Project OSCAR: Occupational Stress Consultation and Research

Overarching Summary Report

Health and Safety Executive

November 2026

RR1232 (2026)

Research Report

© Crown copyright 2026

Prepared 2026

First published November 2026

You may reuse this information (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view the licence: visit the National Archives Website, write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email psi@nationalarchives.gsi.gov.uk.

Some images and illustrations may not be owned by the Crown so cannot be reproduced without permission of the copyright owner. Enquiries should be sent to copyright@hse.gov.uk.

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

This report and the work it describes were funded by the Health and Safety Executive. Its contents, including any opinions and/or conclusions expressed, are those of the authors alone and do not necessarily reflect HSE policy.

Project OSCAR (Occupational Stress Consultation And Research)

Overarching Summary Report

Affinity Health at Work
Professor Jo Yarker, Nathan Palmer, Yass Rad, Dr Rachel Lewis, Professor Fehmidah Munir, Dr Kevin Teoh, Professor Gail Kinman

Institute of Occupational Medicine (IOM)
Rebecca Canham, Katie Clabon, Emily Christopher, Dr Amanda McNamee

Institute for Employment Studies (IES)
Dr Sally Wilson, Dr Zofia Bajorek, Arundhati Dave, Dom Hewitt, Dan Lucy

Affinity Health at Work
London, UK
www.affinityhealthatwork.com

Acknowledgements

The researchers thank all of those who have contributed their expertise to this research, particularly those who kindly gave their time to contribute to our call for evidence or to participate in an interview, knowledge exchange workshop or roundtable.

We thank our HSE Project Steering Group for their input and oversight throughout the research, and the Society of Occupational Medicine for their support in our stakeholder engagement activities.

We thank our Project Advisory Group for their time and insight:

- Kris Ambler, British Association for Counselling and Psychotherapy
- Shelly Asquith, Trades Union Congress
- Prof Carolyn Chew-Graham, Keele University
- Jonathan Gawthrop, OCS
- Prof Neil Greenberg, King's College London
- Prof Max Henderson, University of Leeds
- Helen Jones, Health and Safety Executive
- Prof Karina Nielsen, University of Sheffield
- Nick Pahl, Society of Occupational Medicine
- Rachel Suff, Chartered Institute of Personnel and Development
- Prof Anthony Woolf, Arthritis and Musculoskeletal Alliance
- Anli Zhou, Faculty of Occupational Medicine

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
CIPD	Chartered Institute of Personnel and Development
GB	Great Britain
H&S	Health and Safety
HSE	Health and Safety Executive
IES	Institute for Employment Studies
IOM	Institute of Occupational Medicine
NICE	National Institute for Health and Care Excellence
OSCAR	Occupational Stress Consultation and Research
PAG	Project Advisory Group
PSG	Project Steering Group
SOM	Society of Occupational Medicine
WHO	World Health Organisation
WRS	Work-related stress

Contents

Acknowledgements 5

Research ethics statement 6

Abbreviations 7

Key messages 10

Executive summary 11

1 HSE Foreword 15

2 Background to Project OSCAR 16

2.1 The challenge of work-related stress 16

2.2 Why Project OSCAR was commissioned 17

3 What we did 19

4 What we found 20

4.1 There is currently no shared understanding of WRS 20

4.2 WRS is identified across three systems with limited coordination, leading to different responses 21

4.3 Practice is often reactive 22

4.4 Psychosocial risks are not consistently recognised or linked to interventions 23

4.5 Interventions operate across levels of control depending on their design and implementation 23

4.6 Context plays an important role 25

4.7 Participatory approaches show promise 25

4.8 Effective implementation requires capability, participation and practical support 26

4.9 Evaluation and shared learning are limited 26

4.10 There is enough evidence to take action 27

5 Key considerations 28

6 Conclusions 30

7 What next for organisations and practitioners? From evidence to action 31

7.1 Understanding the problem: identifying psychosocial risks 31

7.2 Good practice in selecting and combining interventions 31

7.3 Catalogue of interventions for WRS 32

7.4 Implementing interventions 34

7.5 Evaluating interventions and sharing learnings 35

References 36

8 Appendix 1: Evidence map: Key findings mapped to supporting evidence sources 38

9 Appendix 2: Evidence map: Key considerations mapped to key findings 41

10 Executive summary – Report 1 Defining and identifying work-related stress 43

11 Executive summary – Report 2 Interventions to prevent and manage work-related stress 46

12 Executive summary – Report 3 Barriers and enablers to effectively manage work-related stress 50

Key messages

Why the work was done

Work-related stress (WRS) remains a leading cause of work-related ill health in Great Britain (GB). Yet important questions remain about how WRS is identified, prevented and managed in practice. The Health and Safety Executive (HSE) commissioned this research to strengthen the evidence base and inform further guidance.

What we did

Project OSCAR used a multi-method research approach combining evidence reviews, interviews, and stakeholder engagement to address three research questions:

1. How WRS is defined and labelled by organisations and medical professionals.
2. What interventions are effective for preventing and managing WRS.
3. What are the enablers and barriers to organisations effectively reducing the risks of WRS.

What we found

- There is no shared understanding of work-related stress (WRS).
- WRS is identified across multiple systems with limited coordination.
- Responses to WRS are often reactive.
- Psychosocial risks are not consistently recognised or linked to interventions.
- Interventions do not always operate at a single level of control.
- Organisational context influences effectiveness, including culture and resources.
- Participatory approaches show promise in helping organisations identify risks and develop solutions.
- Implementation approach and capability matters, with participation, leadership engagement and practical support shaping outcomes.
- Evaluation and shared learning are limited, reducing opportunities to learn what works in practice.
- There is enough evidence to take action; the challenge is translating knowledge into coordinated prevention.

What this means

While the evidence does not provide clear answers about “what works” in every setting, it highlights practical opportunities to improve how WRS is identified and managed. Using available evidence alongside professional judgement, worker participation, and local knowledge, can help organisations implement and refine approaches that reduce psychosocial risks over time. The challenge is not a lack of knowledge about WRS, but how knowledge is translated into a shared understanding and coordinated action across health and work systems.

Executive summary

Introduction

Work-related stress (WRS) is a leading cause of work-related ill health in Great Britain (GB). There is strong evidence linking specific working conditions, often referred to as psychosocial hazards, to stress and poor mental health outcomes. These working conditions include factors such as high job demands, low levels of control, poor support, role ambiguity and poorly managed organisational change, and underpin the HSE's Management Standards for WRS. While many employers take steps to address WRS, practice is often inconsistent, reactive and largely focused on individual-level support rather than prevention. There is also no consistent understanding across workplace and healthcare systems of what WRS means, how it should be identified, or who is responsible for managing it.

Several reviews and guidance documents already exist on workplace mental health, including those produced by international bodies such as the World Health Organisation (WHO, 2022) and the National Institute for Health and Care Excellence (NICE, 2022). These provide valuable evidence on interventions that improve mental health and wellbeing outcomes. However, they are largely outcome-focused and place limited emphasis on whether interventions reduce exposure to the psychosocial hazards that give rise to WRS. In addition, organisations report challenges in identifying and managing WRS risk, including uncertainty about effective interventions and barriers to implementing existing guidance.

The Health and Safety Executive (HSE) commissioned a programme of research to address three research questions:

1. How is WRS assigned and labelled by organisations and medical professionals?
2. What interventions are effective for preventing and managing WRS?
3. What are the enablers and barriers to organisations effectively reducing the risks of WRS?

This report provides an overview of the key findings from the research programme. Detailed findings from each study are reported in three accompanying reports:

- Report 1 Defining and labelling of work-related stress
- Report 2: Interventions to prevent and manage work-related stress
- Report 3: Barriers and enablers to effectively managing work-related stress

What we did

We used a multi-method approach to help us answer the research questions with the following stages:

- **A call for evidence** with the WRS research, policy and practice community.
- **Systematic searches and reviews of evidence**.
- **Interviews with healthcare professionals, organisational leaders, advisory professionals and stakeholders** from sectors with higher levels of WRS.
- **Stakeholder consultation workshops** to review and refine findings and explore implications for guidance and regulation.
- **Ongoing input from an HSE steering group and independent advisory group** to ensure relevance to policy and regulatory needs.

This approach allowed Project OSCAR to combine insights from research evidence, professional practice and policy discussions, providing a robust picture of how WRS is currently understood and managed. Findings from these sources were synthesised to identify common themes, areas of convergence and divergence, and identify new insights.

What we found

There is no shared understanding of work-related stress

People use different terms alongside stress, like “burnout” or “psychosocial risk”. Professionals within organisations (e.g. human resources, wellbeing leads and managers) often use the HSE definition, while healthcare professionals tend to use the Word Health Organisation (WHO) definition or National Health Service (NHS) frameworks. People seem to have different ideas about what stress is and these differences are likely, in part, to explain why interventions and support are so varied and piecemeal.

Many agree that it can be hard to tell whether stress is caused by work or by other things, like problems at home or personal issues, which can also affect your ability to work. Some say WRS can mean that work made things worse, even if it wasn’t the main cause. It is important to acknowledge this complexity when labelling and supporting people with WRS so that they get the right help at the right time.

WRS is identified across three systems with limited coordination, leading to different responses

The pathways through which WRS is identified vary depending on whether concerns are raised within the workplace, through occupational health, or through healthcare services. These systems operate largely independently, which can lead to different interpretations of WRS and different responses. When WRS is first identified through healthcare services, it may be addressed primarily through clinical treatment and sickness absence rather than through workplace risk management or work adjustments. This can contribute to the medicalisation of WRS, and because of limited coordination, delay preventative action in the workplace.

Practice is often reactive

Across the research and stakeholder consultations, responses to WRS frequently occur once an individual has experienced significant stress or health impacts. In many cases, organisational action begins after problems have escalated rather than through earlier identification and management of psychosocial hazards.

Psychosocial risks are not consistently recognised or linked to interventions

There is strong evidence linking working conditions/psychosocial hazards to stress and poor health outcomes. However, psychosocial risks are not consistently recognised or targeted by interventions, and the evidence base rarely links these interventions clearly to the psychosocial hazards they are intended to address.

Interventions do not always operate at a single level of control

Their function (preventing harm, supporting coping or responding to harm) depends on their design, intended outcomes and how they are implemented in practice.

Context plays an important role

Findings across the research highlight that organisational context plays an important role in determining whether interventions are implemented and sustained. Factors such as leadership commitment, organisational culture and available resources can act as either barriers or enablers to effective WRS management.

Participatory approaches show promise

Participatory approaches, where workers and managers collaborate to identify risks and develop solutions, were consistently highlighted across the research as promising approaches. These approaches can help organisations identify workplace risks and develop interventions that are relevant to the organisational context.

Effective implementation requires capability, participation and practical support

Evidence showed that effectiveness is not only shaped by what employers implement but how the interventions are implemented. Stakeholders reported challenges in interpreting existing tools and guidance into practical organisational action.

Evaluation and shared learning is limited

Structured evaluation of interventions was reported to be relatively uncommon. Organisations often introduce several changes at any one time, making it difficult to attribute outcomes to any one intervention. There are also limited opportunities to learn from practice or build an understanding of what works in different contexts.

There is enough evidence to take action

The relationship between working conditions and stress is well established. The challenge now lies in translating this knowledge into practice through clearer identification of psychosocial hazards, stronger links between risks and interventions, and more effective

implementation. Continued learning from organisational practice and evaluation will help strengthen understanding of what works in different contexts.

Key considerations for the future

- **Establish a shared understanding of WRS across workplace and healthcare settings,** through clarifying roles and responsibilities for employers, managers, and healthcare professionals and strengthening coordination between systems**,** with clearer referral routes and better communication between occupational health, primary care, and employers.
- **Promote a psychosocial hazard-led understanding of WRS,** centred on how work is organised and managed, rather than focusing primarily on individual symptoms or outcomes. Without this, prevention and management efforts are likely to remain reactive and fragmented.
- **Support employers to select appropriate interventions**, through promoting a systemic approach to intervention that recognises organisational context, and that no single intervention is sufficient. Effective approaches usually combine actions across organisational levels and should be tailored to the specific psychosocial risks and context of the organisation.
- **Build implementation capability,** through emphasising participation, improving the knowledge, skills and confidence of leaders, managers, health and safety, human resources and occupational health professionals to manage psychosocial risks, and providing clear, accessible guidance.
- **Strengthen the problem – solution – impact link,** by supporting employers to use stress risk assessments and indicator tools to diagnose problems, select appropriate interventions to those psychosocial risks, and evaluate whether the risks have reduced over time.
- **Strengthen evaluation and organisational learning,** embedding evaluation and learning as a routine part of prevention and increasing the value of documenting and sharing good practice.

Conclusion

Preventing and managing WRS remains a complex challenge. This does not mean that organisations should delay action. By making better use of the available evidence, alongside stress risk assessment, professional judgement and contextual knowledge, employers can take a more preventative and proportionate approach to managing WRS. Strengthening coordination across health and work systems, alongside learning from implementation and evaluation, will help build understanding of what works in different organisational contexts.

1 HSE Foreword

The Health and Safety Executive (HSE) commissioned Project OSCAR to support delivery of HSE's strategic objectives in Protecting people and places. The Project OSCAR findings make a significant contribution to the evidence-base informing HSE's approach to preventing psychosocial risks that can lead to workers experiencing work-related stress.

Managing psychosocial risks is one of the most significant challenges facing organisations and workers in the modern world of work. Existing reviews and reports are largely outcome-focused and have placed limited emphasis on intervening to reduce exposure to the psychosocial hazards that give rise to work-related stress. There is uncertainty about effective interventions for preventing the causes of work-related and barriers to implementing guidance effectively.

This was the motivation for commissioning new research to examine how work-related stress is understood and what interventions are effective for preventing and managing the causes of it, along with an improved understanding of the enablers and barriers to effectively implementing these interventions. We would like to recognise the commitment and expertise of the research team, and to congratulate them on delivering an extremely competent programme of work that will help drive forward progress on many fronts.

There are important implications for HSE's work and for others engaged in identifying and managing psychosocial risks, particularly employers and also practitioners, academics and researchers who are seeking to strengthen the growing evidence base in this field.

Working together is essential to delivering meaningful, lasting impact, and we hope that these findings inspire collaborative action across a range of different stakeholders to prevent work-related stress.

2 Background to Project OSCAR

2.1 The challenge of work-related stress

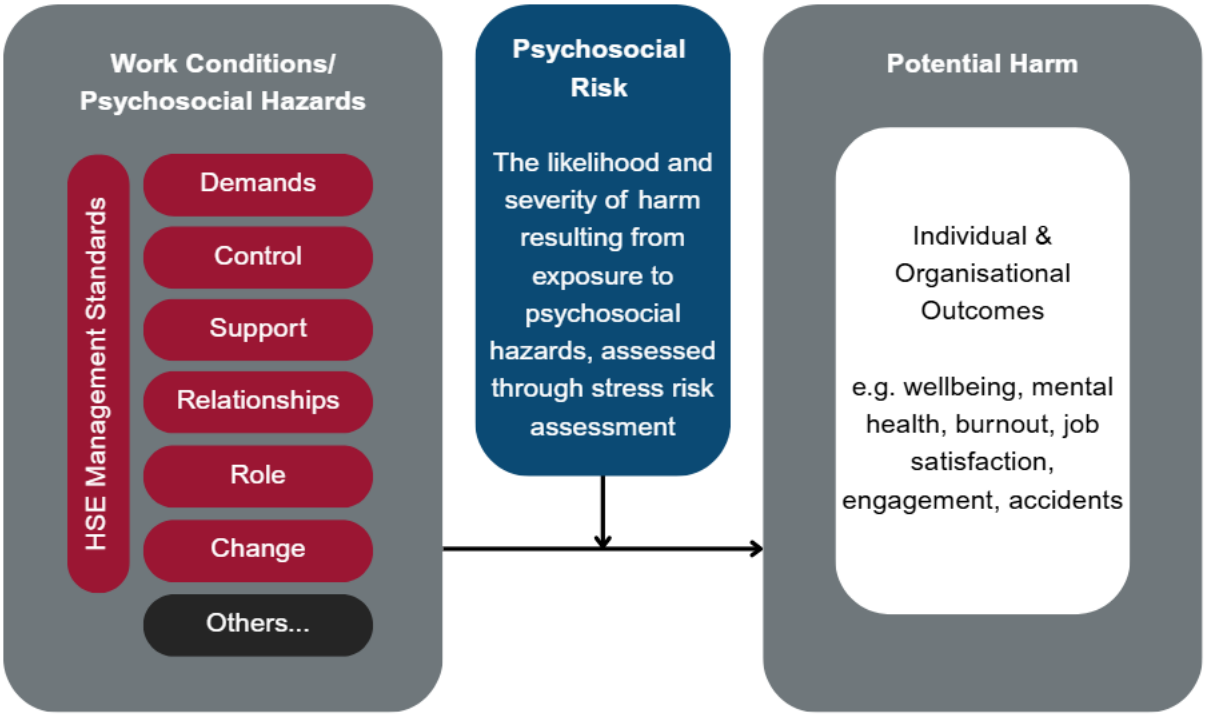
Stress is one of the most significant occupational health challenges in GB. It accounts for almost half of all cases of work-related ill health and the number of working days lost due to illness (HSE, 2024). Prolonged exposure to WRS is strongly linked to poor mental health outcomes, such as depression (e.g., Madsen et al., 2017), and can contribute to serious mood disorders, and burnout (Dunning et al., 2022; Howard et al., 2021; Khamisa et al., 2015; 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., Hassard et al., 2018; Knapp & Wong, 2020; Kinman, 2019). At a national level, it is associated with increased healthcare costs (BMA, 2016) and lower workforce participation (HSE, 2024).

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 (Leka & Jain, 2024; Niedhammer et al., 2021). 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. Organisational and individual stress risk assessments aim to identify psychosocial hazards and implement measures to reduce the risk of harm.

Despite this evidence, many employers are not taking action to identify and reduce the risk of WRS. According to the Chartered Institute of Personnel and Development (CIPD) Health and Wellbeing Report (2025) only 40% of the 726 organisations surveyed reported taking steps to identify causes of stress using surveys, interviews or stress risk assessments/stress audits.

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



2.2 Why Project OSCAR was commissioned

There is a perception that managing psychosocial risks and WRS is more complex than managing physical risks. This is because the causes and impacts of stress are shaped by a mix of personal, organisational, and wider system factors. Unlike many physical hazards, where the relationship between the hazard and outcome is more directly measurable, WRS is often 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.

Within Project OSCAR we are interested in considering predominantly primary interventions at work. Health and Safety (H&S) professionals may also describe these as “controls” or “control measures”. We intentionally use the term “managing” rather than “eliminating” WRS. While employers have a duty to manage work-related risks, total elimination is often neither feasible or proportionate, given the dynamic nature of work and the influence of personal, health-related, and environmental factors.

It is important to recognise that many factors involved in managing WRS can sit outside the traditional scope of how organisations comply with H&S 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 influence what individual

employers are able to change. While the employing organisation is ultimately responsible for managing WRS under H&S law (HSE, n.d), the actions taken often sit with human resources or occupational health teams. These teams may be less familiar with H&S 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 (MHFA) 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 risks. 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 (IOM), the Institute for Employment Studies (IES), and the Society of Occupational Medicine (SOM) to lead the Occupational Stress Consultation and Research Programme - Project OSCAR.

Project OSCAR is designed to provide the HSE with robust evidence to inform policy development and practical guidance for employers on preventing and managing WRS going forward. The research addresses three priority questions identified by the HSE which have been explored within 3 detailed reports:

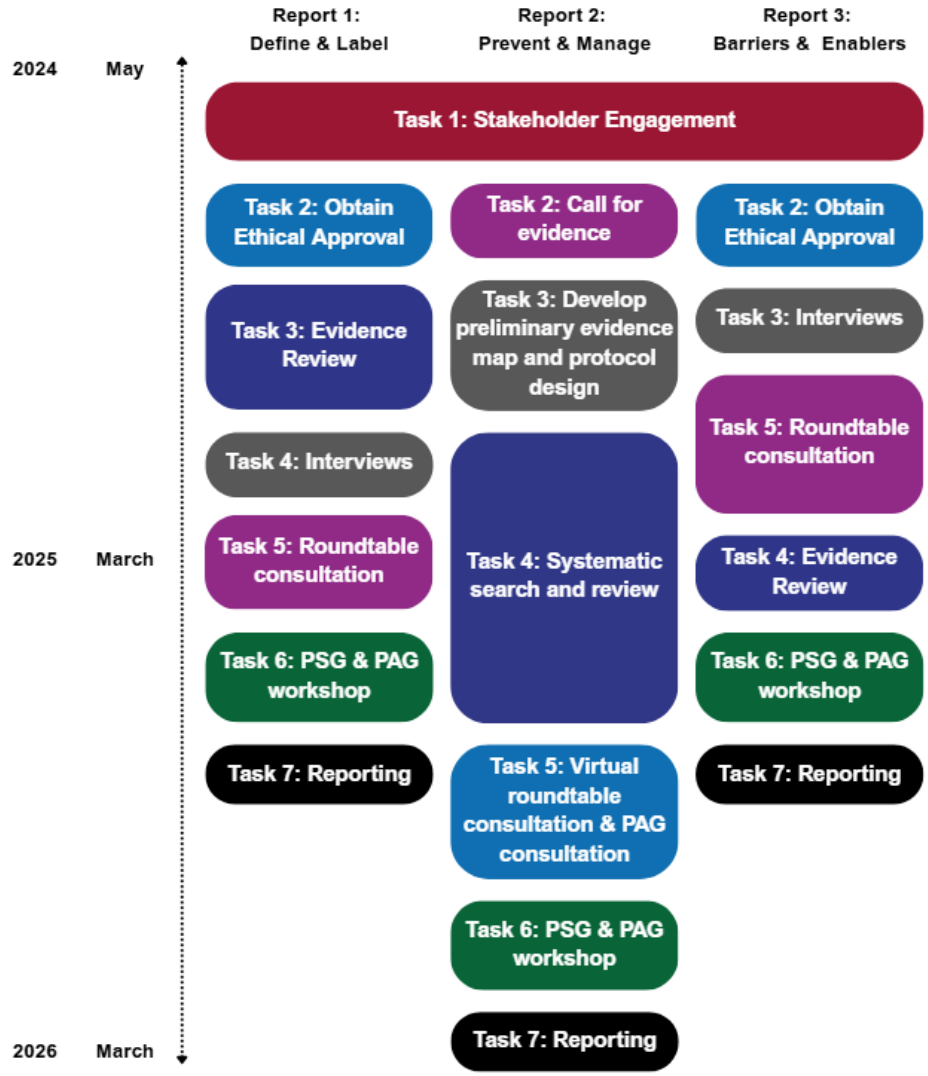
- Report 1: Define & Label — How is WRS defined and labelled by organisations and medical professionals?
- Report 2: Prevent & Manage — What interventions are effective for preventing and reducing WRS?
- Report 3: Barriers & Enablers — What are the enablers and barriers to organisations effectively reducing the risks?

This report provides an overview of the key findings from the research programme.

3 What we did

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

Figure 2 Flow chart methodology of research undertaken



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 and involved an iterative approach to navigate the complexity and size of the evidence base. Full details of the methods used and supporting materials are provided in the detailed reports (report 1, report 2 and report 3).

4 What we found

This section draws together the findings from all three research reports. A map summarising how each data source contributed to the findings presented in this section can be found in Appendix 1: Evidence map: Key findings mapped to supporting evidence sources.

4.1 There is currently no shared understanding of WRS

Across healthcare, occupational health and organisational systems, work-related stress is defined and understood in different ways. People use different terms alongside stress, such as “burnout” or “psychosocial risk”. Professionals in organisations (such as people in HR, wellbeing leads and managers) often use the HSE definition, while healthcare professionals tend to use the World Health Organisation (WHO) definition or National Health Service (NHS) frameworks. While the term is widely used, there is no clear or shared understanding of what it means, how it should be assessed, or who is responsible for addressing it**,** which can lead to confusion, delays in support, and missed opportunities to prevent harm.

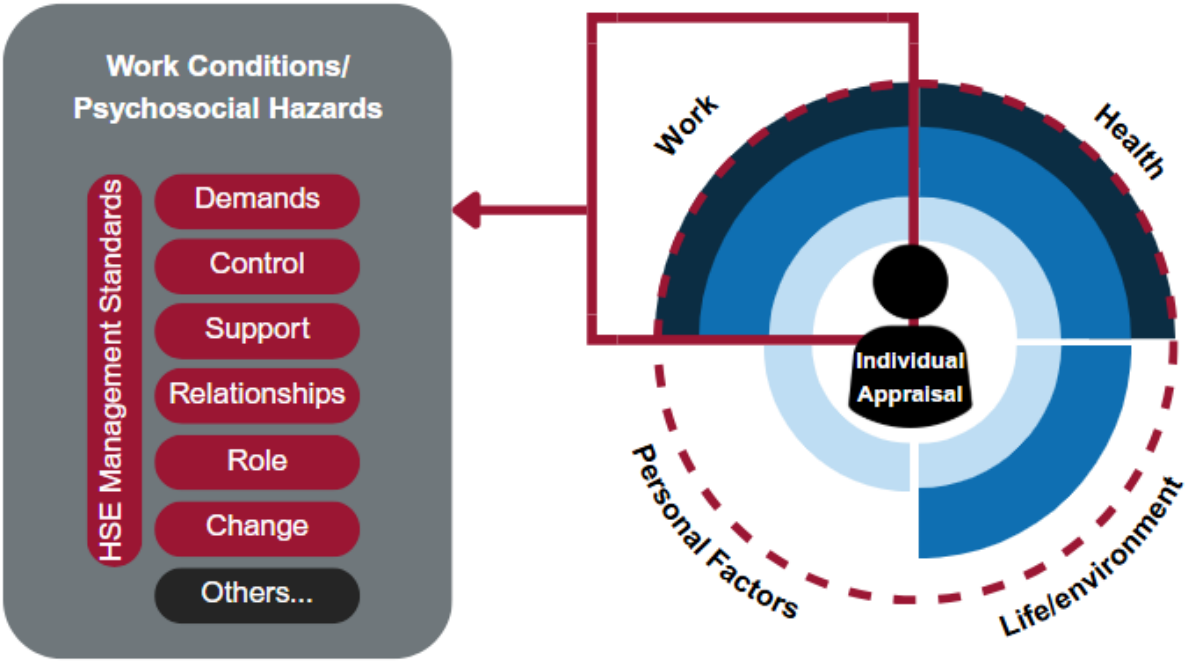
The research shows that it is often difficult to determine whether stress is caused by work alone or by a combination of factors inside and outside of work. In practice, the process of labelling WRS is therefore often less about determining whether work has caused stress and more about identifying opportunities to alleviate stress. This may be through workplace adjustments or, in some cases, time away from work through sickness absence. These differences in understanding contribute to variation in how WRS is recognised, recorded and acted upon across different settings.

Stress may be caused by work, exacerbated by work, or alleviated through work. While the first two are commonly recognised, the potential for good work to support health and recovery is less often discussed.

To support a shared understanding, the research developed a conceptualisation of stress that reflects how working conditions, individual experiences, and organisational responses interact in practice. Drawing on findings detailed in Report 1, the model illustrates how psychosocial hazards within the working environment interact with individual appraisal and wider personal circumstances to shape the experience of stress. It highlights that stress arises through the interaction between working conditions and how these conditions are perceived and interpreted by the individual, rather than from the presence of a single hazard alone (Figure 3).

Our research suggests that identifying psychosocial hazards – the work-related factors that can create risk of WRS – and recognising the broad range of potential outcomes, both to mental and physical health, could help. For employers, this helps to clarify responsibilities and provides a basis for taking action on the factors they can influence, whilst remaining aware of the larger picture. Focusing on defined hazards creates a clearer remit for employer activities in assessing risk and identifying effective interventions in the work environment.

Figure 3 Conceptualisation of stress based on Define and Label Report



4.2 WRS is identified across three systems with limited coordination, leading to different responses

The pathways through which WRS is identified vary depending on whether an individual first raises a concern with their employer, an occupational health professional or a healthcare professional. Each of these systems have different roles and expertise, presenting different opportunities and challenges for recognising and responding to WRS.

Within healthcare settings, WRS is often identified when individuals consult their GP and when fit notes are issued**.** However, GPs typically have limited time, limited knowledge of the workplace context, limited access to work-related assessment tools, and few options for referral to work-focused intervention. As a result, WRS identified through this pathway may be treated primarily through clinical treatment and sickness absence, rather than through workplace risk management or work adjustments. Although sickness absence is commonly used as a response, there is limited research evidence describing when time away from work is beneficial and under what circumstances it supports recovery.

Occupational health professionals use structured assessment tools, such as the HSE Management Standards, to assess workplace factors. They draw on knowledge of the workplace context to recommend work adjustments and organisational changes. However,

their ability to influence organisational action can be constrained by contractual arrangements, limited access to organisational data, and resource pressures.

Within workplaces themselves, identification of WRS often relies on worker disclosure, line manager judgement, or organisational monitoring systems such as surveys or absence data.

In practice, the process of labelling WRS often involves negotiation between multiple stakeholders, including the workers themselves, managers, healthcare professionals and occupational health practitioners. A key part of this process is the discussion about the extent to which work contributes to an individual's experience of stress, and whether any work adjustments or interventions may help reduce and manage that stress, regardless of whether work is the primary cause.

Across these systems, workers play a central role in shaping how stress is described and whether this information is shared. However, differences in expertise, priorities and available interventions mean that WRS may be framed differently depending on where it is first identified.

Overall, the findings highlight that WRS is often identified within healthcare systems, but the causes frequently lie within workplace systems. The lack of coordination between these systems can delay preventative action and contribute to the medicalisation of WRS. Strengthening coordination between these systems and taking a joined-up approach, alongside greater use of stress risk assessments and earlier workplace intervention, may help ensure that work-related causes of stress/psychosocial hazards are addressed more effectively.

4.3 Practice is often reactive

The consultation process showed that responses to WRS cases frequently occur only once an individual has experienced significant stress or health impacts. Many stakeholders emphasised that by the time something is labelled as 'stress', it is too late, the situation has already escalated and caused harm.

In many cases, the process of identifying WRS begins when a fit note is issued or when a worker reports difficulties. This means that organisations are often responding to problems after they have escalated, rather than addressing the underlying work conditions / psychosocial hazards earlier.

This reactive pattern is reinforced by organisational pressures including high workloads, limited resources and competing priorities, which can push preventative activity down the agenda. Stakeholders also reported that mental health and stress are not always prioritised at senior leadership level, particularly when organisations are under pressure to meet operational or performance targets.

Together, these factors mean that WRS is often addressed once problems have escalated rather than through proactive identification and management of psychosocial risks as part of a stress risk assessment process.

4.4 Psychosocial risks are not consistently recognised or linked to interventions

There is strong evidence linking working conditions/psychosocial hazards to stress and poor health outcomes. However, psychosocial risks are not consistently recognised or targeted by interventions. Across the research and stakeholder discussions, terms such as stress, wellbeing, burnout and mental health are often used interchangeably. This conflation of terms, and the focus on outcomes, can obscure the underlying working conditions that create risk.

In practice, discussions about WRS largely focus on individual experiences or symptoms rather than systematically identifying the psychosocial risks, such as workload or lack of control. As a result, responses may focus on individual case management rather than identifying wider organisational risks. A wide range of interventions are currently used by organisations to address WRS, including leadership development, communication initiatives, participatory approaches and job design interventions. The interventions identified in this research are presented in section 7.3 Catalogue of interventions for WRS.

Similarly, the review of interventions found that many studies evaluate interventions in terms of outcomes such as stress, burnout or wellbeing, rather than measuring whether they reduce exposure to underlying psychosocial hazards or working conditions. As a result, it is often unclear which interventions are most effective for addressing particular workplace hazards or under what conditions they are most likely to succeed. This makes it difficult for organisations to select interventions that directly target the psychosocial risks identified through stress risk assessments or other organisational data.

Taken together, these findings suggest that while the relationship between working conditions and stress-related outcomes is widely recognised, psychosocial risks are not consistently identified or linked to interventions in practice.

4.5 Interventions operate across levels of control depending on their design and implementation

Consistent with HSE guidance (Step 3: Evaluate the risks - explore problems and develop solutions), interventions are typically assigned as primary (preventing harm at source), secondary (mitigating risk and supporting coping), or tertiary (managing and responding to harm once it has occurred).

Levels of control

Note. *Some interventions can be assigned in multiple ways depending on the context and intention of their implementation. Interventions may also operate across multiple levels simultaneously.*

- **Prevention/Primary interventions** aim to reduce or eliminate organisational causes of stress by addressing work-related hazards at source.
- **Development/Secondary interventions** aim to target the reactive stage of stress, helping workers and managers to better identify and manage stressors and symptoms as they occur. This includes activities such as stress awareness training, resilience building, or mindfulness programmes.
- **Support/Tertiary interventions** aim to treat the consequences of stress and support recovery and return to work. These include access to counselling, employee assistance programmes, and occupational health or rehabilitation services.

However, our findings indicate that this assignment is not fixed, but contingent on both the core ingredients of the intervention and the intent and quality of its implementation. The same intervention may operate at different levels of control depending on its design and delivery.

For example, line manager training focused only on awareness or signposting is likely to function as a secondary intervention, supporting recognition and response. In contrast, training that equips managers with the skills, authority, and expectations to proactively identify psychosocial hazards, conduct risk assessments, and implement changes to work design operates as a primary intervention.

Some interventions may operate at more than one level at the same time. For example, organisational policies, tools, or frameworks can include preventative elements while also providing opportunities for early identification and response. In addition, some interventions may not appear to be preventative in isolation but form part of a wider preventative strategy. See section 5 for guidance on what can be deemed as a preventative intervention.

This highlights the need to select interventions not only by what they are, but how they work, what they aim to achieve and how they fit within a broader system of risk management. Categorising risks in a fixed way can oversimplify practice and may obscure whether interventions are genuinely addressing root causes or responding to their consequences.

4.6 Context plays an important role

Findings across the three studies highlight that organisational context plays an important role in determining whether interventions to prevent and manage WRS are implemented and sustained.

For example, workplaces characterised by openness, trust and psychological safety were more likely to report engagement with interventions and early discussion of work-related stress. In contrast, organisational cultures characterised by stigma, blame or low trust could discourage disclosure and delay action. Operational pressures, staff shortages and competing organisational priorities were also commonly reported as factors that limit organisations' ability to prioritise preventative approaches to managing WRS.

However, there is currently limited robust evidence describing how interventions are implemented in different organisational contexts, including what works in practice across sectors and organisational sizes. Much of the available insight comes from practitioner reports, case studies and other forms of grey literature. As a result, while there are examples of promising practice, we lack systematic evidence on what works, for whom, in which circumstances.

4.7 Participatory approaches show promise

Where evidence for many intervention strategies was mixed and lacking detail on psychosocial hazards targeted, participatory approaches stand out as particularly promising due to their context specific nature and tailored approach. Participatory interventions refer to those where workers are involved in the process of identifying risks and designing solutions to manage these (see Figure 4).

These approaches can support a shared understanding of workplace risks and help ensure that interventions are relevant to the organisational context. They may also increase engagement with interventions and support more sustainable implementation. This aligns with the broader principles of risk management, where consultation with workers is recognised as an important part of identifying risk and developing effective control measures.

Participatory approaches may be particularly valuable in addressing the specific psychosocial hazards present in a workplace because they draw on workers' knowledge and experiences within their organisation. This can help organisations move beyond responding to individual cases of stress towards a systemic approach, identifying and addressing the underlying working conditions that contribute to WRS.

However, participatory approaches require organisational commitment, time and resources to implement effectively.

Figure 4 Participatory intervention process



4.8 Effective implementation requires capability, participation and practical support

Evidence from the barriers and enablers research (see Report 3) highlights that the effectiveness of interventions is shaped not only by what organisations implement, but by how interventions are implemented. Successful implementation was commonly associated with worker participation, leadership engagement and organisations having the capability and resources to act on identified psychosocial risks.

Stakeholders also reported challenges in interpreting existing guidance and translating this into practical organisational action. Access to clear and practical tools, examples of good practice and opportunities for shared learning were identified as factors that may support organisations in implementing approaches to preventing and managing WRS.

4.9 Evaluation and shared learning are limited

Much of the academic evidence relies on experimental or single-intervention evaluation models. In practice, organisations often introduce multiple changes at the same time, or across long periods of time, making it difficult to attribute outcomes to any single intervention.

Across the research and the understanding of practice through consultation, structured pre- and post- evaluation of interventions was reported to be relatively uncommon. As a

result, there is limited learning about the intended and unintended consequences of actions taken to manage psychosocial risks. This can reduce iteration and progress, creating further uncertainty within organisations as to what the best next steps would be to manage WRS.

Going forward, greater visibility of learnings from practice, and greater specificity about organisational context, including clearer reporting of the psychosocial hazards the interventions are aiming to address, may help strengthen understanding of how psychosocial risks are effectively managed in different contexts.

4.10 There is enough evidence to take action

The findings highlight that the academic evidence base does not always provide the clear answers that organisations need when deciding what interventions may be most effective in managing the psychosocial hazards identified in their stress risk assessment. However, generating more evidence, though helpful, will not necessarily give organisations the confidence they need to act. Organisations often make decisions using a broader understanding of evidence than academic research alone, including professional expertise, regulatory duties and contextual knowledge.

Instead, the focus should be on translating existing knowledge into practical action through better identification of psychosocial hazards, clearer responsibilities and coordination across systems, and more context-specific implementation and evaluation of interventions.

Organisational stress risk assessment provides a practical and legally recognised starting point for this process, enabling organisations to identify hazards, prioritise action and select interventions that are appropriate to their context. Individual stress risk assessments can complement this by helping to understand how risks are experienced by workers and to inform appropriate support or adjustments, but on their own are not sufficient to meet legal duties or to address underlying organisational causes.

Using available evidence alongside professional judgement, worker participation and local knowledge can help organisations implement, evaluate, and refine approaches that reduce psychosocial risks over time.

5 Key considerations

The key considerations draw together insights from across the three research reports, and the synthesis of evidence presented in this report. For detailed considerations for each of the research questions, see the full research in report 1, report 2 and report 3.

Project OSCAR highlights several opportunities to strengthen how WRS is identified, prevented and managed:

5.1 Establish a shared understanding of WRS across workplace and healthcare settings

- **Develop a shared understanding of WRS** that works across workplaces and healthcare settings. Without a shared understanding of what WRS is and what action is required by whom, intervention and support will remain piecemeal and uncoordinated.
- **Clarify roles and responsibilities** for employers, managers, and healthcare professionals by strengthening regulatory guidance.
- **Strengthen coordination** between systems**,** with clearer referral routes and better communication between occupational health, primary care, and employers.
- **Strengthen integration with other relevant legislative requirements,** including the Equality Act 2010, employment law and disability accommodations.

5.2 Promote a psychosocial hazard-led understanding of WRS

- **Focus on how work is organised and managed**, rather than primarily on individual symptoms or outcomes. Without this, prevention and management efforts are likely to remain reactive and fragmented.

5.3 Support employers to select appropriate interventions

- **Support employers to take an integrated, systemic, participative, and evaluative approach to intervention**. Recognising that no single intervention is sufficient and that combinations of actions across organisational levels are often required.
- **Strengthen the problem – solution – impact link**, by supporting employers to use stress risk assessments and indicator tools to diagnose problems, map appropriate interventions to those psychosocial risks, and evaluate whether the risks have reduced over time. This should be understood as a **cyclical process,** reviewed regularly and updated as business contexts change.

5.4 Build implementation capability

- **Increase emphasis on participation and implementation**, recognising the role of worker involvement, context and delivery quality in determining whether interventions are effective in practice.
- **Strengthen organisational capability to manage psychosocial risks** through improving the knowledge, skills and confidence of leaders, managers, health and safety, human resources and occupational health professionals.
- **Ensure guidance and tools are clear, accessible and practical** so that employers with different levels of expertise and resources can take action, and in doing so encourage a more consistent approach across GB employers.
- **Support organisations to translate guidance into practice**, through sharing good practice, implementation support and shared learning.

5.5 Strengthen evaluation and organisational learning

- **Embed evaluation and learning as a routine part of prevention,** encouraging organisations to define intended outcomes, monitor both process and impact, and adapt interventions as work and business contexts change.
- **Improve how evidence is generated, used and shared**, by valuing well-documented organisational practice alongside academic research, and supporting learning about what works, in what contexts, and why.

6 Conclusions

This programme of research set out to examine how WRS is defined and labelled, what evidence exists on interventions to prevent and manage WRS, and the barriers and enablers that influence employers in taking action. Drawing together findings from across the three research studies, the evidence highlights strengths in current practice and opportunities to translate existing evidence into co-ordinated, effective practice across work and health systems.

Effective action depends on selecting, implementing and evaluating interventions that address the underlying psychosocial risks, not only their outcomes. Implementation influences effectiveness, but it cannot compensate for interventions that do not target the source of risk.

Preventing and managing WRS remains a complex challenge. However, this complexity should not delay action. The findings from this research suggest that the challenge is not a lack of knowledge about WRS, but how existing knowledge, tools and evidence are translated into coordinated and preventative action across organisations.

7 What next for organisations and practitioners? From evidence to action

The findings from Project OSCAR have implications for a range of stakeholders involved in preventing and managing WRS. These are explored in more detail within the three accompanying reports. This section summarises the overarching themes emerging from the programme to help organisations and practitioners translate the evidence into action when identifying, preventing and managing WRS.

Please note, this is not intended to provide prescriptive guidance or policy recommendations. Decisions relating to future policy, regulation or formal guidance sit outside the scope of this research and will be considered separately by those responsible and particularly the Health and Safety Executive.

7.1 Understanding the problem: identifying psychosocial risks

Preventing and managing WRS begins with understanding the sources of the problem. In practice this involves:

- **Recognising the range of factors that may contribute to WRS,** including work-related, personal and wider environmental influences, while focusing on those aspects of work that employers can assess and manage.
- **Identifying and managing risks early within organisations**, using organisational stress risk assessments and tools to identify psychosocial hazards and take preventative action.
- **Exploring individual experiences of stress**, using individual stress risk assessments to understand how WRS may cause, exacerbate or alleviate stress and to identify appropriate support or workplace adjustments.

7.2 Good practice in selecting and combining interventions

Preventing or reducing psychosocial risk and WRS should be the primary aim of any organisational approach, with interventions focused on reducing exposure to psychosocial hazards at source.

No single intervention is sufficient to prevent or reduce WRS or associated outcomes. Effective approaches typically involve combining interventions that operate at different levels of control within a systemic and integrated organisational strategy (Nielsen et al., 2024).

Criteria for identifying primary (preventative) interventions could be helpful in guiding employers. **In practice, an intervention is more likely to be considered primary where it meets the following criteria:**

- Targets psychosocial hazards directly. The intervention addresses working conditions (e.g., demands, control, support, role clarity, relationships, change), rather than focusing primarily on individual symptoms or coping.
- Acts on the design, organisation or management of work. The intervention results in tangible changes to how work is structured, allocated or managed (e.g. workload, job design, staffing, processes, decision-making).
- Is informed by organisational stress risk assessment. The intervention is selected in response to identified risks using organisational data (e.g. surveys, risk assessments, absence data), rather than applied generically.
- Aims to reduce exposure to risk across groups or systems. The intended impact is to reduce risk at a team, function or organisational level, rather than solely supporting individuals.
- Includes authority and mechanisms for change.
- Those responsible for implementation (e.g. leaders, managers) have the capability, accountability and organisational support to make changes to work.
- Is embedded within a broader risk management approach. The intervention forms part of a coordinated, preventative strategy, rather than a standalone initiative.
- Includes evaluation of impact. Success can be assessed in terms of reductions in psychosocial hazards or improvements in working conditions, not only individual outcomes (e.g. stress or wellbeing).

Research emphasises the importance of combining these approaches within a coherent strategy aligned to organisational priorities, developed with strong stakeholder involvement and supported by a careful implementation process. For further information about the barriers and enablers to effectively managing WRS see Report 3.

Existing guidance, including the WHO (2022) and NICE (2022) guidelines, take a broader focus on workplace mental health. In contrast, this research focuses specifically on interventions addressing WRS and psychosocial hazards.

7.3 Catalogue of interventions for WRS

The research identified a wide range of interventions used by organisations to prevent and manage WRS. These interventions vary in their focus, level of application, and the psychosocial risks they aim to address. Table 1 presents a structured overview of the interventions currently used in practice. Interventions have been categorised as primary,

secondary or tertiary based on their primary aim in relation to psychosocial risk. The categorisation is indicative rather than fixed, operating at different levels depending on their design, intent and implementation.

The catalogue is intended to illustrate the range of approaches used in practice and discussed in the evidence, rather than to recommend specific solutions. Evidence relating to primary prevention interventions is examined in detail in the accompany intervention review (see Report 2). The effectiveness of secondary and tertiary interventions was not examined in detail as part of this research programme.

Table 1 Catalogue of Interventions for Work-Related Stress

Intervention category	Intervention Strategy	Commonly targeted level of control[1]		
		Primary (Prevention)	Secondary (Development)	Tertiary (Support)
Work design	Changing break structure & form	P		
	Flexible, Remote & Home Working	P		
	Job design	P		
	Physical work environment	P		
Participatory interventions	Participatory interventions	P	S	
Leadership/ manager training	Leadership/manager training - To support others mental health	P	S	
	Leadership /manager training - To support own mental health	P	S	
Interpersonal interventions	Anti-bullying & incivility	P	S	
	Coaching	P	S	
	Mental health awareness training/literacy	P	S	
	Mental health champions	P	S	
	Social/peer support	P	S	
	Teamwork (interprofessional)	P	S	
Skills Training	Skills training		S	
	Selection, Optimisation, and Compensation (SOC)		S	
Staying well	Health promotion		S	T
	Physical activity, lifestyle		S	T
	Volunteering/charity work		S	T
	Sleep interventions		S	T
Psychological Resources	Mindfulness & meditation		S	T
	Acceptance Commitment Therapy (ACT)		S	T

[1] **Note.** Some interventions can be assigned in multiple ways depending on the context and intention of their implementation. Interventions may also operate across multiple levels simultaneously. See section 4.5. for more detail.

Intervention category	Intervention Strategy	Commonly targeted level of control[1]		
		Primary (Prevention)	Secondary (Development)	Tertiary (Support)
	Digital interventions		S	T
	Cognitive Behavioural Therapy (CBT)		S	T
	Positive psychology & Psychological Capital.		S	T
	OTHER - (Alternative relaxation, emotion focused WB promotion, Affect school, Imagery)		S	T
	Resilience		S	T
Therapeutic Approaches	Therapeutic interventions			T
	Counselling			T
	Motivational Interviewing			T
	Emotional Freedom Technique (EFT)			T
Support pathways	Employee Assistance Programme (EAP)			T
	Screening			T
	Occupational health provision			T
	Return to work/absence management			T
	Prevocational training			T
	Supported employment			T
	Vocational interventions			T
	Accelerated recovery programmes			T
Sector specific	Post incident interventions/debriefing			T
	Clinical supervision			T

7.4 Implementing interventions

Evidence highlights that the effectiveness of interventions depends not only on what organisations implement, but how interventions are implemented in practice. There are several factors that influence whether interventions are successfully implemented and sustained, including:

- Link interventions to identified psychosocial risks using organisational or individual stress risk assessments.
- Secure leadership support and establish clear accountability for implementation.
- Involve workers and managers in identifying solutions and shaping interventions.
- Consider organisational context, including sector, resources and operational pressures.

- Plan how interventions will be delivered, including responsibilities, timelines and resources.
- Monitor implementation to check whether planned actions are delivered as intended.

7.5 Evaluating interventions and sharing learnings

Evaluation helps employers understand whether interventions are reducing psychosocial risks and improving working conditions. However, evaluation is not common in practice. Often, several changes are introduced at the same time which can make it difficult to link changes in any specific outcomes to a single intervention. Monitoring progress and reviewing outcomes over time can help employers understand what is working and improve their approach.

- Define what the intervention is expected to change, such as reductions in a specific psychosocial risk or improvements in working conditions (e.g., work demands, manager relationships).
- Collect information before and after the intervention where possible.
- Monitor organisational indicators such as absence data, staff surveys or worker feedback to see if there are changes.
- Review findings over time to understand whether risks or working conditions are changing, remembering sometimes interventions can take some time to have impact and can sometimes have unintended impact.
- Use what is learned to refine or adapt future actions.
- Seek opportunities to share learnings through professional networks, conferences, blogs and industry magazines.

While the evidence base does not provide simple answers about what works, for whom and in what circumstances, taking a structured and proportionate approach can help employers move from reactive responses towards the preventative management of WRS.

8 References

British Medical Association (BMA) (2016) *Ageing and the workplace*. London: BMA.

CIPD (2025) *Health and wellbeing at work 2025*. London: Chartered Institute of Personnel and Development. Available at: https://www.cipd.org/globalassets/media/knowledge/knowledge-hub/reports/2025-pdfs/8920-Health-and-wellbeing-report-2025-/

Dunning, A., Teoh, K., Martin, J., Spiers, J., Buszewicz, M., Chew-Graham, C., Taylor, A., Gopfert, A., Van Hove, M. and Appleby, L. (2022) 'Relationship between working conditions and psychological distress experienced by junior doctors in the UK during the COVID-19 pandemic: A cross-sectional survey study', *BMJ Open*, 12(8), e061331.

Hassard, J., Teoh, K.R.H., Visockaite, G., Dewe, P. and Cox, T. (2018) *Work-related stress: A global review of trends, prevalence and interventions*.

Health and Safety Executive (HSE) (2024) *Health and safety at work: Summary statistics for Great Britain 2024* [PDF]. London: HSE. Available at: https://www.hse.gov.uk/statistics/assets/docs/hssh2324.pdf

Health and Safety Executive (n.d.) *Stress*. Available at: https://www.hse.gov.uk/stress/

Howard, M.C., Follmer, K.B., Smith, M.B., Tucker, R.P. and Van Zandt, E.C. (2021) 'Work and suicide: An interdisciplinary systematic literature review', *Journal of Organizational Behavior*, 2, pp. 260–285.

Khamisa, N., Oldenburg, B., Peltzer, K. and Ilic, D. (2015) 'Work-related stress, burnout, job satisfaction and general health of nurses', *International Journal of Environmental Research and Public Health*, 12(1), pp. 652–666.

Kinman, G. (2019) 'Sickness presenteeism at work', *British Medical Bulletin*, 129(1), pp. 69–78.

Knapp, M. and Wong, G. (2020) 'Economics and mental health: The current scenario', *World Psychiatry*, 19(1), pp. 3–14.

Leka, S. and Jain, A., 2024. Conceptualising work-related psychosocial risks: current state of the art and implications for research, policy and practice. *Policy And Practice*. Mackay, C.J., Cousins, R., Kelly, P.J., Lee, S. and McCaig, R.H. (2004) '"Management Standards' and work-related stress in the UK: Policy background and science', *Work & Stress*, 18(2), pp. 91–112. doi:10.1080/02678370410001727474.

Madsen, I.E.H., Nyberg, S.T., et al. (2017) 'Job strain as a risk factor for clinical depression: Systematic review and meta-analysis', *Scandinavian Journal of Work, Environment & Health*, 43(3), pp. 1–14.

National Institute for Health and Care Excellence (NICE) (2022) *Mental wellbeing at work (NICE guideline NG212)* [PDF]. Available at: https://www.nice.org.uk/guidance/ng212/resources/mental-wellbeing-at-work-pdf-66143771841733

Niedhammer, I., Bertrais, S. and Witt, K., 2021. Psychosocial work exposures and health outcomes: a meta-review of 72 literature reviews with meta-analysis. *Scandinavian journal of work, environment & health*, *47*(7), p.489.Nielsen, K., De Angelis, M., Innstrand, S.T. and Mazzetti, G. (2023) 'Quantitative process measures in workplace mental health interventions: A systematic review and the IPEF framework', *Work & Stress*, 37(1), pp. 1–28.

Teoh, K.R.H., Dunning, A., Taylor, A.K., Gopfert, A., Chew-Graham, C.A., Spiers, J., … and Riley, R. (2024) 'Working conditions, psychological distress and suicidal ideation: Cross-sectional survey study of UK junior doctors', *BJPsych Open*, 10(1), e14.

World Health Organisation (WHO) (2022) *WHO guidelines on mental health at work*. Geneva: WHO. ISBN 978-9240053052.

9 Appendix 1: Evidence map: Key findings mapped to supporting evidence sources

Key finding	Relevant report(s)	Evidence summary	Literature review	Interviews	Consultation / workshops	Evidence mapping
There is no shared understanding of WRS	Report 1	Evidence from literature and stakeholder interviews shows variation in how WRS is defined and interpreted across workplace, occupational health and healthcare systems. Different terminology and thresholds for identification contribute to inconsistent responses.	✓	✓	✓	
WRS is identified across multiple systems with limited coordination	Report 1	Interviews with GPs, OH practitioners and organisational leaders show that WRS may be identified through healthcare, occupational health or workplace systems. These systems operate largely independently, resulting in varied responses and delayed workplace action.	✓	✓	✓	
Practice is often reactive rather than preventative	Reports 1 & 3	Interviews and consultation findings suggest that WRS is often addressed only after a worker reports symptoms, receives a fit note or takes sickness absence. Preventative risk identification and earlier action are less common.		✓	✓	

Psychosocial risks are not consistently recognised or linked to interventions	Reports 1 & 2	Evidence across literature reviews, interviews and consultations shows that discussions of stress often focus on individual wellbeing rather than the psychosocial hazards that create risk. Many interventions are evaluated against outcomes such as stress or wellbeing rather than reductions in psychosocial hazards, making it difficult to link risks and solutions.	✓	✓	✓	✓
Interventions do not always operate at a single level of control	Report 2	Findings from the evidence mapping, systematic search and review and consultation emphasises that assigning interventions to a specific level of control is dependent on their function, design, intended outcomes, and how they are implemented in practice.	✓		✓	✓
Organisational context influences effectiveness	Report 3	Evidence across literature, interviews and consultation shows that organisational culture, leadership commitment and available resources influence whether interventions are implemented and sustained.	✓	✓	✓	
Participatory approaches show promise	Report 2	Literature and consultation findings highlight participatory approaches, where workers help identify risks and design solutions, as promising approaches for addressing psychosocial hazards and supporting implementation.	✓		✓	
Effective implementation requires capability, participation and practical support	Report 3	Stakeholders emphasised that implementation depends on leadership engagement, worker participation and organisational capability. Challenges were reported in interpreting	✓	✓	✓	

		guidance and translating it into practical organisational action.				
Evaluation and shared learning are limited	Reports 2 & 3	Evidence from the intervention review and stakeholder consultation suggests that structured evaluation of interventions is relatively uncommon. Organisations often implement multiple changes simultaneously, making it difficult to attribute outcomes and limiting opportunities for shared learning about effective approaches.	✓	✓	✓	✓
There is sufficient evidence to take action on WRS	Reports 1–3	Synthesising findings across the programme indicates that the relationship between psychosocial hazards and stress is well established. The key challenge lies in translating knowledge into practice through implementation, coordination and learning.	✓	✓	✓	✓

10 Appendix 2: Evidence map: Key considerations mapped to key findings

Key consideration	Relevant report(s)	Linked key findings
Develop a shared understanding of WRS across workplace and healthcare settings	Report 1	No shared understanding of WRS; WRS identified across multiple systems
Clarify roles and responsibilities for employers, managers and healthcare professionals	Reports 1 & 3	WRS identified across multiple systems; Organisational context influences effectiveness
Strengthen coordination between healthcare, OH and workplace systems	Reports 1 & 3	WRS identified across multiple systems
Strengthen integration with wider legislative frameworks	Reports 1 & 3	Organisational context influences effectiveness
Focus on how work is organised and managed rather than primarily on individual symptoms or outcomes.	Reports 1 & 2	Psychosocial risks are not consistently recognised or linked to interventions
Support organisations to take an integrated and systemic approach to intervention	Report 2	Psychosocial risks are not consistently recognised or linked to interventions; Organisational context influences effectiveness; Interventions do not always operate at a single level of control
Strengthen the problem–solution–impact link through risk assessment and evaluation	Report 2	Psychosocial risks are not consistently recognised or linked to interventions; Evaluation and shared learning are limited

Increase emphasis on participation and implementation quality	Reports 2 & 3	Participatory approaches show promise; Effective implementation requires capability, participation and practical support
Strengthen organisational capability to manage psychosocial risks	Report 3	Effective implementation requires capability, participation and practical support
Ensure guidance and tools are clear, accessible and practical	Report 3	Effective implementation requires capability, participation and practical support
Support organisations to translate guidance into practice through shared learning	Reports 2 & 3	Evaluation and shared learning are limited; Effective implementation requires capability, participation and practical support
Embed evaluation and organisational learning	Reports 2 & 3	Evaluation and shared learning are limited
Improve how evidence is generated, used and shared	Report 2	Evaluation and shared learning are limited; Psychosocial risks are not consistently recognised or linked to interventions

11 Executive summary – Report 1 Defining and identifying work-related stress

11.1 Introduction

Work-related stress (WRS) is a leading cause of work-related ill health in Great Britain (GB). While the term is used widely, there is no clear or shared understanding, even among health and work professionals, of what it means, how to assess it, or who is responsible for tackling it. This can lead to confusion, delays in support, and missed chances to prevent harm. The Health and Safety Executive (HSE) commissioned this research to support its strategic objective to reduce work-related ill health, with a specific focus on mental health and stress. The research aims to understand how WRS is currently defined and labelled in practice, and what can be done differently to reduce its impact and improve support.

11.2 Methods

We used several sources of information to help us answer the research question:

- A **systematic review** of research published between 2014 and 2024.
- **In-depth qualitative interviews** with 39 participants across three professional groups: healthcare professionals (HCPs), occupational health professionals (OHPs), and organisational leaders (OLs).
- **Two stakeholder consultation workshops** to review and refine findings and explore implications for guidance and regulation.

We looked across the data to spot common themes, answer our research questions, and identify new insights.

11.3 Key findings

11.3.1 There is currently no widely agreed definition of WRS

People use different terms alongside stress — like “burnout” or “psychosocial risk”. Professionals in organisations often use the HSE definition, while healthcare professionals tend to use the Word Health Organisation (WHO) definition or National Health Service (NHS) frameworks. People seem to have different ideas about what stress is and these differences are likely, in part, to explain why interventions and support are so varied and piecemeal.

Many agree that it can be hard to tell whether stress is caused by work or by other things, like problems at home or personal issues, which can also affect your ability to work. Some say WRS can mean that work made things worse, even if it wasn’t the main cause. It is

important to acknowledge this complexity when labelling and supporting people with WRS so that they get the right help at the right time.

11.3.2 Organisational leaders are unsure of their responsibilities

Leaders use individual and organisational stress risk assessments in different ways, depending on their level of knowledge, their influence in the organisation, and how clear they are about their legal duties. Many are unclear about their responsibilities as an employer and feel there is not much pressure from the regulator. As a result, stress risk assessments and action planning are not always prioritised.

11.3.3 GPs label WRS but lack tools, time, and workplace knowledge

GPs often label WRS when writing fit notes. But they face several challenges – short appointment times, little knowledge about the person's job or workplace, and few options to refer them elsewhere. This can lead to WRS being treated as a medical issue rather than a work-related one. Many stakeholders are concerned that this may increase stigma (negative judgements made on individuals affected by WRS) and delay action in the workplace.

11.3.4 Occupational health professionals give structured advice, but system and contract issues can limit their impact

OHPs often use evidence-based tools like the HSE Management Standards to guide their assessments. In doing so, they tend to describe WRS as "perceived" or "likely" to manage legal risk and avoid implying that the employer is liable for an individual's health condition. These tools are not well known among GPs or organisational leaders, who often do not have access to them or the training to use them properly. Despite their expertise, the impact of their input can be constrained by contractual arrangements, limited access to organisational data, and resource pressures.

11.3.5 Labelling WRS involves negotiation with the worker

Workers shape how WRS is described and who is told about it, as they must give their permission for information to be shared and influence the wording used. This often involves a negotiation between the worker and others – such as their manager or GP – and can affect both the type and timing of support.

11.3.6 The system may contribute to over-medicalisation

Many said the system, being the work and health systems, treats WRS like a medical condition, rather than a response to difficult working conditions. As a result, time off work is often the main support. Stakeholders worry this may unintentionally reinforce stigma and the idea that stress is a personal weakness, rather than a normal response to challenging work – and one that employers could help prevent or improve. This is not to say clinical support or time off are never needed – for some, they are essential. But a more balanced, joined-up approach that also tackles workplace causes would better support people and reduce harm.

11.3.7 Poor coordination between health and workplace systems limits early support

Healthcare, occupational health, and workplace systems rarely work together. Even though there is widespread agreement that work affects health, there is no shared definition, no consistent tools, or clear pathway to refer people for support. This lack of joined-up working makes it harder to spot WRS early, make better use of the data available or provide coordinated support.

11.4 Key considerations

This study highlights opportunities for all those with an interest to make responses to the potential for work-related stress (WRS) more consistent, timely, and effective:

- **Clarify roles and responsibilities** for employers, managers, and healthcare professionals by strengthening regulatory guidance.
- **Develop a shared understanding of WRS** that works across workplaces and healthcare settings. Without a shared understanding of what WRS is and what action is required by whom, intervention and support will remain piecemeal and uncoordinated.
- **Provide GPs, line managers, and other non-specialists, better access** to simple, evidence-based tools and training.
- **Promote prevention-first approaches** in organisations to reduce the reliance on medical diagnosis or time off work.
- **Strengthen coordination** between systems**,** with clearer referral routes and better communication between occupational health, primary care, and employers.
- **Strengthen integration with other relevant legislative requirements,** including the Equality Act 2010, employment law and disability accommodations.

11.5 Conclusion

Work-related stress is widely recognised as a serious workplace health issue. But unclear definitions, poor coordination, and confusion over responsibilities are getting in the way of effective support and delaying action. In many cases, work issues become medicalised before the employer is made aware of the problem – reducing the opportunity for early workplace intervention.

Improving guidance, expanding access to tools, enhancing regulatory interventions, and building better coordination between key roles can help make sure support is provided earlier, more fairly, and with a stronger focus on prevention.

This summary brings together findings from research, interviews, and stakeholder consultations. It outlines practical, evidence-informed ideas for improving how WRS is defined, labelled, and managed in GB workplaces.

12 Executive summary – Report 2 Interventions to prevent and manage work-related stress

12.1 Introduction

Work-related stress (WRS) is a leading cause of work-related ill health in Great Britain (GB). There is strong evidence on the working conditions that can contribute to stress, often referred to as psychosocial hazards, and a growing body of evidence on interventions that can improve mental health and wellbeing outcomes. Although many employers take steps to identify and reduce WRS, current practice is often inconsistent, reactive and largely focused on individual-level support rather than prevention. Many employers also say that they are unsure whether their current approaches are effective.

Several reviews and guidance documents already exist on workplace mental health, including those produced by international bodies such as the World Health Organisation (WHO) and the National Institute for Health and Care Excellence (NICE). These provide valuable evidence on interventions that can improve mental health and wellbeing outcomes. However, they are largely outcome-focused and place limited emphasis on whether interventions reduce exposure to the psychosocial hazards that give rise to WRS. We currently lack a systematically organised record of interventions and their efficacy to guide decision making in relation to WRS.

The Health and Safety Executive (HSE) commissioned this research to complement existing reviews and to support its strategic objective to reduce work-related ill health, with a specific focus on mental health and stress. This report focuses on preventing and managing WRS through psychosocial hazards, and examines how far the existing evidence base aligns with a hazard-led approach to stress risk management, in line with HSE's remit.

12.2 Methods

We used several sources of information to help us answer the research question:

- **A call for evidence** with the WRS research, policy and practice community (80 submissions, 400+ registrations).
- **A systematic search and review of evidence** on control measures and interventions for WRS, prioritising research published since 2020.
- **Two stakeholder consultation workshops** to review and refine findings and explore implications for guidance and regulation.

Findings from these sources were synthesised to identify common themes, areas of convergence and divergence, and identify new insights.

12.3 Key findings

12.3.1 A wide range of interventions are used, but evidence is fragmented

The review identified a broad range of interventions aimed at preventing or managing WRS including job design, leadership and manager training, participatory approaches, interpersonal interventions, and changes to the physical work environment. This reflects the complexity of WRS and the different ways organisations attempt to address it in practice. However, the evidence base is fragmented, with substantial variation in how interventions are defined, delivered and evaluated, limiting comparison across studies.

Across research and practice sources, approximately 80 distinct interventions were identified. These were consolidated into a structured catalogue of 40 interventions across 10 broad categories, spanning primary, secondary and tertiary approaches.

12.3.2 The evidence base is immature and uneven

Across intervention types, the quality of evidence is typically low to moderate, with limited quantities of robust evaluative research. Using the NESTA Standards of Evidence, much of the evidence sits at early stages of development, reflecting the challenges of evaluating complex organisational interventions in real-world settings rather than a lack of activity or innovation.

12.3.3 Most evidence focuses on outcomes, not psychosocial hazards

Across most reviews, interventions were evaluated primarily in relation to outcomes such as stress, burnout, wellbeing or mental health. Few studies explicitly assessed whether interventions led to changes in underlying psychosocial hazards, such as workload, control, role clarity or workplace relationships. As a result, it is often unclear whether reported improvements in outcomes reflect meaningful reductions in psychosocial risk. This makes it hard for employers to know what action to take, and hard for inspectors to make recommendations to employers where hazards are identified.

This limitation also applies to many interventions that are not designed or labelled as stress interventions, but which may nonetheless influence psychosocial hazards. Examples include leadership and management capability development, change management, communication practices, and aspects of work and job design. These approaches are often implemented for broader organisational purposes and are rarely evaluated in relation to WRS or hazard reduction, meaning their potential contribution to preventing and managing WRS may be under-recognised.

12.3.4 Evidence for primary prevention is mixed and context-dependent

Evidence of effectiveness is mixed and highly dependent on organisational context and implementation. Leadership, interpersonal and mental health awareness interventions often improve knowledge, confidence or perceived support, but show limited evidence of sustained reductions in WRS when used in isolation.

12.3.5 Context, implementation and participation influence effectiveness

Both the evidence review and stakeholder consultation highlight that how interventions are implemented is as important as what is implemented. Organisational context, sector, workforce characteristics and worker involvement all influence effectiveness. Reviews commonly synthesise evidence across diverse settings, limiting their usefulness for guiding decisions in individual organisations.

12.3.6 Risk assessment remains central to prevention

Given the limitations of the evidence base, stress risk assessment plays a critical role in identifying suitable interventions to prevent and manage stress. Stress risk assessment enables organisations to identify relevant hazards, prioritise action and select interventions that are proportionate and appropriate. Evidence relating to interventions can inform this process, but it cannot replace a structured risk management approach.

12.3.7 Limited evaluation and shared learning from practice

The review found limited evidence of organisations evaluating interventions in relation to psychosocial hazards or sharing learning from implementation. Compared with some European initiatives, there is relatively little accessible documentation of sector-specific good practice, opportunities for shared learning.

12.4 Key considerations

This review highlights opportunities to strengthen research and practice by:

- **Strengthen the problem – solution – impact link**, by supporting employers to use stress risk assessments and indicator tools to diagnose problems, map appropriate interventions to those psychosocial risks, and evaluate whether the risks have reduced over time. This should be understood as a **cyclical process,** reviewed regularly and updated as business contexts change.
- **Promote a shared, hazard-led understanding of WRS**, centred on how work is organised and managed, rather than focusing primarily on individual symptoms or outcomes. Without this, prevention and management efforts are likely to remain reactive and fragmented.
- **Support organisations to take an integrated, systemic approach to intervention**, recognising that no single intervention is sufficient and that combinations of actions across organisational levels are often required.
- **Recognise the potential of interventions implemented for broader organisational purposes** (e.g., leadership development, change management, communication) in contributing to preventing and managing WRS where they address psychosocial hazards, even when this is not their primary aim.
- **Increase emphasis on participation and implementation**, recognising the role of worker involvement, context and delivery quality in determining whether interventions are effective in practice.

- **Embed evaluation and learning as a routine part of prevention**, encouraging organisations to define intended outcomes, monitor both process and impact, and adapt interventions as work and business contexts change.
- **Improve how evidence is generated, used and shared**, by valuing well-documented organisational practice alongside academic research, and supporting learning about what works, in what contexts, and why.

12.5 Conclusion

Preventing and managing WRS remains a complex challenge. While a wide range of interventions are currently in use, the evidence base is fragmented and often does not clearly demonstrate whether interventions reduce exposure to the psychosocial hazards that give rise to stress or other individual or organisational outcomes. Existing evidence, when used in isolation, is insufficient to support clear hazard-led decision-making.

This does not mean that organisations should delay action. Rather, it highlights the need to make better use of the evidence that is available, alongside stress risk assessment, professional judgement and contextual knowledge. A clearer alignment between identified risks and intervention choice, together with a greater attention to implementation, monitoring and evaluation, can support a more preventative and proportionate management of WRS.

This report brings together evidence from multiple sources. It provides a structured catalogue of interventions, examines their efficacy in relation to WRS, and highlights opportunities to strengthen learning by encouraging employers, practitioners and researchers to review, evaluate and share learning from real-world implementation in GB workplaces.

13 Executive summary – Report 3 Barriers and enablers to effectively manage work-related stress

13.1 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.

13.2 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.

13.3 Key findings

13.3.1 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.

13.3.2 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.

13.3.3 Data and measurement are weak or inconsistent

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

13.3.4 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.

13.3.5 Participation helps, but time is constrained

Participatory approaches, which involve workers 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.

13.3.6 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.

13.3.7 Perceived enforcement gap reduces urgency

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

13.4 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.

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

This report and the work it describes were funded by the Health and Safety Executive. Its contents, including any opinions and/or conclusions expressed, are those of the authors alone and do not necessarily reflect HSE policy.