpose of this research was to build the evidence base on how work-related stress (WRS) is understood, identified and managed in practice across workplaces. This will be used to help support developments in preventing and reducing the effects of psychosocial hazards in the workplace.

Affinity Health at Work and partners, the Institute of Employment Studies and the Institute of Occupational Medicine, used a multi-method research approach combining evidence reviews, interviews, and stakeholder engagement.

The findings are published in an overarching summary report and three thematic reports addressing the programme's key research questions:

- Overarching summary report: brings together key findings from across the programme
- Report 1: How is WRS defined and labelled by organisations and medical professionals?
- Report 2: What interventions are effective for preventing and managing WRS?
- Report 3: What are the enablers and barriers to organisations effectively reducing the risks of WRS?

The reports will be of interest to employers, practitioners, policymakers, academics and researchers working to improve the prevention and management of psychosocial risks.

In summary, the research found that:

- there is no shared understanding of how work-related stress is defined and labelled
- organisational responses to work-related stress are often reactive rather than preventative
- effective prevention depends on linking interventions to identified psychosocial risks and involving workers in developing solutions
- stronger evaluation and sharing of learning would improve understanding of what works in practice
- the key challenge is how existing knowledge is translated into coordinated prevention activity

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