Promising practices for health and wellbeing at work

A review of the evidence landscape

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Preface

There are many examples of workplace wellbeing interventions, both emerging and maturing. These are provided from within employer organisations, procured from the provider marketplace or through a mixture of both. There are various commercial and organisational reasons supporting the implementation of workplace health. A paramount aim is to improve the health outcomes and/or modifiable lifestyle behaviours of staff to support individual and organisational wellbeing. Whilst sounding simple, it is difficult to understand with confidence what impact workplace wellbeing approaches are generating.

This research project was commissioned by Public Health England to generate a better understanding of how to address this gap. It is hoped that the study will support organisations in how they consider the evidence of improved health outcomes when purchasing or developing workplace wellbeing interventions. The report presents case studies of health and wellbeing interventions based on submissions presented to an open portal. A number of examples that demonstrate positive commitment to data collection and an understanding of the impact of their intervention are highlighted.

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Background

Workplace wellbeing is an emerging area, with many organisations developing approaches to support the UK workforce. A growing body of research has demonstrated that the support of wellbeing in the workplace has a positive impact on staff, business and organisations. This includes benefits in terms of reduced absenteeism and presenteeism[1] as well as improved productivity.

The aim of this study is to develop an understanding of the landscape of workplace wellbeing interventions as well as the extent and quality of evidence being collected about interventions available on the market and being offered in-house by employers. We hope this will support organisations in developing their workplace wellbeing offer and aid understanding of whether interventions are having a positive health outcome and how to capture and gauge the evidence.

Public Health England (PHE) commissioned RAND Europe to report on the evidence of improved health outcomes across a series of workplace health topics that included areas such as nutrition, mental health, physical activity, domestic violence and menopause. A case study analysis using the Nesta Standards of Evidence was undertaken. The Standards use a stepped hierarchy to assess the level of evidence underlying an intervention: ranging from being able to articulate clear intervention logic at level 1, to being able to offer evidence of consistent, reliable results at scale at level 5. They were developed to support Nesta grant funding and have been adopted for a range of purposes, including, for example, in a previous PHE-funded report by the ukactive Research Institute and the National Centre for Sport and Exercise Medicine in Sheffield, which used the Nesta Standards to grade the evidence underlying physical activity interventions.[2]

Methodology

Applying the Nesta Standards, RAND Europe designed a case study data capture questionnaire. This is further outlined in Chapter 1 of this report. The questionnaire was promoted as an online survey to provider organisations delivering wellbeing solutions and services as well as employing organisations that were developing and delivering them direct to their own employees. Over a five-week period, 117 submissions were captured. These were categorised according to workplace health topic and graded against the application of the Nesta levels. The process was supported and moderated by an academic and

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[1] The practice of being at one's workplace longer than the work task requires, often as a result of workplace insecurity (https://en.oxforddictionaries.com/definition/presenteeism)

[2] ukactive Research Institute and the National Centre for Sport and Exercise Medicine in Sheffield (2014).

expert review panel. All case studies that were graded at Nesta level 2 or above are outlined in the report, while others are spotlighted.

Findings

The research considers insights gained from the body of submissions. It identifies that:

- **Providers of wellbeing interventions submitted the majority of case studies.** However, a third were submitted by employers, highlighting the offer available to their own staff. Submissions were received from both small and large organisations. Organisations also provided a range of approaches taking into account health inequalities amongst participants.

- **Mental health featured strongly amongst the submissions received.** A number of submissions were also received on the subjects of domestic violence, sleep and menopause. Unexpectedly, no submissions involved financial resilience or smoking. This may not necessarily mean that these topics do not feature in the wellbeing landscape, only that that they did not feature in the submission body.

- **Although some submitting organisations did provide substantial evidence of the impact of their intervention on health and wellbeing outcomes, few interventions reached a grade above Nesta level 2.** This does not necessarily mean that these interventions are less effective, but that academically rigorous methods of data collection or evaluation are not being used to investigate their effectiveness.

- **Organisations collected a variety of data types in order to explore the impact of their interventions, including health measures, business indicators and unstructured feedback.** Some interventions (e.g. those undertaken directly by the target population) were able to collect data about the change in individuals' health and wellbeing, while others (e.g. submissions focusing on line manager training) focused more on perceptions and confidence in dealing with health issues, rather than direct health outcomes. Offers of line management training, for example, seldom assessed whether those being line managed were experiencing any benefit. Some organisations also focused on business indicators such as absence rates, although the relationship between these indicators may not necessarily act as a direct proxy for the health and wellbeing of staff (reduced absence rates might be a sign of increased presenteeism, for example).

Main messages

This study provides insight into a complex landscape with many levels of objectives and stakeholders. The workplace wellbeing sector appears vibrant but is still maturing in its ability to provide strong evidence for health and wellbeing outcomes. Nonetheless, a number of submissions demonstrated good practice in collecting and analysing data and exploring the impact of their intervention on a small scale.

While individual interventions may be useful, it is also important to understand how these relate to a wider health and wellbeing offer, including providing for different health and wellbeing conditions and recognising the importance of wider workplace organisation and positive line management practices. There is an exciting opportunity for organisations to build the evidence base with regard to how they and the broader workplace wellbeing market support the health of the English workforce.

Acknowledgements

Abbreviations

BAME	Black, Asian and minority ethnic
BCR	Benefit-cost ratio
BHW	Britain's Healthiest Workplace
BMI	Body mass index
CAU	Care as usual
CBA	Cost-benefit analysis
CBT	Cognitive behavioural therapy
cCBT	Computerised cognitive behavioural therapy
CEBR	Centre for Economics and Business Research
CIPD	Chartered Institute of Personnel and Development
CPD	Continuing Professional Development
DASS	Depression Anxiety Stress Scales
EAP	Employee assistance programme
EBM	Evidence-based medicine
EBP	Evidence-based policy
EMAS	European Menopause and Andropause Society
HADS	Hospital Anxiety and Depression Scale
HFNS	Hot flushes and night sweat
HRQOL	Health-related quality of life
HR	Human resources
HSE	Health and Safety Executive
IAPT	Improving Access to Psychological Therapies
IOSH	Institution of Occupational Safety and Health
ITT	Intention-to-treat
KPI	Key performance indicator
LGBT	Lesbian, gay, bisexual and transgender

MAAS	Mindful Attention Awareness Scale
MBA	Master of Business Administration
MBCT	Mindfulness-based cognitive therapy
MBSR	Mindfulness-based stress reduction
MSK	Musculoskeletal
NESTA	National Endowment for Science, Technology and the Arts
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NMES	Non-milk extrinsic sugar
PHE	Public Health England
PSS	Perceived Stress Scale
RCT	Randomised controlled trial
ROI	Return on investment
SBRI	Small Business Research Initiative
SHU	Sheffield Hallam University
SME	Small and medium enterprises
SW@WS	Staying Well @ Work Service
WHO	World Health Organization
WOMAC	Western Ontario and McMaster Universities Osteoarthritis Index

1. Introduction

1.1. Introduction: wellbeing as a driver of health and organisational outcomes in the workplace

There is strong reason to pursue evidence of health outcomes in the workplace. Globally, the business community is recognising a vested interest in ensuring that health and wellbeing outcomes across populations are improved.[3] There is increasing public consciousness that health and wellbeing outcomes influenced through work can have profound impacts on individuals, communities, organisations and societies. In the UK and England, this is coupled with the fact that the working population is ageing.[4] A strong and unified approach to support and maintain a well and productive workforce is therefore in everyone's best interests.

A growing body of research has demonstrated that the support of wellbeing in the workplace has a positive impact on staff, business and organisations. This includes benefits in terms of reduced absenteeism[5] and presenteeism[6] as well as improved productivity.[7] Evidence from Britain's Healthiest Workplace, for instance, shows that an employee who reports being content with his/her current job has on average 6.92 percentage points less work impairment due to absenteeism and/or presenteeism than an employee who is unhappy with his/her job.[8] The findings also suggest that employees in companies that do not acknowledge health and wellbeing as an organisational success indicator report higher work productivity loss due to absenteeism and presenteeism.

As recognition of the benefits of workplace health and wellbeing provision grow, so too has the issue gained prominence on the policy agenda. The Department for Work & Pensions, together with the Department of Health & Social Care, recently set out a ten-year programme of reform in the policy paper *Improving Lives: The future of work, health and disability,*[9] focusing on joining up across the welfare,

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[3] World Economic Forum. 2010. Global Risks Report. As of 4 June 2018:
http://www3.weforum.org/docs/WEF_GlobalRisks_Report_2010.pdf

[4] Office for National Statistics (2017a).

[5] The practice of regularly staying away from work without good reason
(https://en.oxforddictionaries.com/definition/absenteeism)

[6] The practice of being at one's workplace longer than the work task requires, often as a result of workplace insecurity
(https://en.oxforddictionaries.com/definition/presenteeism)

[7] See, for example, What Works Centre for Wellbeing (2017).

[8] Hafner et al. (2015).

[9] Department for Work & Pensions and Department of Health & Social Care (2017a).

workplace and the healthcare system to support prospective and current employees, whatever their health conditions. Similarly, the 2017 publication of the Stevenson/Farmer review, *Thriving at Work*,[10] provided a comprehensive assessment of the current status of and provision for mental health conditions in the workplace. Supporting the link between health and work is therefore seen as a key goal with respect to preventing ill-health[11] and improving lives.[12]

However, whilst the landscape of health and wellbeing interventions is a broad one, it can be difficult to understand 'what works' – or rather, the confidence that we should place in a particular intervention that it will have a positive impact on staff health and wellbeing outcomes. This research project was commissioned by Public Health England (PHE) to begin to address this gap. The report presents findings from a set of case studies collected via an open portal. These offer promising examples of how to develop an evidence base for workplace health and wellbeing initiatives. Collectively they represent the emergence of a developing, although by no means mature, evidence base. They encapsulate both traditional workplace health topics such as nutrition and activity as well as newer themes such as domestic violence and menopause. In this regard, the study adds to the increasing number of reviews and toolkits that PHE has been developing across workplace health.

Evaluating the impact of an intervention ensures that workers receive the best value for resources spent and that organisations deploy evidence-based and effective approaches shown to work, getting the best return on their investment. This develops the wider knowledge base for employers and policy-makers to inform boards and decision-makers *how* particular types of health and wellbeing interventions work, *why* they work, for *whom*, and under *what circumstance.* In turn this stimulates the development of a mature and evidence-based value chain.

This report looks to develop the baseline understanding of this landscape. It is our hope that it will not only be a useful resource for employers interested in exploring interventions available across different workplace wellbeing topic areas, but also inspire them to think strategically about ways of understanding and collecting data about the health and wellbeing of their employees.

The remainder of this chapter presents a discussion of the Nesta Standards of Evidence and their application in this study, and provides a summary of the methods used (with further detail available in Appendix C). Chapter 2 presents a summary of the findings from a high-level analysis of the body of submissions. Chapter 3 details the case studies clustered under 12 key topic areas, with short summaries of each topic area to set the case studies in context. Finally, Chapter 4 offers some concluding remarks on the findings of this study with reference to the wider workplace wellbeing landscape.

1.2. Assessing the evidence: the role of evidence hierarchies

In this study, we make use of an *evidence hierarchy* to assess the extent and quality of the evidence base underlying health and wellbeing interventions available to employers on the market or implemented by employers in-house.

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[10] Department for Work & Pensions and Department of Health & Social Care (2017b).

[11] NHS (2014).

[12] Department for Work & Pensions and Department of Health & Social Care (2017a).

Evidence hierarchies rose to prominence as a key methodological tool underlying the evidence-based medicine (EBM) and, subsequently, evidence-based policy movements, which sought to place greater emphasis on the role of evidence and research in informing a health or policy decision over the judgement of a practitioner. Evidence hierarchies were developed as a method by which the level of evidence underlying interventions can be assessed, with each 'step' implying greater confidence about the effectiveness of the intervention in relation to a particular outcome. Hierarchies differ in the level of evidence required for interventions to progress past each stage, depending on the sector and the nature of the intervention it aims to assess, but in general they range from basic data collection at lower levels, such as expert opinion and case studies, to increasingly rigorous methods of data collection and verification, such as randomised controlled trials (RCTs), systematic reviews and meta-analyses. Hierarchies may also take into account the *quality* of an individual study, by including criteria relating to the robustness of the study design and size of sample group, and the *significance* of the data, by considering the size of effect, the risk that it was caused by chance, and any concurrent negative outcomes.

Numerous hierarchies of evidence have been developed for different contexts in medicine and social policy, ranging from general hierarchies (such as the Maryland Scale of Scientific Methods, which provides a way of scoring the quality of research design and potential sources of bias for quantitative studies[13]), to those specifically designed for a particular thematic area (such as the Kirkpatrick evaluation framework, designed specifically to gather evidence about the effectiveness of training courses).

In this study, we make use of the Nesta Standards of Evidence to frame the level of evidence underlying the effectiveness of workplace health and wellbeing interventions. Nesta, a grant-making foundation that focuses on nurturing innovation in social policy interventions through a combination of programme implementation and research, developed the Standards (depicted in Figure 1) to guide its grant funding. They provide a stepped hierarchy to consider the level of evidence underlying social interventions. This ranges from being able to articulate clear intervention logic at level 1, to being able to offer evidence of consistent, reliable results at scale at level 5.

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[13] Sherman et al. (1997).

Figure 1. Nesta Standards of Evidence

Level 5
You have manuals, systems and procedures to ensure consistent replication and positive impact

Level 4
You have one + independent replication evaluations that confirms these conclusions

Level 3
You can demonstrate causality using a control or comparison group

Level 2
You capture data that shows positive change, but you cannot confirm you caused this

Level 1
You can describe what you do and why it matters, logically, coherently and convincingly

Source: Nesta[14]

The Nesta Standards were specifically designed to cover complex social interventions, and focus less on the nature of the data at each stage than what the data show: that interventions are *based on logic* (level 1), can demonstrate *positive change* (level 2), can demonstrate *causality* (level 3), can verify the results through *replication* (level 4), and can demonstrate that the impact can *remain consistent across different groups and at scale* (level 5). This flexibility makes the Nesta Standards particularly suited to a heterogeneous set of interventions, such as those analysed for this study, or those with only emerging evidence bases, compared to the more specific focus of other evidence hierarchies (for example, the Maryland Scale, which focuses primarily on quantitative experimental data).

Nonetheless, criticisms of the applicability of evidence hierarchies have been raised.[15] While they can provide a useful overview of the extent of evidence underlying a particular intervention, care must be taken to understand how this should be understood in relation to the effectiveness of an intervention, or to other interventions in this field.

Chiefly, it is important to bear in mind that evidence hierarchies, including the Nesta levels, represent a 'hierarchy of evidence, not hierarchy of effectiveness'.[16] While certain interventions may be able to draw

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[14] Puttick & Ludlow (2013).

[15] See, for example, Petticrew & Roberts (2003).

[16] ukactive Research Institute and the National Centre for Sport and Exercise Medicine in Sheffield (2014).

on more extensive bodies of evidence, this does not necessarily mean that they are more effective, nor able to produce a larger effect size, than interventions that have not yet gathered the same level of evidence. Some interventions may be iterative or complex programmes, for which it is expensive to conduct comprehensive evaluations, or which are not well suited to RCTs alone.[17] Other interventions, such as those promoting the distribution of fruit or physical exercise, may be based on existing evidence bases that are well understood and therefore such interventions may be less likely to be evaluated themselves. Nonetheless, while evidence hierarchies may overlook certain interventions that have not yet been able to put in place measures to gather the requisite amount of evidence, they can help to understand which interventions are able to provide evidence of positive impact with more certainty.

It is also important to be cognizant of the context when understanding the potential impact of an intervention. While the interventions featured as case studies in this report have demonstrated clear, structured data collection relating to the impact of their intervention, the impact observed may not always necessarily be transferable to a different setting. When planning to implement workplace health interventions in a different setting, with a different population group, or with local adaptations, employers should be aware that this may result in different impacts than those observed in controlled studies.

Similarly, interventions should not be considered a panacea; even if they can present strong evidence bases as to their effectiveness, they may not make up for other risks to mental or physical health amongst a workforce, such as occupational health risks or a culture of negative line management practices. In striving to provide resources for employees, organisations should account for the organisational culture and context within which they operate.

Finally, it is important to note that effectiveness of an intervention is just one aspect of understanding how useful or appropriate it is to deploy in a particular context. Even interventions shown to be effective in trials may fail to produce positive outcomes if users fail to engage with them, or if there are unexpected negative outcomes. In this regard, employers choosing to deploy a particular health and wellbeing intervention should consider not only the level of evidence pertaining to the health and wellbeing outcomes, but also:[18]

- **Effectiveness**: does this work?
- **Process of service delivery:** how does this work?
- **Salience**: does it matter?
- **Safety**: will it do more harm than good?
- **Acceptability**: will the target group want to engage with the intervention?
- **Cost effectiveness**: is it worth implementing or purchasing this service?
- **Appropriateness**: is this the right intervention for this target group?
- **Satisfaction with the service**: are stakeholders satisfied with the intervention?

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[17] The Medical Research Council guidance on evaluating complex interventions recommends the use of process evaluation or similar in-depth methods alongside RCTs in order to map inputs to outputs. See the MRC guidance on the evaluation of complex programmes at (as of 4 June 2018): https://www.mrc.ac.uk/documents/pdf/complex-interventions-guidance/

[18] Adapted from Muir Gray, J.M. 1996. *Evidence-based healthcare*. London: Churchill Livingstone, as featured in Petticrew & Roberts (2003).

1.3. Study methods and limitations

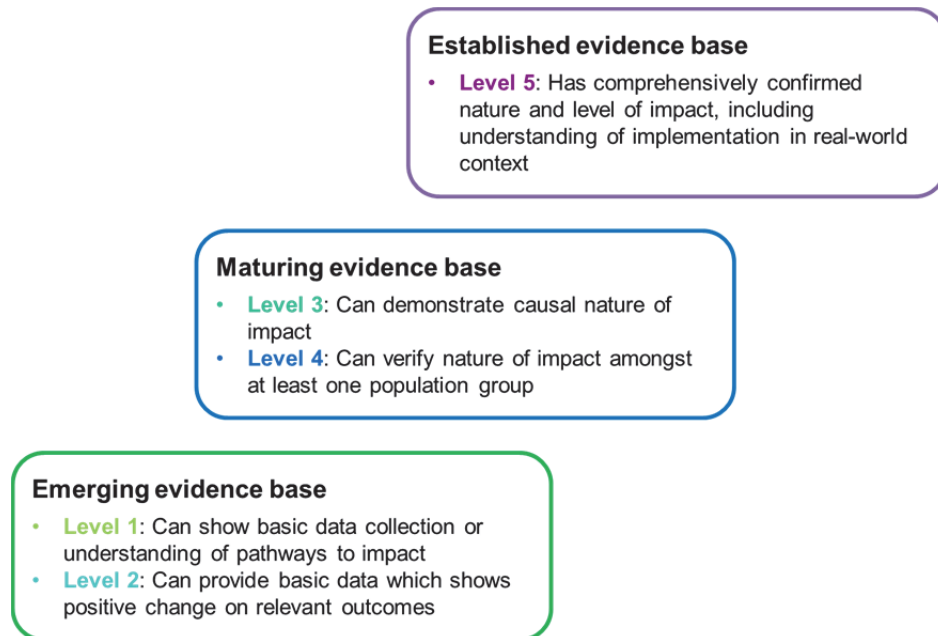Full details of the methodology can be found in Appendix C. The key steps were as follows:

- **Survey design and release:** The project team designed a survey (see Appendix D) through which organisations could submit details of their practice, including the opportunity to upload files to substantiate the detail provided about their evidence base. This was open for five weeks in September and October 2017, and was promoted widely through email alerts, online articles and social media.

- **Sifting:** 117 valid submissions were received and reviewed by the project team. During the initial sifting process, submissions were also coded to one of 13 key topic areas, based on the initial key issue areas selected by Public Health England. Coding was based on the judgement of the researcher, and was based on the stated aims and intent of the intervention from the survey response. In the case of multiple relevant categories (for example, a mental health intervention that also aimed to improve sleep quality), the primary outcome used in the process of collecting data was chosen.

- **Analysis and grading:** All entries were reviewed by the project team in order to determine an initial categorisation against the Nesta levels. Nesta's Standards of Evidence were originally developed to provide a benchmarking of evidence to guide Nesta's own investments in social interventions. In this spirit, and in order to account for the heterogeneous set of interventions under examination, we adapted the Nesta Standards (depicted in Figure 1) for the purposes of this study:[19]
    - **Evidence level 1:** Interventions categorised as level 1 were those that can show at least an emerging commitment to data collection and thoughtful implementation, for example by providing a clear articulation of expected inputs and outputs, or are in the process of external evaluation.
    - **Evidence level 2:** Interventions categorised as level 2 were those that are collecting data which shows positive change amongst the users of their intervention.
    - **Evidence level 3:** Interventions categorised as level 3 were those that can provide evidence of causality to demonstrate that their intervention is having the observed effect through use of a randomised controlled trial (RCT) or comprehensive qualitative evaluation.
    - **Evidence level 4:** Interventions categorised as level 4 were those that can demonstrate robust, independent collection of data which confirms causality by replicating results or providing a comprehensive account of the nature and reasons for the impact.
    - **Evidence level 5:** Interventions categorised as level 5 were those that have shown themselves to be scalable, affordable and with consistent outcomes or an understanding of dosage in different implementation settings. No interventions were categorised as level 5 in this study.

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[19] In our use of Nesta level 1 in this study, we differ from the application of these standards elsewhere (for example, Project Oracle [https://project-oracle.com], who require a Theory of Change in order to reach level 1 standard). This is a pragmatic decision taken in light of resource constraints.

In this regard, we also developed a typology to both reflect the adapted standards and to simplify the categorisation for readers unfamiliar with evidence hierarchies (as depicted in Figure 2):

Figure 2. Nesta evidence standards in this study

Established evidence base
- **Level 5**: Has comprehensively confirmed nature and level of impact, including understanding of implementation in real-world context

Maturing evidence base
- **Level 3**: Can demonstrate causal nature of impact
- **Level 4**: Can verify nature of impact amongst at least one population group

Emerging evidence base
- **Level 1**: Can show basic data collection or understanding of pathways to impact
- **Level 2**: Can provide basic data which shows positive change on relevant outcomes

The submissions were reviewed against the standards by a lead researcher and put through a secondary validation process before submission to the academic panel. Some 19 cases that were considered marginal (for example, those that met most but not all of the criteria for a particular level, or those for which categorisation was considered to depend on the quality of the study) were referred to the expert panel.

Given the scope and timescales of the research we were unable to approach all submitting organisations for further information. In a subset of submissions, the research team considered there to be insufficient information in the submission to come to a proper judgement on the appropriate Nesta level. We referenced these cases as 'requiring further information' (RFI).

- **Moderation by expert panel:** A sample of the submissions, and marginal cases, were also moderated by an expert panel. Where the judgement of the panel differed from the categorisation of the research team, this was discussed to establish clear principles for categorisation, which were then applied to the wider set of interventions.
- **Reporting:** All submissions categorised as level 2 based on the data provided were written up as case studies. The evidence level was presented on the basis of the evidence and data supplied in the submission. For topic areas with only one level 2 submission, additional level 1 submissions were spotlighted to highlight particularly interesting innovations or practices.

Limitations

This study has a number of limitations. Firstly, the case studies are a self-selecting collection of practices, and do not provide a comprehensive, systematic overview of the health-at-work landscape. For this reason, while we consider our results to be illustrative of interesting trends and the use of data collection relating to health and wellbeing interventions in the workplace, the figures and data provided here should not necessarily be considered fully representative of the wider sector.

Secondly, our categorisation of practices has taken place against a study-specific interpretation of the Nesta Standards of Evidence (as outlined above). Submissions have not been subject to an in-depth assessment of impact or exploration of the Theory of Change.[20] The quality and extent of data and text provided by submitting organisations also varied. As a result, not all submissions were considered to have provided sufficient information for a categorisation decision to be made. Strong interventions may have been overlooked as a result.

Thirdly, in the process of developing the case studies, we have made use of data collected and evaluations conducted by third parties. These studies may be subject to their own limitations, which were considered during the review period. However, while such limitations have in part informed the categorisation of practices below, we urge interested readers to seek out the original source where possible in order to consider the full context within which the findings are presented.

Finally, in the same vein, many of the evidence sources provided by participating organisations for this project consist of self-reported data. There is a risk that some data may have been reported incorrectly, or that some negative results have been withheld. It was beyond the scope of this study to independently verify the results, nor verify whether additional unpublished data have been collected. Our conclusions should be considered in this light.

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[20] A Theory of Change is a '*tool to help you describe the need you are trying to address, the changes you want to make (your outcomes), and what you plan to do (your activities). The approach can be used for organisations of all shapes and sizes—from service-delivery charities, to campaigning organisations, to funders. A theory of change is often represented in a diagram or chart, but a full theory of change process involves more than this. It should help you consider and articulate the assumptions and enablers that surround your work and explain why you think your activities will lead to the outcomes you want. It should also challenge you to develop clear aims and strategies and explore whether your plans are supported by evidence*' (Harries, Noble & Hodgson 2014). See also Rogers et al. (2000).

2. Summary findings

2.1. Numbers and types of submissions received

The study received 117 submissions in total, comprising 81 submissions from providers of workplace wellbeing interventions and 36 submissions from employer organisations delivering wellbeing interventions direct to their staff.

As detailed in Table 1 and Figure 3, of the submissions received, the largest grouping (27) was coded as relating primarily to mental health outcomes, followed by holistic work programmes (20, comprising comprehensive and multifaceted health and wellbeing programmes offered by employers) and organisational capacity (19, comprising interventions designed to improve the capacity of the organisation to identify need and improve health and wellbeing amongst staff). Health assessment and education (16, comprising interventions designed to inform employees about their health or provide wider information and guidance) was the next most populous category. Musculoskeletal health received 11 submissions and physical activity received 9. The nutrition and weight management (4), menopause (4), sleep (3), alcohol and drug misuse (2) and domestic violence (2) categories received the fewest submissions. No submissions were received in the smoking or financial resilience categories.

Table 1. Frequency of Nesta level by topic area

Topic areas	RFI*	Level 1	Level 2	Level 3	Level 4	Total
Mental health	10	11	4	2	0	27
Sleep	0	2	0	0	1	3
Alcohol and drug misuse	1	0	1	0	0	2
Musculoskeletal health	8	2	0	1	0	11
Physical activity	3	3	3	0	0	9
Nutrition and weight management	2	1	1	0	0	4
Menopause	2	1	0	1	0	4
Domestic violence	0	2	0	0	0	2
Organisational capacity	9	9	1	0	0	19
Health assessment and education	7	7	2	0	0	16
Holistic workplace programmes	3	17	0	0	0	20
Total	44	56	12	4	1	117

* RFI – Submissions that would require further information to grade accurately.

Figure 3. Submissions by category
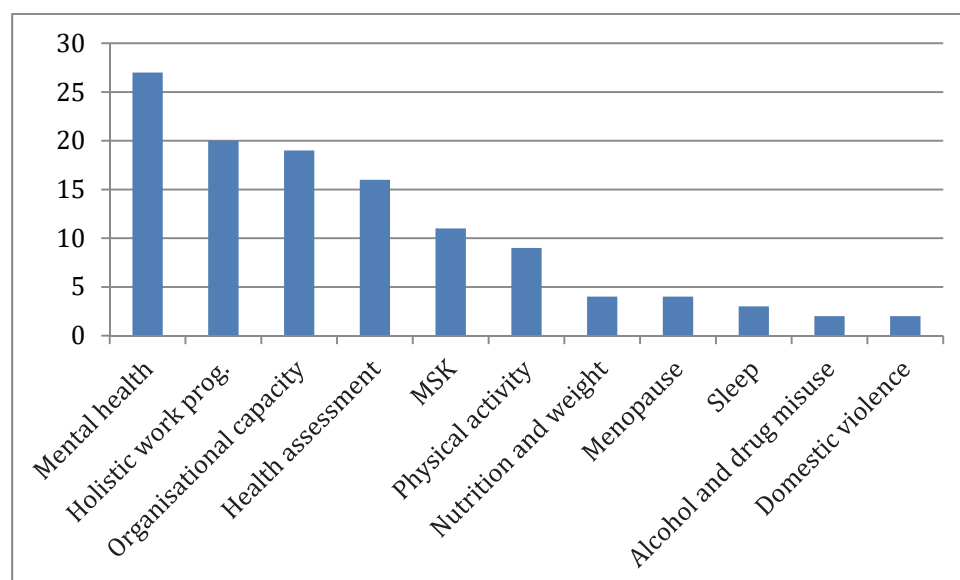
Of the 81 submissions received from providers, 59 were (at least in part) delivered face-to-face in group settings, and 39 were delivered face-to-face with individuals; 48 involved a digital element in the delivery

of the programme, 16 had a telephone component, and 25 were delivered at least in part via literature (e.g. leaflets or booklets).[21]

Some 51 interventions submitted by providers were available exclusively for employers, while 30 were available to the wider public. Among the latter, 14 were available to individuals for a fee, 7 were accessible to the public for free, and 6 could also be accessed through wider NHS, public health or Improving Access to Psychological Therapies (IAPT) services.

2.2. Organisations' use of evidence, data collection and evaluation

Submitting organisations were asked about the reasons why they believed their programme would have a positive impact (see Table 2):

- 71 reported that their programme was based on existing academic research in the field;
- 26 reported that they had received some kind of formal accreditation from a recognised public health or wellbeing organisation, and 20 from another body;
- 42 claimed that their programme was based on another that had been successfully implemented elsewhere;
- 57 claimed that their programme was based on advice from government or professional bodies (e.g. NHS, National Institute for Health and Care Excellence [NICE], Chartered Institute of Personnel and Development [CIPD]);
- 95 collected some kind of formal data or feedback about the programme;
- 31 had conducted at least one external evaluation.

Table 2. Reasons claimed by submissions that programmes would have a positive impact

Activity	Number of submissions
Based on existing academic research	71
Type of accreditation	46
Implemented elsewhere	43
Based on advice from formal sources	57
Data collected about the programme	95
At least one external evaluation	30

Among providers indicating that no external evaluation had taken place, 4 had evaluations under way and 14 reported plans to conduct a formal evaluation. A number of submissions indicated that they had

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[21] Organisations were able to select more than one answer, meaning answers do not sum to 80.

conducted research and/or evaluations of their intervention as part of university courses (typically Master's dissertations).[22]

The majority of organisations collected an element of feedback about their product, through post-event feedback sheets or unstructured feedback, surveys or case studies. A few studies made use of validated health and wellbeing scales or business indicators, such as absence rates or perceptions surveys amongst employers.

Evaluations considering the impact of two mental health training courses targeted at line managers also made use of measures of self-reported confidence and competence (such as participants' confidence in dealing with mental health issues in the workplace, recall of key lessons or the extent to which their subordinates felt comfortable discussing mental health issues). This was offered in lieu of direct health and wellbeing outcomes amongst the wider population.

Notably, digital platforms, by nature of their design, were often able to use usage data to explore the implementation of their programme. For instance, an absence management platform was able to use the absence data collected by organisations using the programme to look at the overall reduction in absences over the period of implementation.[23] Computerised CBT (cCBT) and mindfulness programmes were able to collect anonymous data about the way users were interacting with them (such as the number of modules completed).[24] Wellpoint Kiosks offering individual health checks were able to identify repeat users, and so monitor health data over repeated usage.

Perhaps unsurprisingly, employers were less likely to demonstrate formal and systematic data collection than providers (and thus reach the higher Nesta levels). Nonetheless, some employers demonstrated innovative methods of collecting data about their intervention:

- The **Central and North West London NHS Foundation Trust** Staying Well @ Work Service (SW@WS) is a holistic programme offering personalised coaching, guidance and support for Trust staff who are experiencing mental wellbeing difficulties. At the time of writing, the service was currently being piloted, with a decision to be made about whether it will be continued (based on an assessment of the trial period). As part of the pilot, employees accessing the service answer a pre- and post-service questionnaire to assess their individual wellbeing before and after use of the service. It comprises the Core 34 questionnaire, a 34-item scale to measure different aspects of psychological distress, and the Health and Safety Executive (HSE) Management Standards Indicator Tool, a set of questions relating to causes of stress in the workplace.
- **Sheffield Hallam University** piloted a mindfulness programme in the Facilities Directorate. The programme was implemented over six weeks, involving 25 participants across two cohorts. The programme was evaluated using a pre- and post-survey evaluation using three survey instruments: the Mindful Attention Awareness Scale (MAAS), the Flourishing Scale and the Perceived Stress Scale (PSS). The results, which were based on the small sample of 10 participants who had completed both surveys, indicated some positive improvement on all scales.

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[22] Mindful Employer, Healthy Worker Programme, Workguru.

[23] FirstCare case studies.

[24] Be Mindful, Sleepio, Workguru.

- **Atkins Global** implemented a series of mindfulness seminars for staff, with the option to dial in remotely or watch the webinar online at a later time. To investigate the impact of the seminars, a validated scale (the Warwick-Edinburgh Mental Wellbeing Scale with the option for free-text comments) was used, administered to staff before and three months' after the seminars. The data were subsequently analysed by the University of the West of England to analyse the impact of the pilot. Of around 250 participants, 24 completed both surveys. The organisation reported that post-test scores were higher than pre-test scores, although the results were not statistically significant (potentially due to the small sample size). Some Atkins offices are now running similar mindfulness programmes.

2.3. Return on investment

Return on investment (ROI) figures provide an insight into the economic benefits of implementing a particular workplace health and wellbeing intervention. In short, the values demonstrate how much output is being achieved for a given input, in monetary terms. In the context of workplace interventions such benefits are likely to be reaped through reductions in absenteeism and presenteeism, increasing productivity, reductions in staff turnover, reductions in employer medical costs, and other such work-related outcomes. ROI and benefit-cost ratio (BCR) estimates are often used interchangeably when discussing the return of an investment, both of which are calculated as follows:[25]

$$ROI \ (\%) = \frac{Benefits - Costs}{Costs} * 100$$

$$BCR = \frac{Benefits}{Costs}$$

Benefits and costs are measured financially, allowing for direct comparisons to be made across different interventions, with caution. As explained by Philips (2012), a BCR of 2.95 or 2.95:1 translates to a benefit of £2.95 for every £1 invested. Furthermore, an ROI of 195 per cent means that for every £1 spent on the intervention there is a return of £1.95 in net benefits. However, these values are not discounted, i.e. they do not account for the fact that money today has a greater value than money tomorrow.

There is a considerable amount of evidence in the wider literature relating to the ROI of numerous health and wellbeing interventions in the workplace, of which the majority appears to be positive.[26] It has been argued that undertaking such economic evaluations helps to engage stakeholders and supports sustainable investment in workplace health and wellbeing initiatives.[27]

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[25] Phillips (2012).

[26] Baxter et al. (2016).

[27] Baxter et al. (2016).

Only 23 of the 117 submissions reported measuring the ROI of their intervention. Of these, four submissions provided us with further information and data: benefits were measured in terms of reduced absenteeism, with none appearing to measure the less tangible outcomes. Costs were measured in terms of money spent on the intervention, with no submissions appearing to account for the cost of their staff's time in participating. Interestingly, the indirect costs of workplace programmes (i.e. the opportunity costs of staff time that would otherwise be spent working) are often ignored when estimating the cost of an intervention, which is likely to lead to overstated ROI values. Likewise, considering absenteeism as the only benefit of such workplace interventions is likely to lead to understated ROI values as numerous other potential benefits are ignored.

The reason only a small proportion of submissions consider the ROI of their intervention, which has been observed elsewhere,[28] may be that providers and employers implementing workplace wellbeing programmes put more emphasis on employee outcomes, such as health and wellbeing, than financial returns. The less tangible effects of such interventions, including health, wellbeing, awareness and mindfulness, are often ignored as they are hard to measure financially and their impact on business is little understood. Furthermore, numerous external factors influence the outcomes of a workplace programme, from geographical location to organisational culture, meaning that caution must be exercised when generalising from specific estimates of ROIs.[29]

2.4. Access and diversity

Of the 117 submissions, 69 indicated that they had some measures in place to ensure that the intervention could be accessed by different groups.[30] A number of interventions were bespoke or individualised by design, with the programme adapted for each user or workplace. Some providers noted that, by design, promoting the intervention to different groups and ensuring access was the responsibility of the employer.

Among those submissions that indicated they had measures in place to ensure that the intervention was accessible to different groups, examples include:

- Accessibility for written and audio-visual content, including multilingual versions,[31] large-text resources and software programmes to aid visually-impaired users,[32] subtitles for videos and transcripts of audio content for users with hearing impairments,[33] and paper copies of resources for users without computer access;[34]
- An awards programme that included criteria as part of the award to ensure consultation with a broad range of staff groups;[35]

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[28] Stepanek et al. (2017).

[29] Nicholson (2017).

[30] 13 organisations reported that they had no measures in place; 32 considered it not applicable.

[31] Bristol Zero Tolerance, Virgin Pulse.

[32] WorkingWell Limited.

[33] Be Mindful.

[34] WorkingWell Limited.

[35] Northern TUC.

- Offering health checks during different shift patterns (including at night), to give access to shift workers;[36]
- A 'buddy system' for new employees to champion take-up;[37]
- Learning and development held over webinars to ensure that home workers can attend;[38]
- Website accessibility compliance;[39]
- Direct engagement with charities, persons with disabilities and patient groups.[40]

One intervention – The Employment Passport – was designed specifically to help individuals manage long-term conditions between employers. The initiative, at time of writing under development by Royal Liverpool and Broadgreen University Hospitals Trust, intends to develop a digital record of adjustment needs that an individual can use to communicate those needs to a new employer.

Some employing organisations, in particular those offering holistic programmes, indicated that they collected monitoring and statistical information about access to their programme to track variation,[41] and another employer indicated that it actively engaged with BAME[42] and LGBT[43] forums at its organisation to ensure that there were no barriers to participation amongst these groups.[44] One submission had conducted a preliminary literature review ahead of designing their programme, which identified particularly vulnerable groups.[45]

Only one submission in this study – Mental Health First Aid – identified an evaluation conducted by an external organisation focusing on implementation amongst the BAME community in Bristol, on the understanding that BAME communities may sometimes have specific experiences of the mental health system that should be taken into account.[46] The evaluation resulted in specific recommendations about the applicability of the programme, including that instructors have a thorough understanding of race, culture and mental health to ensure that symptoms are understood in a way that is sensitive to the individual's cultural background; and that additional training in post-traumatic stress be offered to trainers working with individuals who may have come from conflict-affected countries.

2.5. Small and medium-sized enterprises

Among the 36 employing organisations who submitted interventions offered to their own workforce, 11 submissions were from SME employers (including two from a single small employer, and five from a

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[36] Nestlé UK&I.

[37] Forster Communications.

[38] Defra.

[39] Bristol Zero Tolerance, Sleepio.

[40] Discover Your Bounce For Business Ltd, Faculty of Sport and Exercise Medicine, UK.

[41] South Tyneside NHS Foundation Trust.

[42] BAME - Black, Asian and minority ethnic

[43] Lesbian, Gay, Bisexual, Transgender.

[44] King's College London, 'A Healthier Kings'.

[45] British Dietetic Association.

[46] Khaliq (2011).

medium-size employer). Of all providers, 61 provided interventions to organisations of all sizes, with five catering primarily for small or medium-sized organisations.[47]

Despite the aforementioned data collection difficulties, a number of smaller providers and employers have demonstrated innovative ways of collecting data about the impact of their programme, such as collaborating with a local university to conduct an evaluation, or using recognised survey instruments to collect data about the impact of a programme over a longer follow-up period. For example, one organisation made use of an evidence hierarchy to frame their own evidence collection:

- The **Healthy Worker Programme,** implemented by The Healthy Worker company, offers a multi-component health improvement programme. Review sessions are built in at 3, 6 and 12 months following the course end. The Healthy Worker has implemented a 4-stage evaluation of its programme, based on the Kirkpatrick evidence hierarchy.[48] This included a study of 14 course participants in a housing association, who were asked the extent to which they agreed with a number of set statements about their perceptions of the programme's benefits at 3 months and 12 months. A second study compared the absence rates of 116 participants with poor work attendance at two NHS trusts in the 12 months before and after the programme's implementation. This was conducted in conjunction with a local university, with the evaluation forming part of the MBA thesis of the programme's founder.

One submission also focused specifically on wellbeing support to SMEs, delivered by the local Chamber of Commerce:

- **Knowsley Chamber of Industry & Commerce**, in collaboration with Knowsley Public Health, operate a workplace wellbeing guidance and information service for SMEs in Knowsley to encourage them to increase their health and wellbeing provision against eight standards. Grants of £500 are also offered to companies to spend on health and wellbeing activity and guidance on HR and health and safety topics is offered. Some 100 'Workplace Champions' have been trained to act as ambassadors for workplace health within businesses. The scheme has been running for six years. KPIs, including absence rates, are monitored for companies that the programme engages with, and surveys and case studies are conducted with participating organisations.

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[47] Beat the Seat; Horsham District Wellbeing; Knowsley Chamber of Commerce; Curel CIC; and Wellpoint group Limited.

[48] See (as of 4 June 2018): https://www.kirkpatrickpartners.com/Our-Philosophy/The-Kirkpatrick-Model. The Kirkpatrick model is a stepped hierarchy designed specifically for training courses, which requires evidence relating to participant engagement with the programme (level 1); the extent to which participants have learned the material (level 2); the extent to which participants apply what they learn during training in the real world (level 3); and the extent to which target outcomes are achieved (level 4).

3. Case studies

3.1. Presentation of case studies

In this chapter, we present a selection of case studies for each topic area. All case studies that were categorised as level 2 or above based on the data supplied in the survey response are included. As discussed in Chapter 2, the number of case studies able to demonstrate strong data collection varied between different topic areas. Where topic areas contained no examples of case studies scoring Nesta 2 or above, we have chosen studies that spotlight a particularly interesting innovation or practice, and in some areas we spotlight particular case studies graded below Nesta 2. This is because of their clarity of description and ability to offer a greater level of evidence than their counterparts; in addition they exemplify certain characteristics that support the development of their chosen workplace topic area.

The case studies aim to explore some of the interventions available across key workplace wellbeing topics and the strength of evidence supporting them. We hope they will initiate a wider conversation about the way organisations think about knowing and evidencing the positive health impact of their workplace health interventions.

Table 3 lists the case studies outlined in this chapter.

Table 3. Case studies and topic areas

Topic area	Case study	Submission type
Mental health	Be Mindful	Provider
	MHFA	Provider
	The Healthy Worker	Provider
	WorkGuru	Provider
	Bank Workers Charity	Provider
	SHU Facilities Directorate	Employer
Sleep	Sleepio	Provider
	Sleep Well, Work Well	Provider
Alcohol	Dry January	Provider
Musculoskeletal health	ESCAPE-pain	Provider
	Arthritis Research UK	Employer
Physical inactivity	Workplace Challenge	Provider
	StepJockey	Provider
	Virgin Pulse Global Challenge	Provider
Nutrition and weight	Our Path	Provider
Menopause	KCL Menopause at Work	Provider
	Simply Hormones	Provider
Domestic violence	Bristol Zero Tolerance	Provider
	ManKind Initiative	Provider
Organisational capacity	Better Health at Work Award	Provider
	NHS Employers Creating Healthy Workplaces toolkit	Provider
Health assessment and education	SHU Workplace Wellness	Provider
	Wellpoint Group	Provider
Holistic workplace programmes	Forster Well	Employer
	University of Sheffield 'Juice'	Employer

Where statistically significant results are reported, this refers to a significance level of 0.05 or below.

3.2. Mental health

Mental ill-health is prevalent in the working-age population and is associated with high economic and social costs to both individuals and society. The UK Department of Health advises that one in four of us

will experience mental ill-health at some point in our lives, whilst according to data taken from the 2014 Adult Psychiatric Morbidity Survey,[49] around one in five working-age people in England has a mental health condition at any given point in time.[50]

In 2017 the impact of mental health problems was estimated to cost the UK economy between £74bn and £99bn annually.[51] The cost to employers makes up between £32bn and £42bn of this figure, which equates to up to £1,560 per employee per year across the entire UK workforce. These costs break down as £8bn in sickness absence; between £17bn and £26bn in reduced productivity at work, or 'presenteeism'; and £8bn in replacing staff who leave their jobs because of their mental health. As every organisation across the country is affected by mental health problems in the workforce, addressing the problem makes good business sense.

There appears to be disconnect between how leaders think employees' health is being supported and how it is actually being supported, as shown by the 2017 Mental Health at Work Report.[52] According to that study, 61 per cent of CEOs and managing directors believe that employees' mental health is being looked after, compared with just 40 per cent of non-managers. The result is that three out of every five employees say they have experienced a mental health issue in the last year due to work, or where work was a related factor, while 31 per cent have been formally diagnosed with a mental health condition. Despite this, just one in 10 employees (11 per cent) felt able to disclose a mental health issue to their manager. Similarly, there is evidence that inappropriate work environments can exacerbate mental health problems.[53] This illustrates that employers share some responsibility for taking care of the mental health of their employees, and in fact 88 per cent of 2,250 employers surveyed by the Department for Work and Pensions agreed with statement 'employers have a responsibility to encourage employees to be physically and mentally healthy'.[54] This can be achieved by creating an environment where work-related stress levels for employees are manageable, where managers are trained at spotting the signs that a team member may be at risk of mental ill-health, and where routes to help are clearly signposted. The National Institute for Health and Care Excellence (NICE) guidance supports best practice approaches in these areas. *Healthy Workplaces: improving employee mental and physical health and wellbeing*[55] provides step-by-step recommendations on how to improve mental wellbeing at work for different types of employers.

It is important to acknowledge that being in work in itself is considered a protective factor, with unemployment and being out of work key drivers behind mental ill-health.[56] Returning to work has been shown to improve mental wellbeing[57] (although research has also shown that the benefits of work may be contingent on the job in question being of 'good quality'[58]). To account for these and other factors, the

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[49] The survey assesses psychiatric disorder, where possible, to actual diagnostic criteria.

[50] Department for Work & Pensions and Department of Health (2016).

[51] Department for Work & Pensions and Department of Health (2017b).

[52] Business in the Community (2017).

[53] Waddell & Burton (2006); van Stolk et al. (2012).

[54] Young & Bhaumik (2011).

[55] NICE (2017).

[56] Pevalin & Goldberg (2003); Paul & Moser (2009); Noordt et al. (2014).

[57] Paul & Moser (2009); McManus et al. (2012).

[58] Chandola & Zhang (2017).

2017 Stevenson/Farmer Review of mental health in the workplace proposed six core standards for all employers to facilitate a supportive environment for mental health:[59]

- *Produce, implement and communicate a mental health at work plan*
- *Develop mental health awareness among employees*
- *Encourage open conversations about mental health and the support available when employees are struggling*
- *Provide employees with good working conditions*
- *Promote effective people management*
- *Routinely monitor employee mental health and wellbeing.*

Against this backdrop, 27 submissions were coded as 'mental health' in this study. Of these, two were categorised as Nesta level 3 – able to demonstrate evidence of causality – and 5 were categorised as Nesta level 2. These are listed in Table 4.

Table 4. Mental health case studies

Case study	Nesta level	Submission type
Be Mindful	Level 3	Provider
MHFA	Level 3	Provider
The Healthy Worker	Level 2	Provider
WorkGuru	Level 2	Provider
Bank Workers Charity	Level 2	Provider
SHU Facilities Directorate	Level 2	Employer

3.2.1. Case study: Be Mindful

Maturing evidence base (Level 3): Independent evaluations have been undertaken, investigating and validating the effect Be Mindful has on anxiety, sleep quality and work-related fatigue and rumination.

Be Mindful[60] is a four-week online course that guides users through all the elements of mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR). The programme includes 10 online video-led sessions, mindfulness meditation audios, 12 daily-life assignments, and PDF information sheets. These all aim to reduce stress, depression and anxiety among participants, and are measured using self-reporting tools.

Available: Nationally (online).

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[59] Department for Work & Pensions and Department of Health & Social Care (2017b). Additional 'enhanced' standards for employers wanting to lead include *increasing transparency and accountability*; *demonstrate accountability*; *improve the disclosure process*; and *ensure provision of tailored in-house mental health support and signposting to clinical help.*

[60] Be Mindful homepage (as of 4 June 2018): https://bemindful.co.uk/

Reach: The programme is implemented by 17 organisations and reaches approximately 11,000 individuals annually. It is not limited to the workplace setting.

Evidence base: Three external evaluations of the programme have taken place.

- One waitlist RCT evaluated the effect of Be Mindful on occupational health.[61] Some 118 individuals were drawn from the general population, with 60 treated. The evaluation found participants had statistically significant lower levels of work-related fatigue and improved sleep quality at post-test. The effect was maintained at three-month and six-month follow-ups. The research was conducted by the University of Surrey and published in the *Journal of Occupational Health Psychology* in 2016.
- The same waitlist RCT evaluated the effect of Be Mindful on perceived stress, depression and anxiety in the same sample. Participants who undertook the programme reported statistically significant lower levels of perceived stress, anxiety and depression. The effect was maintained at 3-month and 6-month follow-ups.[62] The research was published in *Mindfulness* in 2018.
- A pre- and post-survey evaluation was carried out on 273 individuals who self-referred to the online programme.[63] Perceived stress, anxiety and depression levels of participants were measured immediately before and after the course, as well as at one-month follow-up. Be Mindful had statistically significant beneficial effects on all outcome measures, with further improvement at one-month follow-up. The research was published in *BMJ Open* in 2013.

Scalability: Be Mindful is a standardised web-based programme, with manuals and guidance available for organisations to implement the intervention in differing settings.

3.2.2. Case study: Mental Health First Aid England

Maturing evidence base (Level 3): Multiple evaluations have been undertaken showing an increase in confidence, knowledge, attitudes and behaviour in the international context, although at the time of writing fewer studies consider outcomes relating to improved mental health outcomes.

Mental Health First Aid[64] (MHFA) training aims to provide course attendees with the knowledge and skills to recognise the signs and symptoms of common mental health issues. Following completion of the course, MHFA claim that participants should be able to effectively guide a person in distress or experiencing a period of mental ill-health towards the right support, be that self-help or professional services.

Available: Nationally.

Reach: Over 245,000 people have undergone the MHFA England training to date, including 70,000 in 2017. Individuals can also be trained by MHFA England to deliver the programme and are then able to act as independent instructors. It is not limited to a workplace setting.

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[61] Querstret, Cropley, & Fife-Schaw (2017).

[62] Querstret, Cropley, & Fife-Schaw (2018).

[63] Krusche, Cyhlarova & Williams (2013).

[64] Mental Health First Aid homepage (as of 4 June 2018): https://mhfaengland.org/

Evidence base: A large number of studies have been conducted on the Mental Health First Aid course in international settings. Some of the most relevant research is summarised below:[65]

- In 2014 a meta-analysis of the international published evaluations of the MHFA programme was undertaken to determine its effects.[66] We identified 15 papers through a systematic literature search, none of which were conducted in a UK setting. The synthesis found a statistically significant impact ($p<0.001$) for three outcome measures considered: 'Knowledge' (i.e. 'correct' answers to test questions about treatment methods, 15 studies) with a moderately high effect size; 'Attitudes' (social distance scale, 14 studies) with a moderate effect size; and 'Behaviour' (number of times individual has offered assistance to a person in distress, 9 studies), with a moderate effect size. Importantly, results were homogenous, i.e. they did not vary in effect from one paper to another. Further analysis found no systematic bias or result variation due to study design, and there was no evidence of publication bias. The research was published in the *International Review of Psychiatry* in 2014.

- A 2015 study by Wong et al. identified three studies implemented in Australia and the United States that have assessed the mental health outcomes of the wider population (a football league, a school and a university) and found limited evidence for change in wider population behaviour (e.g. increase in service use, reporting help received).[67]

- Other studies in a UK context included:
  - A large-scale pre- and post-survey evaluation of 11,502 participants in the MHFA England course between October 2011 and December 2012 was undertaken.[68] Respondents were asked to rank different factors out of 10; personal confidence of how best to support others with a mental health issue increased on average by 3.5 points, with knowledge and understanding of how to best support others with a mental health issue increasing by an average of 3.78 points. Furthermore, 96.6 per cent reported the training as 'very good' or 'good', with the report concluding MHFA training meets public health priorities by increasing mental health literacy.
  - MHFA training was delivered to 41 managers in Northumberland's Fire and Rescue Service and was evaluated as part of a random allocation study, with 65 managers receiving a different training course or a one-hour leaflet session.[69] MHFA participants showed statistically significant improvements in attitudes towards mental health, knowledge/efficacy scores, and confidence in helping a friend with mental health problems.

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[65] A summary of evaluations undertaken in the UK context can be found here (as of 4 June 2018): https://mhfaengland.org/mhfa-centre/research-and-evaluation/summary-of-evaluations/

[66] Hadlaczky et al. (2014).

[67] Wong, Collins & Cerully (2015).

[68] See (as of 4 June 2018): https://mhfaengland.org/mhfa-centre/research-and-evaluation/birmingham-and-coventry-uni-mhfa-course-evaluations-summary/

[69] Moffitt, Bostock & Cave (2014).

- An independent evaluation of training given to 55 individuals from public sector organisations, showing statistically significant improvement on measures relating to knowledge and confidence and perception of mental health issues at post-training.[70]
- An evaluation for MHFA and the North East Mental Health Development Unit, which analysed post-course evaluation forms, indicated a statistically significant rise in self-reported knowledge and confidence amongst 382 respondents.[71]
- A 2008 independent evaluation of training delivered in the city of Hull implemented a post-course survey follow-up (mean = 83 days) with 72 participants, who self-reported increased confidence; 85 per cent had offered help to a person in distress.[72]
- A study by NHS Bristol to explore the relevance and utility of MHFA training for black and minority ethnic (BME) communities. The study looked at the experience of 96 participants drawn from BME voluntary and community service organisations, or individuals with a specific BME remit within wider organisations. The study made consequent recommendations for delivery of the programme.[73]
- A formative evaluation of the original 2007 implementation of MHFA in Scotland provided a comprehensive evaluation of the implementation and delivery of the programme, concluding that it was delivering upon its objectives and improving outcomes with regard to the mental health literacy of course attendees.[74]
- A current project by academics at the University of Nottingham and funded by the Institution of Occupational Safety and Health (IOSH) is investigating the use of mental health first aid in the workplace to develop a set of recommendations for workplaces, including variability in implementation, the perceptions and experience of stakeholders and how the impact of mental health first aid might be measured.[75]

Scalability: MHFA training is provided in a standard format, with the instructor training programme accredited by the Royal Society for Public Health and guidance available for organisations to implement the intervention in differing settings.

3.2.3. Case study: The Healthy Worker

Emerging evidence base (level 2): *Quantitative data have been collected that demonstrate a positive change with respect to staff absence.*

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[70] See (as of 4 June 2018): https://mhfaengland.org/mhfa-centre/research-and-evaluation/university-bath-school-health.

[71] See (as of 4 June 2018): https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-first-aid-north-east-england/

[72] See (as of 4 June 2018): https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-first-aid-hull/

[73] See (as of 4 June 2018): https://mhfaengland.org/mhfa-centre/research-and-evaluation/nhs-report-bristol-mhfa-training-bme-communities/

[74] http://www.healthscotland.com/documents/2117.aspx

[75] See University of Nottingham (2018).

The Healthy Worker[76] programme is a multi-component health improvement intervention that reviews the health behaviours and beliefs of participants (including mental wellbeing, social wellbeing, healthy eating, smoking, alcohol consumption and exercise uptake). This is done by undertaking a review of each participant and taking a coaching-based approach to adjust their behaviours and improve their outcomes. The programme is implemented over two non-consecutive days, with reviews at 3, 6 and 12 months post-programme.

Available: Greater London, North West, West Midlands, South East and the Isle of Man.

Reach: 19 organisations have implemented the programme, reaching an estimated 550–650 individuals annually. It is designed for the workplace setting only.

Evidence base: Two internal evaluations of the programme were submitted via the portal, with results suggesting that the programme has a positive impact on health, activity and workplace absence.

  ▪ A longitudinal study involving 117 participants with poor attendance at work was undertaken at two NHS Trusts as part of the founder's MBA dissertation. The number of days absent and number of episodes of absence reduced significantly in the 12 months after the programme compared to the 12 months prior to it (41.4 per cent reduction in days absent; 25 per cent reduction in episodes of absence).[77] Pre- and post-programme staff absence costs were also compared, with a reduction in absence costs of £1,868 per person per annum.

Scalability: The Healthy Worker programme is implemented by facilitators who have undergone a set training programme, with a handbook and supplementary materials provided for consistency.

3.2.4. Case study: WorkGuru

Emerging evidence base (level 2): An RCT of WorkGuru has been undertaken, with results demonstrating a (non-statistically significant) positive impact on stress reduction.

WorkGuru[78] is an eight-week digital stress management programme designed to reduce workplace depression, anxiety and stress. The programme is based on the psychological principals of Cognitive Behavioural Therapy (CBT), positive psychology, mindfulness and problem-solving. It comprises seven core and three additional modules. The programme is predominately self-help based and delivered with the support of an e-coach. Users can choose to complete eight questionnaires to provide insights on their progress throughout.

Available: Nationally (online).

Reach: In the range of 6–19 organisations have implemented the programme, which reaches approximately 300 individuals annually. The programme is purchased directly by employers, who make it available to their staff. It is designed for the workplace setting only.

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[76] Healthy Worker homepage (as of 4 June 2018): https://thehealthyworker.co.uk/

[77] Internal document (*A summary of the evaluation of outcomes from a multi-component health improvement programme, The Healthy Worker Programme*) provided by submitting organization.

[78] WorkGuru homepage (as of 4 June 2018): https://www.workguru.org/

Evidence base: An internal evaluation of the programme was conducted as part of the founder's PhD research:

- A three-arm RCT was undertaken involving 84 individuals with elevated levels of stress from six organisations, with data collected at baseline, post-intervention and at 16-week follow-up.[79] The trial compared WorkGuru with and without a message-board support against a waitlist control. Decreases in depression, stress and anxiety outcomes with small to medium effect sizes were observed in the treatment groups at post-treatment and 16-week follow-up, although all results (with the exception of the stress measure of the Depression Anxiety Stress Scales (DASS) at 16-week follow-up between the control and the treatment group accessing WorkGuru without a message board) were non-statistically significant in the intention-to-treat (ITT) analysis. A significant between-group difference with a medium/large effect size was observed between the treatment group accessing WorkGuru without a message board and the control group on the stress module of the DASS at post-treatment and 16-week follow-up when analysing data from only those participants who had logged into the programme at least three times (per-protocol analysis).

Scalability: WorkGuru is provided in a standardised format via an online platform and accessed on an individual basis.

3.2.5. Case study: Bank Workers Charity line manager mental health training programme

Emerging evidence base (level 2): An independent evaluation demonstrated positive change with regard to manager's perceived responsibility for dealing with mental health issues and awareness of signs of mental health difficulty.

The **Bank Workers Charity,**[80] in conjunction with Mind, piloted a mental health training programme aimed at line managers across four banks. The intervention is made up of three components: two half-day training sessions in a classroom setting; 12 e-learning modules and access to a digital toolkit released on a monthly basis over the intervention period; and a follow-up programme 12 months post-intervention attempting to embed the new approaches. The aim of the health training programme is to improve the way mental health is managed by employers in the banking sector. A digital-only training course based on the programme and relevant to other non-financial sectors is currently being developed.

Available: At the time of writing, the intervention is still in the trial stage.

Reach: The intervention is still in the trial stage. The new digital product will be available to all industry sectors, not limited to banks.

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[79] Carolan et al. (2017).

[80] Bank Workers Charity homepage (as of 4 June 2018): https://www.bwcharity.org.uk/

Evidence base: An external impact evaluation of the programme was conducted in 2016 by the Chartered Institute of Personnel Development (CIPD), comparing treatment and control groups selected by the bank's HR teams: [81]

- Surveys were undertaken at baseline, midline and immediately after the 12-month intervention, with around 200 individuals receiving the training and a further 100 not receiving the training. Statistically significant differences between the treatment and control group were observed at six months with regard to perceived responsibility for managing mental health in their team and awareness of signs of poor mental health, although these differences were no longer statistically significant at 12 months. On the third and fourth measures, knowledge of ways of addressing poor mental health, and employees' views of their manager's ability to deal with poor mental health, the treatment group registered a statistically significant positive difference at six months but had returned to pre-trial levels at 12 months. The evaluators noted that leakage between groups or a natural 'ceiling' on the utility of the intervention at six months may be a factor in this. No statistically significant difference between groups was recorded in terms of the employees' views of overall management style or the employees' own ability to cope with mental health problems. Despite non-statistically significant change on a number of indicators, the evaluation concluded that the programme was well-received by managers and was 'generating positive change' with regard to managers' skills in noticing and dealing with mental health problems.

Scalability: The Bank Workers Charity line manager mental health training programme is designed as a standard format.

3.2.6. Case study: SHU Facilities Directorate Mindfulness Programme

Emerging evidence base (level 2): The SHU Facilities Directorate has collected quantitative and qualitative data that show the mindfulness programme is associated with improvements in participant mindfulness, flourishing and stress.

The **Facilities Directorate**[82] department at Sheffield Hallam University (**SHU**) offered employees the opportunity to undertake a six-week mindfulness programme provided by the Centre for Mindfulness Life Enhancement with the aim of improving productivity and wellbeing.

Available: Staff in the SHU Facilities Directorate department. Mindfulness taster sessions and access to a local mindfulness initiative are also offered as part of the University's wellbeing programme.

Reach: 25 managers and staff have undertaken the programme in two cohorts.

Evidence base: One internal evaluation assessed the impact of the mindfulness course on participants in the second cohort, with improvements observed in mindfulness, flourishing and reduction of stress:

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[81] See (as of 4 June 2018): https://www.bwcharity.org.uk/line-manager-training-evaluation

[82] Facilities Directorate homepage (as of 4 June 2018): https://www.shu.ac.uk/about-us/our-services/facilities-directorate

- A pre- and post-intervention survey was undertaken to capture the impact the programme had on mindfulness, measured on the Mindful Attention Awareness Scale (MAAS); flourishing, measured on the Flourishing Scale; and stress measured on the Perceived Stress Scale (PSS), all of which are made up of responses to relevant questions on a Likert scale.[83] Improvements were observed in all aspects of flourishing, and in all but one factor on each of the mindfulness and stress scales (which remained unchanged).

Additionally, the Facilities Directorate collect qualitative data from participants, capturing factors such as why participants chose to participate, what they liked and disliked about the course and the effect it has had on them.

Scalability: The mindfulness programme is provided externally by the Centre for Mindfulness Life Enhancement, suggesting the approach taken by the SHU Facilities Directorate could be applied elsewhere.

3.3. Sleep

Sleep is fundamental to an individual's health and wellbeing. Around 16 per cent of adults in the UK get fewer than six hours of sleep a night, and a further 19 per cent sleep for six to seven hours per night.[84] It is recommended that working-aged adults, 18–64 years, sleep between seven and nine hours a night, meaning that as many as one quarter of adults in the UK may not be getting sufficient sleep.[85]

Evidence shows that sleep plays an important role in determining cognitive performance and workplace productivity.[86] Such evidence outlines the importance of sleep and its relevance to the workplace setting. Insufficient sleep is costly for employers; not only does it lead to higher levels of absenteeism, but also it increases in presenteeism. A recent RAND Europe report investigated the link between insufficient sleep and workplace productivity, quantifying the economic costs.[87] The study found that workers sleeping fewer than six hours a night lose the equivalent of around six working days each per year, compared to those getting the recommended amount of sleep. Those sleeping six to seven hours lost on average 3.7 working days. At the macroeconomic level, insufficient sleep was found to cost the UK economy up to $50bn [approximately £38bn] per year[88], which accounts for 1.86 per cent of the nation's GDP.

However, while sleep certainly affects the workplace, the workplace also affects sleep. Numerous research studies have found that sleep is not only influenced by individual factors, such as weight and smoking

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[83] Internal document provided by submitting organisation: *Mindfulness Based Life Enhancement: an analysis of the course run for Sheffield Hallam University's Facilities Directorate; January-February 2015.* Authors: John Darwin Mike Pupius and Mark Swales, Sheffield Hallam University, University of Aberdeen, and Centre for Mindful Life Enhancement, April 2015.

[84] Hafner et al. (2016).

[85] National Sleep Foundation (2015).

[86] Nuckols et al. (2009); and Pack et al. (1995).

[87] Hafner et al. (2016).

[88] Converted using XE currency converter on 28 June 2018. Available at: https://www.xe.com/currencyconverter

status, but also by work-related factors, such as job stress, work routine and working hours, and commuting.[89]

In addition to dedicated workplace interventions available on the market, employers can also make their employees aware of the Public Health England campaign 'One You – Sleep'[90] and the NHS 'sleep self-assessment' tool.[91] Both look to raise awareness around the importance of sleep and provide information on how individuals can improve their sleep.

Three interventions in this study were coded as pertaining primarily to sleep outcomes. Of these, one was categorised as level 4.

Table 5. Sleep case studies

Case study	Nesta level	Submission type
Sleepio	Level 4	Provider
Sleep Well, Work Well	Level 1	Provider

3.3.1. Case study: Sleepio

Maturing evidence base (level 4): *Robust independent evaluations have been undertaken, investigating and validating the effect Sleepio has on sleep quality outcomes.*

Sleepio[92] is a digital training programme that aims to improve participants' sleep and in turn their wider mental health, using CBT. This is done through three formats of support: a sleep awareness campaign, a personal sleep test and a computerised CBT (cCBT) programme.

Available: Nationally.

Reach: In the range of 20–49 organisations have implemented the programme, which reaches over 25,000 individuals annually. It is not limited to a workplace setting.

Evidence base: Six RCTs have been published focusing on sleep outcomes following use of the Sleepio programme:

- A waitlist RCT was undertaken on 270 self-identified poor sleepers in a Fortune 500 company, with 135 receiving treatment.[93] The treatment group improved significantly on insomnia symptoms and presenteeism compared to the waitlist group, but there was no statistically significant reduction in absenteeism. Within-group results replicated amongst the waitlist group after receiving the treatment. Results maintained at three-month follow-up (with no waitlist). Two researchers had a commercial interest, and the third's position was funded by Big Health. The research was published in the *Journal of Occupational and Environmental Medicine* in 2016.

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[89] Nishitani, Sakakibara & Akiyama (2013); Park et al. (2013); and Heo et al. (2013).

[90] See (as of 4 June 2018): https://www.nhs.uk/oneyou/sleep

[91] See (as of 4 June 2018): https://www.nhs.uk/Tools/Pages/Sleep-self-assessment.aspx

[92] Sleepio homepage (as of 4 June 2018): https://www.sleepio.com/

[93] Bostock, Luik & Espie (2016).

- An RCT was undertaken involving 164 UK adults meeting criteria for clinical insomnia, with 55 receiving treatment.[94] Those participating in the Sleepio programme had significantly better sleep efficiency and other sleep improvements compared to care as usual (CAU) and imagery relief therapy (placebo), which was sustained at eight weeks. Two researchers declared a commercial interest. The research was published in *Sleep* in 2012.

- An RCT involving 22 adults meeting criteria for clinical insomnia was undertaken, with 13 receiving treatment.[95] Those on the Sleepio programme showed significantly larger reductions in anxiety and insomnia symptoms than an information-control. Two researchers declared a commercial interest, but had 'no access to data'. The research was published in the *Journal of Sleep Medicine & Disorders* in 2015.

- An RCT involving 223 self-identified poor sleepers resulted in the treatment group recording statistically significant improvement on insomnia symptoms and job satisfaction, and mixed results on negative affect and self-control, at 10 weeks.[96] The waitlist group demonstrated no statistically significant improvement on these measures. High attrition. One researcher declared a commercial interest. The research was published in the *Journal of Applied Psychology* in 2017.

- An RCT involving 2,638 university students with symptoms of insomnia demonstrated significantly greater reductions in insomnia, depression and anxiety symptoms at 10 and 22 weeks compared to CAU control.[97] The trial was designed to study the mediation effect of insomnia on psychotic experiences. The study was published in *The Lancet*.

- A non-controlled evaluation of 98 users of an IAPT service with self-reported poor sleep and depression and anxiety symptoms recorded statistically significant reductions in insomnia, depression and anxiety symptoms.[98] Those who completed the study scored significantly lower on depression and anxiety measures at baseline. Participants also received telephone calls from a therapist. One researcher declared a commercial interest and other financial ties.

Scalability: The three aspects of the Sleepio programme are provided in a standardised format, with manuals and guidance available for organisations to implement the intervention in different settings.

3.3.2. Case study: Sleep Well, Work Well

Emerging evidence base (level 1): An external evaluation of the programme is in progress in collaboration with the Advanced Wellbeing Research Centre at Sheffield Hallam University.

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[94] Espie et al. (2012).

[95] Pillai et al. (2015).

[96] Barnes, Miller & Bostock (2017).

[97] Freeman et al. (2017).

[98] Luik et al. (2017).

Westfield Health, a health insurance provider, has developed a programme[99] in collaboration with James Wilson (the 'Sleep Geek'), delivering education seminars that utilise a range of behavioural change techniques to improve sleep health. The programme can be delivered virtually or in person.

Available: Nationally.

Reach: In the range of 6–19 organisations have implemented the programme and the intervention reaches between 1,000 and 4,999 individuals on an annual basis. It is not limited to a workplace setting.

Evidence base: An external evaluation of the programme is in progress in collaboration with the Advanced Wellbeing Research Centre at Sheffield Hallam University.

Scalability: The programme is currently implemented directly by James Wilson. In the longer term, a 'train the trainer' model will be implemented involving Westfield-employed 'Health Coaches'.

3.4. Alcohol and drug misuse

Around 1.6 million adults in England show some sign of alcohol dependence,[100] and 2.7 million adults use illegal drugs annually.[101] Alcohol misuse can lead to severe short- and long-term health outcomes.[102] Short-term, excessive drinking impairs the nervous system, coordination, increases reaction time and can lead to alcohol poisoning, which can cause death. Longer-term alcohol misuse is associated with a higher risk of numerous health issues; for example stroke, liver disease, depression, dementia and cancer. Drug misuse also has detrimental health consequences.[103] Short-term effects vary from changes in wakefulness, heart rate and blood pressure to overdose and even death. Long-term drug misuse is associated with mental illness, heart disease, lung disease, addition and cancer.

Results from an Opinion and Lifestyle Survey undertaken by the Office of National Statistics[104] suggest that in 2016 a quarter of adults in England (26 per cent) binge drank on their heaviest drinking day in the last week. The consumption of alcohol and drugs can have direct negative impacts on the workplace. It can lead to higher absenteeism, increased presenteeism, labour conflicts, more work accidents, company image problems and equipment damage.[105] Through lost productivity alone, the business cost of alcohol-related harm is £7bn in England.[106] A survey by DrugScope and Alcohol Concern found that 60 per cent of employers have experienced problems due to staff drinking alcohol.[107] Another study commissioned by the Health and Safety Executive found that 13 per cent of working respondents reported drug use in the previous year with rates higher among younger employees.[108]

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[99] Sleep Well, Work Well homepage (as of 4 June 2018): https://www.westfieldhealth.com/business/sleep/sleep-well-work-well
[100] PHE (2014a).
[101] PHE (2014a).
[102] NHS choices (2015a).
[103] National Institute on Drug Abuse (2017).
[104] Office for National Statistics (2017b).
[105] EurWORK (2012).
[106] PHE (2018).
[107] TUC (2010).
[108] Smith et al. (2004).

A systematic review of the literature[109] noted that employees' concerns with respect to the potential consequences of self-disclosure to alcohol treatments are a key barrier to implementing workplace interventions, which is something employers should be aware of. Despite such findings, a 2009 systematic review of the literature on workplace alcohol interventions[110] concluded that they have the potential to produce beneficial results and, despite methodological problems with much of the reviewed literature, 95 per cent of the studies they examined reported statistically significant reductions in alcohol-related problems within their specific setting. Further to this, evidence exists demonstrating that individuals who are in employment while receiving treatment for alcohol or drug dependency are more likely to successfully recover.[111]

The Chartered Institute for Personnel and Development (CIPD) has produced a guide to employers that gives information and advice on managing drug and alcohol misuse at work.[112]

Although this section specifically reviews drug and alcohol misuse, there were two interventions that were coded as pertaining primarily to the use more generally of alcohol. None were coded as relating to any drug-related outcomes.

Table 6. Alcohol and drug misuse case studies

Case study	Nesta level	Submission type
Dry January	Level 2	Provider

3.4.1. Case study: Dry January

Emerging evidence base (level 2): an independent evaluation has been conducted (although not necessarily in a workplace context), which has shown positive behavioural change amongst the users of their intervention.

Dry January[113] is a public health campaign/programme run by Alcohol Concern that urges people to abstain from alcohol throughout the month of January, encouraging individuals to start conversations that are hoped to lead to a healthier relationship with alcohol. Organisations are encouraged to sign up to Dry January, with a mobile phone app, posters, internal communications, blogs and a consultation with one of the Dry January team provided to those that do. Communication materials are available to employers to promote the intervention amongst their workforce.

Available: Nationally.

Reach: In January 2018, almost 100,000 individuals signed up to the programme, and 632 organisations requested resource packs. It is not limited to a workplace setting.

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[109] Schulte et al. (2014).

[110] Webb et al. (2009).

[111] Black (2016).

[112] See (as of 4 June 2018):
http://www2.nphs.wales.nhs.uk:8080/WorkplaceHealthDocs.nsf/($all)/C1F6AF500CBEE30E80257D8500556815/$file/Managing%20alcohol%20%26%20drug%20misuse%5B1%5D.pdf?OpenElement

[113] Dry January homepage (as of 4 June 2018): https://www.alcoholconcern.org.uk/dry-january-workplace

Evidence base: Although no evaluations of Dry January have been conducted specifically in the workplace, three wider evaluations have been conducted:

- A pre- and post-survey evaluation of those participating in Dry January in the North West Coast region in 2016 was undertaken by the Centre for Public Health at Liverpool John Moores University.[114] Some 1,829 participants took part, with 720 completing in the initial survey and a further 470 completing the follow-up survey. Improvements were observed in participant health (measured using HRQOL Healthy Days), wellbeing (measured using the Warwick-Edinburgh Mental Wellbeing Scale) and ability to refuse alcohol (measured using Drinking Refusal Self Efficacy tool). Interestingly, 'high risk' drinkers (as measured by the AUDIT score, a self-reported objective measure of problem drinking developed by the WHO[115]) experienced even greater health and wellbeing benefits.

- Further research was carried out by the Centre for Public Health at Liverpool John Moores University in 2016 using the same data in combination with local emergency department data, local ambulance service data and additional qualitative information about Dry January in the workplace.[116] The qualitative data showed a mixed response with respect to how successful Dry January had been in different workplaces; the majority of participants thought monitoring the campaign was difficult, while many felt Dry January was effective at raising awareness to the effects of alcohol consumption on absenteeism and presenteeism in the workplace.

- The University of Sussex undertook an evaluation of Dry January 2014. Some 3,791 participants completed the baseline questionnaire, with a further 857 completing the six-month follow-up survey.[117] At six-month follow-up around half reported a decrease in drinking days per week as well as drinking fewer drinks per drinking day. Whether successful at abstaining from alcohol for a month or not, statistically significant reductions in frequency of drunkenness and AUDIT scores were observed for all participants. There was also a statistically significant increase in drink refusal skills. A minority of participants who did not complete the course successfully reported an increase in drinking days per week (men) or frequency of drunkenness (women).

Additionally, Alcohol Concern offers participating local authorities the opportunity to purchase an evaluation module that is undertaken by an external company. Several of these have been conducted in the past five years, allowing local authorities to gauge the impact of Dry January in their area. These were not provided for this study.

Scalability: Dry January provides standardised communications materials to workplaces, although tailored and bespoke support is available.

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[114] Unpublished document: *Dry January: Key Findings report: North West Coast region.*

[115] Saunders et al. (1993).

[116] See (as of 4 June 2018): http://www.cph.org.uk/wp-content/uploads/2016/09/Evaluating-the-Impact-of-Dry-January-2016-NWC.pdf

[117] See (as of 4 June 2018): http://sro.sussex.ac.uk/57508/

3.5. Musculoskeletal health

Musculoskeletal (MSK) conditions include a range of ailments that cover injury, damage or disorder of the joints or other tissues in the upper/lower limbs or the back.[118] Figures from 2008 show that MSK conditions affect 6.5 million people in the workforce, with this predicted to rise to 7 million by 2030.[119]

Good MSK health is essential not only for a good quality life but also for productivity in the workplace, as it is imperative to mobility, dexterity, balance and coordination, all of which are vital at work. The impacts of MSK conditions on the workforce can be evidenced by the fact that, according to the Office for National Statistics, sickness absence attributed to back, neck and muscle pain was responsible for over 30 million lost days in 2016, making MSK-related conditions responsible for 22 per cent of all days lost due to illness.[120]

The development of back and neck pain is a multifactorial process and so the preventative strategies vary greatly. A report by the Health and Safety Executive, last updated in 2017, found that from 2014 to 2017 the industries with the highest rates of work-related MSK conditions were agriculture, forestry and fishing, construction, transportation and storage, and human health and social work activities.[121] According to the report, MSK is not only associated with prolonged sedentary positions, but also continual repetition of movement, concentrated force on specific areas of the body, and a pace of work that does not allow employees sufficient recovery time. Furthermore, numerous jobs involve the use of computers and it has been shown that observed postures of individuals and MSK pain are strongly linked.[122] In this regard, ergonomic interventions tend to target risk factors such as lifting, repetitive work and static posture.[123] Overall, the effects of MSK are wide reaching and it is important that employers of all types consider the implications on their organisations and take action to mitigate its effects.

Therefore it is of great importance to identify effective interventions for the successful prevention, management and rehabilitation of musculoskeletal injuries in the workplace. Ergonomic improvements can help to remove the risks that lead to musculoskeletal injuries. Business in the Community, a charity focusing on encouraging responsible business and employer practices, has produced a toolkit for employers that outlines the importance of MSK in the workplace and provides information on how to manage the MSK health of staff.[124]

For this study, 11 submissions were coded as relating primarily to MSK health, including five from the same organisation (Arthritis UK). Of these, one submission was graded as level 3. This is presented below,

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[118] See (as of 4 June 2018): http://www.hse.gov.uk/msd/

[119] Public Health England Health and work infographics Spotlight on musculoskeletal conditions (MSK). See (as of 4 June 2018):
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/618541/Health_and_work_infographics.pdf

[120] Office for National Statistics (2016a).

[121] HSE (2017).

[122] Robertson, Huang & Lee (2017).

[123] van Tulder, Koes & Bombardier (2002); Reference 4 in Driessen et al. (2010).

[124] See (as of 4 June 2018):
https://wellbeing.bitc.org.uk/sites/default/files/business_in_the_community_musculoskeletal_toolkit.pdf

alongside the Arthritis UK entries as a single case study, which together demonstrated a strategic and rounded approach to MSK provision at work.

Table 7. Musculoskeletal health case studies

Case study	Nesta level	Submission type
ESCAPE-pain	Level 3	Provider
Arthritis Research UK	Level 1	Employer

3.5.1. Case study: ESCAPE-pain

Maturing evidence base (Level 3): Independent controlled evaluations have been undertaken, investigating and validating the effect ESCAPE-pain has on physical functioning.

ESCAPE-pain[125] (Enabling Self-management and Coping with Arthritic Pain using Exercise) is an evidence-based six-week rehabilitation programme that includes both an education component to learn about the causes of chronic hip and knee joint pain and coping strategies, as well as a tailored exercise programme. It was developed by St George's University of London, Kingston University and the Health Innovation Network (the South London Academic Health Science Network [AHSN]) for people experiencing chronic knee and/or hip pain. It is implemented in 12 sessions and is available through the workplace, NHS clinical departments and leisure and community centres. It attempts to help participants understand their problem, advises them on how to cope with chronic joint pain, and introduces them to exercises aimed at alleviating pain. Ultimately the programme attempts to help participants change the course of their condition and improve their lives. The programme is endorsed by the National Institute for Health and Care Excellence.

Available: Nationally.

Reach: In the range of 50–99 organisations have implemented the programme, which reaches between 500–999 individuals annually. It is not limited to a workplace setting.

Evidence base: Five academic papers have been published investigating the efficacy and effectiveness of ESCAPE-pain using both quantitative and qualitative data:

- An external cluster RCT was undertaken with three arms: treatment as usual, usual care with ESCAPE-pain delivered individually and usual care with ESCAPE-pain delivered to a group of eight participants.[126] Some 418 individuals aged 50 or above reporting knee pain for over six months were recruited from 54 inner-city primary care practices (76 participants withdrew during the study). Those participating in ESCAPE-pain had statistically significant better physical functioning following the six-week course, according to the physical function sub-score of the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC-func)

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[125] ESCAPE-pain homepage (as of 4 June 2018): http://www.escape-pain.org/

[126] Hurley et al. (2007).

measure, than those undergoing treatment as usual.[127] Improvements were similar whether participants received individual or group rehabilitation. The research was published in *Arthritis & Rheumatism* in 2007.

- Using data from the same clinical trial, an economic evaluation of ESCAPE-pain was undertaken.[128] The resulting paper found that although the intervention had small cost implications, it was more likely to be cost-effective in improving function than treatment as usual. The probability of rehabilitation being more cost-effective than usual care was 90 per cent, with group treatment reducing costs without compromising clinical effectiveness. The research was also published in *Arthritis & Rheumatism* in 2007.

- The long-term outcomes of ESCAPE-pain were examined with a 30-month follow-up study of the same sample, with 283 participants providing observations.[129] The clinical improvements found in the first study, six months post-intervention, were found to have declined over time but participants still had statistically significant better functioning, according to the WOMAC measure, than the control group. Furthermore, the cost benefits of ESCAPE-pain were also still present. The research was published in *Arthritis Care & Research* in 2012.

- A separate pragmatic RCT was undertaken to compare the clinical effectiveness and costs of ESCAPE-pain to that of outpatient physiotherapy.[130] 67 participants were recruited from primary care practices, with 27 assessed at 12-month follow-up having undergone physiotherapy, 21 assessed at 12-month follow-up having undergone ESCAPE-pain, and the remaining withdrawing or being lost to follow-up. Both interventions produced sustained physical benefits, assessed using the WOMAC measure, and psychological benefits, assessed using the Hospital Anxiety and Depression Scale (HADS).[131] However, ESCAPE-pain cost less and was more cost-effective. The research was published in *Physiotherapy* in 2009.

- A qualitative study was undertaken in an attempt to determine the channels through which ESCAPE-pain has positive impacts.[132] Semi-structured interviews were undertaken with 29 participants pre-intervention and 23 participants post-intervention. It appeared to achieve improvements by increasing people's treatment belief in safety and the utility of exercise to control symptoms, rather than by changing beliefs about the causation or prognosis of knee pain. The research article was published in *BMC Musculoskeletal Disorders* in 2010.

Additionally, the Health Innovation Network report that they monitor outcomes in 60 NHS clinical departments and 50 leisure and community centres where the intervention is available to understand the outcomes in a real-world setting, which can often vary significantly from clinical trials.

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[127] WOMAC is a self-reported objective measure of osteoarthritis, which includes a physical function sub-score. See Bellamy et al. 1988.

[128] Hurley et al. (2007).

[129] Hurley et al. (2012).

[130] Jessep et al. (2009).

[131] Zigmond & Snaith (1983).

[132] Hurley et al. (2010).

Scalability: ESCAPE-pain is provided in a standard format. Guidance is available to organisations looking to implement the programme in different settings.

3.5.2. Case study: Arthritis Research UK MSK health initiatives

Emerging evidence base (Level 1): *Arthritis Research UK demonstrates an innovative, integrated and consistent approach to championing MSK health in the workplace at multiple organisation touchpoints, and is basing a current office redesign on a key industry charter.*

Arthritis Research UK[133] submitted five interventions that they provide to their employees that are summarised here as one case study, outlining the integrated organisational approach being taken to improve MSK health in the organisation:

- '*My healthspan*' provides employees with a personalised health assessment by external trained consultants, with a focus on MSK health.
- The '*workplace assessment*' attempts to identify any issues in the workplace that may lead to MSK issues, including provision of equipment such as sit-stand desks, chair-supports and ergonomic keyboards and mice, and further tailored adjustments for staff with MSK conditions upon request.
- '*Flex working*', being piloted at the time of writing, is a system aimed at supporting employees suffering from MSK conditions who experience fluctuating symptoms. It includes offering flexible working hours and working locations and the provision of equipment (such as lightweight laptops and IT systems) that provides for flexibility in working position and posture.
- The '*internal communications campaign'* promotes movement in the workplace and provides information and education on MSK health. It includes a slide in presentations reminding people that it is a standing friendly presentation; promotion of movement in office spaces, standing meetings/presentations and active travel; physical stretching sessions in some training events; a focus on arthritis during staff induction processes and compulsory information sessions for employees; and the provision of information on the organisation's intranet about MSK health.
- A current redesign of one office space (to be applied in time to other offices) with MSK health in mind, including features designed to promote movement, a range of working spaces and furniture to support MSK health, and a dedicated 'wellbeing space' and 'retreat room' for staff. The design is based in part upon the 'Well Building' standards.[134]

Available: The wellbeing initiatives are provided in Arthritis Research UK's workplace.

Reach: The wellbeing initiatives are provided to all Arthritis Research UK employees.

Evidence base: Arthritis Research UK has demonstrated a strong strategic approach to improving MSK health in their workplace. Many of the interventions are only in the pilot phase.

Scalability: The Arthritis Research UK interventions are provided internally for the Arthritis Research UK workforce.

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[133] Arthritis Research homepage (as of 4 June 2018): http://www.arthritisresearchuk.org/

[134] See (as of 4 June 2018): https://www.wellcertified.com/

3.6. Physical activity

Physical activity, or lack thereof, is becoming an increasing concern with regard to the working population in England. According to PHE, physical inactivity accounts for one in six deaths, as well as 'wider health, social and economic costs for individuals, families and communities in England'.[135] Worryingly, the UK is around 20 per cent less active than it was in the early 1960s, with this expected to rise to around 35 per cent by 2030 if no action is taken.[136]

As the UK economy has become more focussed on the provision of services, more and more jobs have become sedentary, offering very little physical activity.[137] Physical inactivity is an independent determinant of health, therefore no amount of exercise can compensate for spending large amounts of time sedentary.[138] Prolonged inactivity is associated with a higher risk of numerous severe detrimental health outcomes including cancer, type 2 diabetes, heart disease and premature death.[139] Businesses with an inactive workforce are therefore likely to have a less healthy workforce, with productivity lost through absenteeism and presenteeism as a result.

Tackling physical inactivity is particularly important as it accounts for the majority of sedentary behaviour among desk-based employees.[140] Promisingly, evidence on the effect of workplace interventions tackling physical inactivity is generally positive. Chu et al. (2015) undertook a systematic review of interventions tackling workplace sitting. On average, workplace sitting was reduced significantly by 40 minutes per 8-hour day, with multi-component and environmental interventions achieving a reduction of 89 and 73 minutes respectively. Gray (2017)[141] undertook a systematic review of workplace interventions tackling physical activity more generally. Across the 28 studies considered, consistent evidence was found that such interventions can be effective at increasing physical activity and reducing sedentary behaviour among employees. It is worth noting that not all the evidence is positive. Pereira et al. (2015)[142] identified eight studies of interest in their systematic review of workplace physical activity interventions. One high-quality and another moderate-quality study found statistically significant improvements in productivity, whereas two high-quality and four moderate-quality studies did not observe the same benefits. This suggests that the type of intervention and the context within which it is implemented have a major influence on its impact, as might be expected.

NICE (2008) also provide guidance on physical activity in the workplace, outlining how to encourage employees to become more physically active in an attempt to increase the physical activity levels of the working population.

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[135] PHE. 2014b, 4.

[136] Ng & Popkin (2012).

[137] ukactive (2015).

[138] Biswas et al. (2015).

[139] Schmid & Leitzmann (2014); NHS Choices (2016).

[140] Chu et al. (2015).

[141] Gray (2017).

[142] Pereira et al. (2015).

In this study, 26 submissions were coded as relating to physical activity. Of these, three were categorised as Nesta level 2. These are presented below.

Table 8. Physical activity case studies

Case study	Nesta level	Submission type
Workplace Challenge	Level 2	Provider
StepJockey	Level 2	Provider
Virgin Pulse Global Challenge	Level 2	Provider

3.6.1. Case study: Workplace Challenge

Emerging evidence base (level 2): *An independent evaluation has demonstrated positive change with regard to physical activity for previously inactive participants.*

The **Workplace Challenge,**[143] delivered by County Sports Partnership Network, is a programme aimed at tackling physical inactivity in the workplace. Employees complete a digital activity log over the course of eight weeks, with workplaces competing with other organisations at a national and local level. The log is available on a smartphone app (which can connect to a Fitbit). Employees can sign up individually, or organisations can sign up as a workforce, with individual and company prizes offered as incentives. Champion training, inter-workplace activities and support from County Sports Partnerships for the development of workplace physical activity is also available as part of the programme. The programme is funded by Sport England and delivered through the network of local County Sports Partnerships (CSPs).[144]

Available: Nationally.

Reach: The programme is implemented by over 3,600 organisations and to date has reached over 63,000 individuals. It is designed for the workplace setting only.

Evidence base: Two external evaluations of the intervention have taken place, covering two phases of the programme's implementation:

- A mixed-methods evaluation was undertaken by Loughborough University across the first two years of the programme's implementation (2013–2014), looking at the outcomes for two separate cohorts.[145] Statistically significant improvements in the proportion of previously inactive participants reporting at least one 30-minute session of sport per week were observed at 3 months and 6 months in year one, and at 3, 6 and 9 months in year two, rising from rising from 44.3 per cent to 69.8 per cent at 9 months in year two. (No statistically significant increases were observed

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[143] Workplace Challenge homepage (as of 4 June 2018): http://www.workplacechallenge.org.uk/

[144] This intervention was also submitted by Oxford Brookes University, who signed up to the challenge as an employer.

[145] See (as of 4 June 2018): http://www.ssehsactive.org.uk/research-and-evaluation-resources-and-publications-item/534/index.html

for previously active participants, except a decrease in the proportion recorded at 9 months in year two.) The proportion of active participants meeting physical activity guidelines (150 minutes of moderate intensity physical activity a week) also rose significantly for previously inactive participants at all time points across both years, rising from 60.7/54.2 per cent to 78.6/86.0 per cent at 9 months in years one and two). Mixed or non-statistically significant results were observed on the active travel to work, BMI and business indicator measures. In addition, the evaluation analysed the experiences of implementing organisations and national partners to identify key enablers and barriers.

- A similar study was undertaken by Loughborough University to evaluate the programme in its third and fourth years of operating (2015–2016).[146] As before, a statistically significant increase in the proportion of participants taking part in at least one 30-minute session of sport per week was observed at 3 and 6 months. Time spent doing physical activity each week increased significantly at all time points for previously inactive participants and this increase was still observed after a 9-month follow-up period. Case studies were also conducted to further investigate the reality of implementation, and recommendations proposed for future implementation.

Scalability: CSPs that implement the Workplace Challenge in different counties receive standard training and marketing materials. The online element of the Workplace Challenge is provided in a standard format. 'Workplace champions' who implement the challenge undergo standard training. Manuals, standard promotional materials and guidance are available for organisations wishing to implement the intervention in different settings.

3.6.2. Case Study: StepJockey

Emerging evidence base (level 2): An external evaluation was undertaken with results indicating a positive change in the level of physical activity levels (stair-climbing) following introduction of prompts.

StepJockey[147] aims to increase the use of stairs in multistorey office buildings through the use of a behavioural change programme. A network of signs is put up at all stair entrances and lift/stair decision points in an attempt to nudge employees into taking the stairs instead of the lift. Furthermore, employees are given access to a mobile application within which employers can encourage further stair use and other movement in the office.

Available: Nationally.

Reach: In the range of 100–249 organisations have implemented the programme, which reaches over 25,000 individuals annually. It is not limited to a workplace setting.

Evidence base: One external evaluation was submitted:

- A mixed-methods evaluation was undertaken in 2012 to measure the impact of Step Jockey across three sites over four weeks as part of its initial Small Business Research Initiative (SBRI) assessment.[148]

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[146] Adams & Musson (2017).

[147] StepJockey homepage (as of 4 June 2018): https://www.stepjockey.com/

[148] See (as of 4 June 2018): https://www.stepjockey.com/content/docs/StepJockey_Trial_Results_Final.pdf

Quantitative data on quantity of stair journeys (compared to a two-week pre-trial baseline) and weight were collected through journey monitors and participant questionnaires. Qualitative data were also collected with respect to experiences and behavioural changes via focus groups and questionnaires. Statistically significant increases in stair usage were observed across all three sites (total change of +2 per cent; +8 per cent in two sites; the third site recorded both a statistically significant increase of 27 per cent amongst certain participants and also a decrease of 14 per cent amongst other participants, with an average of +16 per cent). Additionally, 92 per cent of participants who reported being influenced by the prompts reported that their behaviour had become ingrained.

Scalability: Step Jockey is a standardised programme, with manuals and guidance available for organisations to implement the intervention in different settings.

3.6.3. Case Study: Virgin Pulse Global Challenge

Emerging evidence base (level 2): *Data have been collected that demonstrate positive change amongst participants of the Global Challenge on activity levels and health outcomes.*

The **Virgin Pulse Global Challenge**[149] is a 12-week programme (involving a 100-day challenge) to encourage physical activity in the workplace. Firstly, employees undertake an online health assessment that provides feedback and recommendations to support their progress. Then, in teams of seven, they are provided with wearable activity trackers as they attempt to reach their daily target of 10,000 steps a day. New virtual locations are unlocked on the application as they achieve their target, competing among thousands of other employees worldwide.

Available: Nationally.

Reach: The programme has been implemented by over 1,500 organisations and reaches over 300,000 individuals annually. It is designed for the workplace setting only.

Evidence base: The 2017 Global Challenge final report was submitted to the portal:[150]

- 263,687 Global Challenge participants completed a baseline survey and 107,999 members completed an endline survey (with 105,289 participants globally – 36 per cent of participating employees – answering both the baseline and endline surveys). Notable results included:
    - The percentage of employees who met the conditions for 'optimal' on the World Health Organisation 5-item Wellbeing Index (WHO-5) rose by 31 per cent;
    - The number of participants meeting the recommended 10,000 steps per day rose from 9 per cent pre-challenge to 69 per cent;
    - 55 per cent of participants reported an increase in productivity or concentration at work;
    - An increase was reported for the proportion of participants meeting recommendations for alcohol consumption (increase of 17 per cent), water intake (+42 per cent), eating 5 portions of fruit and vegetables (+52 per cent) and improved sleep health (+87 per cent)

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[149] Virgin Pulse Global Challenge homepage (as of 4 June 2018): https://globalchallenge.virginpulse.com/

[150] Internal document: *Virgin Pulse Global Challenge: 100 Day Journal Global Final Report.*

- o The most sedentary participants (those taking fewer than 500 steps per day pre-challenge) saw the greatest improvement in health, although those demonstrating higher levels of health pre-challenge (self-reported as 'very good' or 'excellent') saw a decline in overall health scores at post-challenge (-4 per cent and -13 per cent respectively; no further details offered in document).

Scalability: The Global Challenge is targeted at organisations of all sizes and is provided in a standard format, with guidance available for organisations implementing the intervention in different settings.

3.7. Nutrition and weight management

Only around a quarter of adults ate the recommended five or more portions of fruit and vegetables a day in 2015,[151] and across the 19–64-year-old population as a whole the average saturated fat and sugar (non-milk extrinsic sugar 'NMES') intakes were above dietary recommendations.[152] In the UK, 58 per cent of women and 68 per cent of men are overweight or obese, with obesity prevalence rising from 15 per cent in 1993 to 27 per cent in 2015.[153]

Diet can affect the day-to-day performance of an individual; low and fluctuating sugar levels shorten attention span and slow information processing, whereas eating regular well-balanced meals helps to maintain productivity.[154] Additionally, individuals consume a third of their daily calories at work, highlighting the potential for businesses to have a significantly positive impact on the diet and weight of their employees.[155] Absenteeism is not the only issue; employees in good health have been found to be up to three times more productive than those that are not.[156]

Research into workplace interventions aimed at tackling diet, nutrition and weight management is wide reaching. A 2010 systematic review assessed the effects of worksite interventions on employees' diets, measured in terms of energy, fat, fruit and/or vegetable intake.[157] Across 16 studies, eight interventions focussed on educating employees about the importance of diet, and the remaining interventions altered the workplace environment – either alone or in combination with education. In general, workplace interventions led to positive changes in fruit, vegetable and total fat intake. A more recent study supports these findings.[158] It evaluated the effectiveness of six dietary modification workplace interventions that had been evaluated using RCTs. All interventions involved workplace dietary modification, with three also incorporating nutrition education. The paper concluded that, from the limited evidence available, such

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[151] NHS Digital (2017).

[152] PHE & Food Standards Agency (2016).

[153] NHS Digital (2017).

[154] Workplace Wellbeing Charter. Undated. Healthy Eating at Work: a guide for employers. Accessed: http://docplayer.net/27154523-Healthy-eating-at-work-a-guide-for-employers.html

[155] Ibid.

[156] Vaughan-Jones & Barham (2010).

[157] Mhurchu, Aston & Jebb (2010).

[158] Geaney et al. (2013).

interventions alone and in combination with nutrition education increase fruit and vegetable intake. However, the evidence base still has a long way to go before hard conclusions can be drawn. Of 17 studies examining the effect of workplace interventions promoting a healthy diet across Europe, none of the evidence collected on them was regarded as 'strong', and only seven of the studies gathered evidence of a 'moderate' quality.[159] Further studies are needed, replicating the provision of such interventions in numerous settings for conclusions to be drawn in a wider context.

Public Health England has also produced a 'Healthy Eating at Work' guide for employers, which was developed by Health@Work.[160] It provides an overview of the topic, allowing organisations to consider their current practice and identify ways of improving it.

Table 9. Nutrition and weight management case study

Case study	Nesta level	Submission type
Our Path	Level 2	Provider

3.7.1. Case study: OurPath

Emerging evidence base (level 2): *Data collected via a pre-post survey demonstrated positive change with respect to overall weight.*

OurPath[161] is a six-week digital and coaching programme aimed at encouraging behavioural change in four areas: education on nutrition, exercise, sleep, stress management and positive psychology; peer group support; personalised private health mentoring; and results tracking technology, e.g. wearable activity trackers. The initial six-week programme is followed by a less-intensive follow-up programme and community support.

Available: Nationally.

Reach: In the range of 6–19 organisations have implemented the programme, which reaches between 500 and 999 individuals annually. It is not limited to a workplace setting. The programme will be rolled out in 2018 as one of the interventions offered by a pilot NHS Diabetes Prevention Programme.[162]

Evidence base: An internal evaluation of the intervention has taken place:

- A pre- and post-survey evaluation of 77 subjects met the inclusion data for six-week completion. This represents 85 per cent of subjects from a total of 98 paying participants recruited through digital advertising and deemed obese according to their Body Mass Index (BMI) score.[163] These individuals achieved a statistically significant weight loss from their baseline of 5.3 per cent after the six-week programme. Of those who provided a weight reading at three months post-

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[159] Maes et al. (2012).

[160] Workplace Wellbeing Charter (Undated)

[161] OurPath homepage (as of 4 June 2018): https://www.ourpath.co.uk/

[162] NHS England (2017).

[163] See (as of 4 June 2018): http://futurehospital.rcpjournal.org/content/4/3/173.abstract

programme (42 individuals) and six months post-programme (15 individuals), a mean weight loss of 6.7 per cent and 8.2 per cent respectively was recorded. The research was published in the *Future Healthcare Journal* in 2017.

Scalability: OurPath is a standardised digital programme, with manuals and guidance available for organisations to implement it in differing settings. Dietitians delivering aspects of the programme are provided with a standardised communications structure.

3.8. Menopause

The menopause and its effects are highly relevant to establishing support and equality of access within workplace settings. There are now around 4.3 million women in employment in the UK aged 50 years and over,[164] which accounts for around 29 per cent of the entire female workforce.[165] The majority of these women will experience or will have experienced the menopause and its symptoms, with the average age for women in the UK to reach the menopause being 52 years.[166]

The symptoms of menopause affect the workforce in differing ways, with around 40 per cent of women reporting in a 2010 survey that the symptoms did not negatively affect their job performance.[167] However, for those managing the menopause, symptoms can include, but are not limited to, hot flushes, night sweats, difficulty sleeping, headaches, changes in energy, and aches and pains.[168] Such symptoms may lead to poor concentration, tiredness, poor memory, depression, anxiety and loss of confidence.[169] Employment may also offer key benefits to those experiencing the menopause; in a review of literature on menopause in the workplace, Jack et al. (2016) found evidence that women in paid employment report fewer and less severe symptoms than those who are unemployed, with some reporting that work helps them cope with their symptoms.[170]

In an in-depth review of menopause in the workplace, the Government Equalities Office[171] cited that unsympathetic colleagues and managers mean that women often do not speak up about the difficulties they are facing. Where workplaces lack support, this may impact on economic participation in the form of absenteeism, presenteeism, lower job satisfaction and time management issues.[172] Although no value of the economic cost has been estimated in a UK setting, one study in the United States estimated the cost of

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[164] Kopenhager & Guidozzi (2015).

[165] Calculated using data from ONS, which states 32.21 million people were in work in the UK in 2017 (https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/january2018) and data from the World Bank, which states 46.5 per cent of the UK labour force were female in 2017 (https://data.worldbank.org/indicator/SL.TLF.TOTL.FE.ZS?locations=GB).

[166] TUC (2014).

[167] However, a third of the women who answered in this manner also noted that they had had to make additional efforts to ensure that their performance was not affected (Griffiths, MacLennan & Wong 2010).

[168] NHS Choices (2015b).

[169] Kopenhager & Guidozzi (2015).

[170] Jack et al. (2016).

[171] Brewis et al. (2017).

[172] Brewis et al. (2017).

untreated menopause symptoms to employers to be around $370m over one year.[173] However, despite the vast number of individuals affected, the problem is not a well-understood one. There is no universally accepted definition of the menopause or the menopause transition, making a comparison of studies difficult, and the creation of a robust evidence base problematic.[174]

Nonetheless, the amount of research on this topic is increasing, particularly examining the relationship of menopause with employment. Surveys of the experience of women in the workplace have resulted in recommendations for how the workplace environment could be adapted to their needs, such as changing organisational culture; training; provision of specialist advice; tailored absence policies; flexible working hours; and relatively low-cost environmental changes, particularly with respect to heating and ventilation.[175] As the Government Equalities Office has noted,[176] many workplace interventions are low cost and easy for employers to implement; and those that may be more expensive or challenging may only be necessary temporarily.

A number of organisations have also produced guidance on menopause and the workplace, providing an overview of the issues at hand, guidance for managers and employers to tackle the issue, and guidance for women in need of support. The Faculty of Occupational Medicine of the Royal College of Physicians[177] suggests the following workplace steps to facilitate a supportive environment for menopausal women, based on research carried out by the European Menopause and Andropause Society (EMAS):

- Providing training for managers and employees to raise awareness of the topic and potential employee needs;
- Facilitate communication about symptoms and needs;
- Review the physical workplace environment, including adapting temperature and ventilation, providing cold drinking water and washroom facilities at all workplace locations;
- Considering adapting working hours or shifts to the needs to the individual, for example if sleep is disturbed.

Unison,[178] the Trades Union Congress[179] and Business in the Community[180] have also released guidance on the same topic.

Four submissions were received on the topic of menopause. Of these, one was categorised as level 3 and one as level 1, with the others classified as 'requiring further information'.

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[173] Brewis et al. (2017). This may not be directly comparable to the UK context given contextual differences such as the size of the working age population and employment practices.

[174] Brewis et al. (2017).

[175] See, for example: Griffiths, MacLennan & Hassard (2013); Hunter, Hardy & Griffiths (2017); Jack et al. (2016).

[176] Brewis et al. (2017).

[177] Faculty of Occupational Medicine of the Royal College of Physicians (undated).

[178] See (as of 4 June 2018): https://www.unison.org.uk/content/uploads/2013/06/On-line-Catalogue204723.pdf

[179] TUC (2014).

[180] See (as of 4 June 2018): https://age.bitc.org.uk/sites/default/files/women_menopause_workplace.pdf

Table 10. Menopause case studies

Case study	Nesta level	Submission type
KCL Menopause at Work	Level 3	Provider
Simply Hormones	Level 1	Provider

3.8.1. Case study: King's College London Self Help CBT intervention for menopause

Maturing evidence base (level 3): *An RCT study has been conducted demonstrating the benefits of the intervention on problematic menopausal symptoms and other outcomes, such as sleep quality and work impairment.*

Menopause at Work aimed to help women in the workplace manage problematic menopausal symptoms, as well as to raise awareness about menopause in the workplace. Employees were targeted with a brief self-help booklet involving information, exercises and homework tasks based on CBT principles, to be completed over four weeks.

Available: The study has now completed. For full details please see the referenced publication.[181]

Reach: The approach informs the development of further workplace health practice in this area.

Evidence base: At time of writing, the intervention was conducted as one RCT over multiple workplace settings:

- Women aged 45–60 years with ten or more 'hot flushes and night sweat' (HFNS) incidents per week were recruited from eight organisations for an RCT comparing the CBT intervention to waitlist control.[182] Some 124 women were recruited, with 60 allocated to the self-help intervention, and 64 to the waitlist control. The self-help intervention group saw a significant reduction at 6 weeks and 20 weeks compared to the control group in scores on the HFNS-Problem-rating scale (which measures the extent to which episodes of hot flush and night sweats are considered problematic). Significant reductions in favour of the treatment group were also recorded at 6 and 20 weeks for hot flush and night sweat frequency, work and social adjustment and sleep quality, and at 20 weeks for presenteeism-related, self-reported work impairment. Follow-up interviews with 27 participants in the treatment group found that the majority (87 per cent) felt that the intervention had a positive impact, and explored the reasons for this. Conclusions suggest that an unguided self-help CBT booklet is a potentially effective management option for working women experiencing problematic HFNS.

Scalability: The employee self-help intervention was delivered as a standard, self-guided booklet. Although the booklet is not available to the public, interested parties are being referred by the project to Hunter & Smith (2014).

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[181] Hardy et al. (2018).

[182] Hardy et al. (2018).

3.8.2. Case study: Simply Hormones

Emerging evidence base (level 1): *It has clearly been articulated why Simply Hormones workshops are likely to relate to positive impacts with respect to managing the menopause in the workplace, and the intervention is based on relevant literature.*

Simply Hormones[183] delivers menopause workshops in workplaces to discuss the impact of the menopause in the workplace. The content is adjusted depending on the audience, with programmes tailored to three main groups: line/HR managers, occupational health nurses and managers, and women's groups. Each workshop runs through the same basic principles: outlining what the menopause is, when it happens, its symptoms, the challenges it brings about and how to tackle these successfully. The workshop is available as a live workshop or through an online platform.

Available: Nationally.

Reach: In the range of 20–49 organisations have implemented the programme and the intervention reaches between 1,000 and 4,999 individuals on an annual basis. It is not limited to a workplace setting.

Evidence base: No formal research into the programme has taken place, but numerous papers and guidance were submitted by the organisation as background research that had influenced the establishment and subsequent developments of the Simply Hormones programme, including covering all recommendations set out in the Government Equalities Office report:[184]

- University of Nottingham (2011)
- Altmann (2015)
- TUC (2014)
- Brewis et al. (2017).

As well as developing the programme on well-established practices, some qualitative and quantitative data is also collected from participants. The submission stated that as the intervention is in the early stages of implementation, data are not yet sufficient to infer reliable results. This is an example of good practice when implementing a new workplace programme.

Scalability: The course is delivered by trained staff and standard manuals and guidance are available to implement the course in different settings.

3.9. Domestic violence

Domestic violence is experienced by around 8.5 per cent of women and 4.5 per cent of men annually in England and Wales.[185] In other words, over 1.4 million women and 700,000 men suffer from violence at the hands of a partner or ex-partner annually.[186]

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[183] Simply Hormones homepage (as of 4 June 2018): https://simplyhormones.com/

[184] Brewis et al. (2017).

[185] Office for National Statistics (2015).

[186] PHE (2015).

The effects of domestic violence have a direct impact on the workplace. Understandably, individuals suffering from domestic violence are likely to be living in fear and distracted from their day-to-day jobs. Of respondents to a 2014 Trades Union Congress (TUC) survey who had experienced domestic violence, 56.7% reported they had to take time of work, 49.1% reported being late for work and 86.0% reported that their work performance had been affected by being distracted, unwell or tired.[187] Absenteeism is not the only issue for business. Numerous studies find that perpetrators of domestic violence directly interfere with victims' jobs before, during and after work hours.[188] Having said that, it is important to highlight the importance of employment. One of the conclusive findings of 30 years of research into domestic violence is that employment is critical to reducing the effects of violence.[189] Furthermore, many people suffering from violence maintain commitment to their job and to the quality of their work as it is one of the few safe spaces where they can be physically separate from their abuser.[190]

Few studies have looked into the effectiveness of workplace domestic violence interventions, but some undertaken to date have demonstrated a positive impact. One recent study looked at the effectiveness of a 'Domestic Violence and the Workplace' training course in the US.[191] A waitlist RCT was undertaken, with 14 counties given the intervention and another 13 counties acting as controls, receiving the training after a six-month delay. The intervention was found to have significantly positive effects on the organisational culture towards domestic violence, domestic violence knowledge tests and the provision of information on domestic violence from employer to employee.

In 2014, Public Health England launched a campaign against domestic violence, the 16 Days of Action campaign, which provided information for businesses to raise awareness around the issue and provide them with information on how they can tackle domestic violence. Further to this, the Department of Health teamed up with SafeLives to develop employer's guidance on responding to colleagues experiencing domestic violence.[192] It outlines how to recognise the signs of domestic violence and how to respond to them.

Domestic violence and the workplace setting remains an under-explored area. This is highlighted by the fact that of all our submissions, only two interventions fell under the domestic violence category. Both were categorised as level 1.

Table 11. Domestic violence case studies

Case study	Nesta level	Submission type
Bristol Zero Tolerance	Level 1	Provider
ManKind Initiative	Level 1	Provider

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[187] TUC (2014)

[188] Showalter (2016); Swanberg & Logan (2005); Wathen et al. (2015).

[189] Kahui et al. (2014).

[190] PHE (2015).

[191] Glass et al. (2016).

[192] Department of Health and SafeLives (2018).

3.9.1. Case study: Bristol Zero Tolerance

Emerging evidence base (level 1): the Bristol Zero Tolerance initiative has an external evaluation planned for 2018.

Bristol Zero Tolerance[193] is an initiative attempting to make Bristol a city free from gender-based violence, abuse, harassment and exploitation. The Zero Tolerance initiative works with local employers to raise awareness of gender-based violence issues with their employees and customers. Once a business pledges 'Zero Tolerance', Bristol Women's Commission help create a tailored plan of action aimed at tackling domestic violence. Included in this is 'Domestic Abuse: It's Your Business' training, highlighting the issues at hand and outlining how to deal with them.

Available: South West England.

Reach: In the range of 50–99 organisations have implemented the programme, which reaches between 10,000 and 24,999 individuals annually. It is designed for the workplace setting only.

Evidence base: Being a relatively new programme, there is limited data available about the impact of the intervention. Despite this, Bristol Women's Commission conducts interviews with key businesses to gain an insight into the impact Zero Tolerance is having through the creation of case studies. Feedback has reportedly been positive. Additionally, an external evaluation of the initiative is planned for 2018 once the programme has been active for a sufficient period of time.

Scalability: Bristol Zero Tolerance work with and provide tailored guidance to organisations looking to implement the intervention in different settings.

3.9.2. Case study: ManKind Initiative

Emerging evidence base (level 1): The intervention has received CPD accreditation.

The **ManKind Initiative**[194] provides a one-day domestic abuse training course aimed at supporting male victims. The training is provided on-site by qualified Independent Domestic Violence Advisers. The course runs through the following areas: types of domestic abuse against men; the experiences of male victims and barriers they have faced; how they can escape; how support services should respond; how to create male victim friendly services and the signs of male domestic abuse and what can be done by employers and other organisations. To date the course has been delivered to employers, police forces, local authorities and charities. Shorter training courses and summary presentations are also available.

Available: Nationally.

Reach: 15 organisations have implemented the programme(s) to date, reaching around 1,000 individuals. It is not limited to a workplace setting.

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[193] Bristol Zero Tolerance homepage (as of 4 June 2018): https://www.bristolzerotolerance.com/

[194] Mankind Initiative homepage (as of 4 June 2018): http://new.mankind.org.uk/for-professionals/training/

Evidence base: No formal research into the programme has taken place, but the intervention has received external accreditation and cited the external guidance with which it complies:

- The ManKind course has been accredited as qualifying for seven Continuing Professional Development (CPD) points after an external review was conducted by the CPD Certification Service.
- The programme complies with the National Institute for Health and Care Excellence (NICE) domestic violence and abuse quality standard.[195]

Scalability: The ManKind Initiative training course is a standardised programme, and information is available for organisations looking to undertake the intervention in different settings.

3.10. Organisational capacity

Submissions in this category comprised those that focused on improving the capacity of organisations to understand, assess and address health and wellbeing needs within their organisation. This may involve strategies or methods of data collection to understand the current health and wellbeing gaps and needs of employees, or targeted training programmes for managerial staff to be able to recognise and act upon health and wellbeing issues in the workplace and implement strong and effective people management processes.

One intervention submitted to the study was graded as level 2.

Table 12. Organisational capacity case studies

Case study	Nesta level	Submission type
Better Health at Work Award	Level 2	Provider
NHS Employers Toolkits	Level 1	Provider

3.10.1. Case study: Better Health at Work Award

Emerging evidence base (level 2): Internal and external evaluations have been undertaken, demonstrating that the BHAWA is viewed favourably by participating organisations with regard to workplace health and wellbeing. Additional in-depth qualitative analysis has provided additional understanding of the mechanisms of impact and reality of implementation.

The **Better Health at Work Award** (BHAWA),[196] implemented by the public health system in the North East and coordinated by the Northern Trades Union Congress, is a certification scheme implemented to

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[195] NICE (2016).

[196] BHAWA homepage (as of 4 June 2018): http://www.betterhealthatworkne.org/

recognise employers who have taken action to encourage health and wellbeing amongst their workforce.[197] The award is progressively certified at Bronze, Silver and Gold level, depending on the level of activities and policies in place. Participants who achieve Gold certification and engage with the programme for at least three years are also eligible for a Continuing Excellence award.

Available: North East England and Cumbria.

Reach: 351 organisations engaged with the award in 2017, of which 65 per cent were SMEs. The programme reached over 200,000 employees. It is designed for the workplace setting only.

Evidence base: One external evaluation of the BHAWA and another more recent internal report were submitted:

- A 2012 external evaluation by Durham University, NHS Public Health North East and Brightpurpose Consulting considered the impact of the BHAWA between 2009 and 2012.[198] Some 232 organisations, made up of 209,319 employees, participated in the Award, with analysis undertaken on information gathered through interviews, focus groups and a survey of 77 participating organisations. The study found that the majority of organisations agreed that the BHWA had improved staff health and morale. Significant reduction in absence days per full-time-equivalent employee was observed for organisations at the Silver and Gold award levels only.
- The 2016 Annual Report considered the impact of the BHAWA more recently.[199] In 2016 alone the Award had a direct reach of 196,036 individuals, just over 17 per cent of the working population in the area. Implementing organisations again saw positive health and wellbeing outcomes, with reductions in sickness absence of up to 2.7 days per employee annually.

Scalability: Each level of the Better Health at Work Award is classified with standardised criteria, with the programme open to all organisations in the area regardless of size or sector.

3.10.2. Case study: NHS Employers Creating healthy workplaces toolkit

Emerging evidence base (level 1): The toolkits are based on NICE guidance and endorsed by NICE.

NHS Employers,[200] the organisation representing employers and HR professionals in the NHS, has created a series of online toolkits to provide guidance to support employers to ensure healthy working environments for their employees. The *Creating healthy workplaces*[201] toolkit aims to support employers by providing clear and structured guidance on improving employee health and wellbeing. It covers six areas of employee wellbeing which are the subject of by NICE guidance: long-term sickness, mental wellbeing, obesity, smoking and physical activity. It also includes a checklist of practical steps to implement the guidance.

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[197] This intervention was also submitted by Hartlepool Borough Council, who signed up to the award scheme as an employer.

[198] Braun (2015).

[199] BHAWA (2016).

[200] NHS Employers homepage (as of 4 June 2018): http://www.nhsemployers.org/

[201] See (as of 4 June 2018): http://www.nhsemployers.org/news/2015/09/creating-healthy-workplaces-a-toolkit-for-the-nhs

Evidence base: The toolkit is based on NICE guidelines across different issue areas and the toolkit itself is endorsed by NICE. NICE guidelines are based on comprehensive syntheses of existing research on a topic.

Available: Nationally (online).

Reach: The toolkits are openly available online.

Scalability: The toolkits are in the form of a standard online tool.

3.11. Health assessment and education

Submissions in this category comprised those that focused on educating individuals about their health and wellbeing, for example through the use of information campaigns or seminars covering multiple or holistic health and wellbeing topics; providing employees with individual sessions with nurses, GPs or other healthcare practitioners; or by the provision of 'health checks' or similar assessments in order to inform individuals about their personal health and wellbeing indicators.

Some concerns have been raised that health checks could result in under- or over-treatment by misidentifying risk factors, or cause undue concern to individuals about their health risks. Despite these concerns, health checks are offered free on the NHS to anyone aged 40–74 on the grounds that the benefits of checks are likely to outweigh the risks,[202] and are offered in the workplace environment by a number of providers.

Some 17 submissions in this study were coded as pertaining to health assessment and education initiatives.

Table 13. Health assessment and education case studies

Case study	Nesta level	Submission type
SHU Workplace Wellness	Level 2	Provider
Wellpoint Group	Level 2	Provider

3.11.1.   Case study: Workplace Wellness Programme: Sheffield Hallam University in Partnership with Yorkshire and Humber Academic Health Science Network

Emerging evidence base (level 2): *widespread data have been collected to determine the effects of SHU Workplace Wellness, which has shown change amongst the users of their intervention.*

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[202] See (as of 4 June 2018): https://www.nhs.uk/conditions/nhs-health-check/pages/pros-and-cons-of-the-nhs-health-check.aspx

The **SHU Wellness**[203] programme is an hour-long service is provided to employees directly by Sheffield Hallam University (SHU) or through employers that have been trained by the university.[204] The programme provides a combination of a health and fitness assessment alongside behavioural change techniques. Individual's blood pressure, cholesterol, heart rate, diabetes risk, lung function, aerobic fitness and body composition are tested. Instantaneous results are generated and fed back in a personalised report, with advice on how to make positive health and lifestyle adjustments provided in an action plan.

Available: Yorkshire, North East England.

Reach: A total of 20 organisations have implemented the programme with 90 staff trained and 7,695 individual baseline assessments completed. It is designed for the workplace setting only.

Evidence base: Several studies have been carried out to examine the effect of the SHU Workplace Wellness programme, in its pilot and full implementation stage. The research has found evidence that the intervention was associated with changes in participant behaviour and statistically significant improvements in health. Below are summaries of the two studies focused on the full implementation stage:

- The programme was introduced in Sheffield Teaching Hospitals, with data collected on 50 participants (10 male and 40 female) at baseline who had expressed interest in the programme.[205] There was a statistically significant improvement in in total cholesterol, cardiovascular health, aerobic fitness and waist circumference at six months. Furthermore, 87 per cent reported making changes to their lifestyle, with 71 per cent improving healthy eating and increasing exercise levels. No significant changes were recorded on the broader physical and mental health scale (SF12). The report was published in 2012.

- A more recent study has examined the longitudinal impact of the SHU Wellness programme over a four-year period.[206] Some 427 respondents underwent a health check each year for five years and were followed across this time, being assessed on a range of health measures and health behaviours. The study showed significant improvements after one year for those with an 'at risk' profile on each indicator at baseline for cholesterol and blood pressure indicators, with the improvements largely maintained across the subsequent three years. The majority of indicators showed no significant change at year one when including participants with baseline measures within the 'ideal' range. The research was published in *Perspectives in Public Health* in 2016.

Scalability: The SHU Workplace Wellness programme is not provided in a standard format, but manuals and guidance are available for organisations to implement the intervention in different settings. Staff implementing the intervention undergo a five-day training programme and one-day assessment.

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[203] SHU Wellness homepage (as of 4 June 2018): https://www4.shu.ac.uk/research/cses/commercial-services/wellness

[204] This intervention was also submitted by Spectrum Community Health CIC, who signed up to the challenge as an employer.

[205] Maynard et al. (2012).

[206] Flint et al. (2016).

3.11.2.   Case study: Wellpoint Health Kiosks

Emerging evidence base (level 2): *Data from external evaluations have demonstrated positive change amongst users of the kiosks with regard to reductions in body weight, fat, BMI and heart health.*

The **Wellpoint Group**[207] provide health screening kiosks for the workplace or public spaces. The health kiosks measure and provide information on participants' health, such as weight, blood pressure and body fat. The Well.Me digital platform provides tailored health and lifestyle information in the attempt to adjust long-term behaviour, and reduce the risk of health conditions such as cardiovascular disease, obesity and diabetes.

Available: Nationally.

Reach: 81 organisations are implementing the kiosks directly at the time of writing in addition to further partnerships with third-party providers with their own client base. It is not limited to a workplace setting.

Evidence base: Three external evaluations of the intervention were submitted to the survey, with results suggesting that the health kiosks and digital platform have a positive impact on behaviour and health outcomes, as well as appearing to be cost effective.

- As part of a two-month pilot project across the London borough of Tower Hamlets, Wellpoint kiosks were placed across the community for nine weeks in 2010, with the aim of allowing healthcare to be accessed outside of the traditional settings.[208] Quantitative data were collected through the health kiosks and telephone interviews, with qualitative data also collected in follow-up interviews. The majority of the 152 repeat users aged 40–74 (11 per cent of all users) observed reductions in their weight (63%), body fat (59%), BMI (63%) and heart age (59%) across the period (compared to the percentage with gains being 36%, 39%, 37% and 32% respectively). Furthermore, participants reported that the kiosks made them considerably more aware of their health and the risk of long-term conditions.

- An observational study evaluated data on blood pressure from a UK employer implementing Wellpoint kiosks across six sites.[209] Around 35,000 measurements were taken from 9,500 participants. A small, clinically and statistically significant decrease in blood pressure was observed in users, with results sustained at 6- and 12-month follow-up. The abstract was published in the *Journal of Human Hypertension* in 2015. No full article has been published.

- A cost-benefit analysis (CBA) of Wellpoint health kiosks provided in a popular and accessible city centre location in Hull was undertaken.[210] Across 12 months from 2010 to 2011, a total of 13,265 assessments were undertaken across three units. Compared to the cost of a nurse providing the equivalent number health assessments during the same period, a saving of £144,000 was estimated through the use of Wellpoint kiosks.

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[207] Wellpoint homepage (as of 4 June 2018): https://well.me/PublicHome/Kiosk

[208] Internal document: '*An evaluation of the contribution that digital devices can make in improving health and wellbeing in Tower Hamlets.*'

[209] Fleming et al. (2015).

[210] Internal document: '*Health Central: Activity Data for Wellpoint.*' Barlow, S., Public Health Directorate, June 2011.

Scalability: Wellpoint Group health kiosks are provided in a standard format, with manuals and guidance available for organisations to implement the intervention in different settings.

3.12. Holistic workplace programmes

Many organisations will choose to implement multiple workplace wellbeing interventions across a range of health and wellbeing topics, to provide a holistic programme to meet varied employee needs. Submissions included in this category covered a range of wellbeing initiatives offered to staff or outlined a strategy for delivering health and wellbeing provision in the workplace. A review of the literature on workplace wellness programmes and a survey of employers in the US context identified five key facilitators of successful wellbeing programmes:[211]

- *Broad outreach and clear messaging from organizational leaders;*
- *Making wellness activities convenient and accessible for all employees;*
- *Making wellness an organizational priority among senior leaders;*
- *Leveraging existing resources and building relationships with health plans to expand offerings at little to no cost;*
- *Approaching wellness with a continuous quality improvement attitude, and solicit feedback from employees to improve programs.*

While holistic wellbeing programmes can address a range of employee needs, the increasing complexity of the offer may make it more difficult to evaluate the programme and understand the contribution of each component to the overall goal. (No submissions coded as holistic workplace programmes reached above a level 1 in this study.) Nonetheless, many organisations have taken steps to understand the outcomes of their programmes by monitoring business-level indicators such as absence days, productivity and output, and employee-level indicators such as satisfaction, wellbeing, and specific health and wellbeing outcomes.

A number of awards and standards have also been developed to benchmark organisations' wellbeing provision and in doing so provide a clear pathway for organisations to develop their offer in key issue areas. Awards such as the Northern TUC Better Health at Work Award (reviewed above) and the Public Health England-backed Workplace Wellbeing Chatter provide a set of standards against which organisations' health and wellbeing offer can be reviewed, while the Britain's Healthiest Workplace (BHW) competition provides organisations with a method of collecting data about staff health, wellbeing and engagement with wider health and wellbeing provision.

Some 21 submissions were coded as holistic wellbeing programmes in this study. Of these, none achieved higher than level 1. We present below two examples of submissions that showed a clear commitment to a structured, data-driven approach to implementing their wellbeing programme.

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[211] Mattke et al. (2013).

Table 14. Holistic workplace programme case studies

Case study	Nesta level	Submission type
Forster Well	Level 1	Employer
University of Sheffield 'Juice' platform	Level 1	Employer

3.12.1.   Case study: Forster Well

Emerging evidence base (level 1): Although no formal evaluations have taken place, the submission articulated a clear underlying logic and despite its small size has taken steps to collect data and feedback from participants on health and wellbeing outcomes.

Forster Well is the employee wellbeing scheme implemented by Forster Communications.[212] Each employee receives a 'wellness card' with which to collect stamps across five areas of wellbeing – physical exercise, nutrition, culture, social engagement and community support – for activities such as eating five fruit and veg a day or volunteering. Completion of the card (eight stamps) within a financial quarter was rewarded with an extra hour off work or a £25 voucher. As of 2017, the stamp element has been discontinued.

Available: Implemented internally by Forster Communications.

Reach: Forster Communications is an SME with 25 employees.

Evidence base: Forster Communications has collected feedback from participants and evaluated the wellbeing offer internally through a survey. The company also participates yearly in the Britain's Healthiest Workplace competition, which collects data on employees' health and wellbeing, and for which they have won the 'Small Organisation' category in 2016 and 2017.

Scalability: The programme was designed for Forster Communications.

3.12.2.   Case study: University of Sheffield 'Juice' platform

Emerging evidence base (level 1): Although no formal evaluations have taken place, the submission articulated a clear underlying logic.

Juice[213] is the branded online wellbeing platform implemented by the University of Sheffield for its staff. The platform includes the ability to book on-site exercise classes and health checks and access online health resources, as well as activities such as an annual walking competition and social groups such as the Book Group and needlework. The platform links to occupational health services and the employee assistance programme (EAP). Health campaigns on issues such as mental health, MSK health and sleep are delivered through Juice.

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[212] Information about Forster Well available at (as of 4 June 2018):
https://www.forster.co.uk/wp-content/uploads/2014/Forster-Well-introduction4.pdf

[213] Juice homepage (as of 4 June 2018): https://www.sheffield.ac.uk/hr/wellbeing

Available: Implemented internally by the University of Sheffield.

Reach: The platform is accessible by 8,000+ employees internally.

Evidence base: The Juice platform was piloted with 1,000 employees in 2012 before being rolled out to the wider staff body. The activities programme is delivered in conjunction with the university Sports Department involving accredited trainers and in line with KPIs agreed with HR. The University also conducts a biennial Staff Survey and collects data through the platform, including numbers of bookings and a live feedback 'star rating' submitted on an ongoing basis by individuals (as of time of writing, 4.5/5). The University also participated in the 100 Best Companies to Work For survey in 2016 and 2017, which measures different aspects of staff engagement amongst the workforce and provides year-on-year data.

Scalability: The programme was designed for the University of Sheffield.

3.13. Research topic areas receiving no case study submissions

Although case studies on smoking and financial resilience were expected, we note that none that focussed primarily on these topic areas were submitted. We include here a summary review for the two topics to support further consideration.

3.13.1.   Smoking

As of 2016, 7.6 million adults in the UK were smokers.[214] Although England has the lowest smoking rates of all the home nations, 15.5 per cent of all adults smoke – a large minority. Data from 2016 indicate that around 4.3 million employed individuals in England smoke cigarettes.[215]

Smoking and its effects are highly relevant to the workplace. Due to the health effects of smoking, an organisation with higher rates of smoking will have greater absenteeism and lower productivity.[216] Research carried out by the Centre for Economics and Business Research (CEBR), on behalf of the British Heart Foundation, considered the cost of smoking to the UK economy.[217] The report found that productivity losses due to smoking cost UK businesses £8.7bn annually; made up of smoke breaks and additional days off due to smoking-related illness.

The argument for employers to take action is compelling, particularly when considering findings that demonstrate the workplace itself impacts smoking rates. A whole strand of literature examining the impact of working environment on smoking behaviour exists, which was systematically reviewed by Albertsen, Borg & Oldenburg (2006). The review identified 22 studies of interest, finding strong evidence that the work environment affects the amount individuals smoke. Summarising the results, high job demands was the main channel through which smoking was affected, as it is associated with higher amount of smoking.

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[214] Office for National Statistics. 2016b.

[215] Office for National Statistics. 2017c.

[216] MacKenzie et al. (1994).

[217] CEBR (2014).

Further to this, resources at work aimed at tackling smoking were positively associated with cessation and negatively associated with relapse and the amount smoked. Such evidence suggests that workplaces are in a unique position to directly tackle smoking, which would in turn reduce its burden on business, benefitting everyone.

Workplaces can implement numerous different interventions in an attempt to reduce smoking among employees. Cahill & Lancaster (2014) examined the literature on the effectiveness of such workplace interventions. Only studies analysed with RCTs or quasi-RCTs were included. They identified 31 studies of interventions targeted at individual workers, such as self-help material, and another 30 interventions applied to the workplace as a whole, such as environmental cues. The following types of interventions had a sizable and statistically significant impact on smoking cessation: group therapy, individual counselling, pharmacotherapies and multiple intervention programmes aimed solely or mainly at smoking. Self-help materials were less effective, but did have a significant beneficial impact. Interestingly, two relapse prevention programmes did not help to sustain long-term abstinence and workplace incentives, such as vouchers, did not appear to improve the chances of quitting. The paper concludes that the strongest evidence of effect exists in interventions aimed at individual smokers, suggesting these may be the most appropriate measures for employers to take.

The National Institute for Health and Care Excellence (NICE) provides guidelines on workplace interventions on smoking.[218] It also provides information to employers to help them support and encourage employees to stop smoking.

No interventions were received that could be coded as primarily relating to smoking outcomes in this study.

3.13.2. Financial resilience

An individual's financial situation has a direct impact on their health, and particularly their wellbeing. In the UK around one in six people have problem debt, i.e. they struggle to keep up with debt repayments, but less than one in five of them seek advice.[219] This translates to 8.2 million people in the UK having financial troubles, of which 77 per cent are in employment.[220]

Numerous definitions of financial wellbeing exist.[221] Hayhoe et al. (2000) define financial wellbeing as the satisfaction an individual has with their financial status. Analysis of a YouGov survey of 100 employers and over 2,000 UK employees found that just under half of respondents worry about their finances, with one in five losing sleep as a result.[222] Unsurprisingly, the report found that employees' activity in the workplace is affected by their financial worries, with a business's net profit damaged by as much as 4 per cent due to lost productivity. An empirical study, carried out in the United States, supports this

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[218] NICE (2007).

[219] Money Advice Service (2016).

[220] ONS (2017a).

[221] See for example: Fergusson, Horwood & Beautrais (1981); Goldsmith (2000).

[222] Barclays (2014).

evidence.[223] The research found that financial stress affected absenteeism at work amongst those seeking assistance in debt management, and those with higher levels of financial stress were more likely to experience higher levels of absenteeism. Not only that, but presenteeism was likely to be an issue too, with many individuals spending work hours handling their finances. Finally, it is worth noting that almost 80 per cent of employees reported they were not satisfied with the efforts of their employer when it came to managing their finances, implying that there is significant room for improvement.[224]

There is a reasonable amount of evidence for employers to draw upon when considering whether financial education in the workplace is effective. One study examined the impact of an eight-hour workplace financial education programme on a group of university employees.[225] A pre- and post-assessment of participants found that statistically significant improvements were made in financial knowledge, financial behaviours, and perhaps most importantly, financial wellbeing. Another study investigated the effectiveness of a similar intervention in a chemical production company.[226] They found that the majority of participants took positive actions to improve their financial wellbeing post-intervention. Overall, they found strong evidence supporting the effectiveness of workplace financial education because it resulted in better financial wellness for workers. Hira & Loibl (2005) gathered data from a national sample of employees and examined the link between workplace financial education and workplace satisfaction. They found that those participating in such interventions formed a greater understanding of their personal finances through heightened levels of financial literacy. Importantly, employees who gained such financial literacy and confidence in their personal finances were more likely to be satisfied with and supportive of their company. Kaiser & Menkhoff (2017) undertook a systematic review of studies examining the impact of financial education. Financial education was found to have a significantly positive impact on financial behaviour and literacy.

However, Kaiser & Menkhoff (2017) also raise some important weaknesses in the existing literature. The impact of such workplace interventions varies greatly depending on the type of intervention, the setting, the target population and so on. Furthermore, they found mandatory financial education to be slightly less effective than non-mandatory equivalents. They concluded that the success of an intervention depended on educational intensity that is offered at a 'teachable moment', i.e. when teaching directly links to decisions of immediate relevance. Another recent review of the literature concluded that the workplace financial wellness interventions evidence base requires strengthening in order to develop well-designed programmes that can be scaled up.[227] They found that, despite numerous studies in the area, evidence concerning the efficacy of such interventions is limited as causal effects were rarely determined. Moreover, methodological shortcomings in existing studies have limited the evidence concerning return on investment and hampered efforts to develop best-practise recommendations. These recent systematic reviews of the literature suggest that there is still much work to be done in the area, which is also highlighted by the fact we received no submissions concerned with financial resilience.

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[223] Kim et al. (2006).

[224] Barclays (2014).

[225] Kim (2007).

[226] Garman et al. (1999).

[227] Hannon et al. (2017).

The Financial Advice Working Group produced a report in 2017 on financial wellbeing in the workplace for HM Treasury and the Financial Conduct Authority.[228] It outlines the issues at hand, summaries the lay of the land and provides a practical resource for employers and employees.

No submissions were received that could be coded as primarily relating to financial wellbeing.

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[228] Financial Advice Working Group (2017).

4. Concluding remarks

This study provides insights into a complex workplace wellbeing landscape with many levels of objectives and stakeholders. In this final chapter we identify a set of core themes relating to: the workplace wellbeing landscape; the provider and employer delivery split; the management of integration and workplace culture; and data collection and evaluation by organisations. Within each theme we highlight some of the main findings from the survey before considering what these may mean in the wider context of workplace wellbeing, providing a set of considerations. It is noted that the information provided has been self-reported and it has not been within the scope of this study to independently verify all of the information supplied. Nevertheless, the study offers important learning from and for the sector, which we consider further here. In this way we hope the report may inform both the practice and purchase of workplace wellbeing solutions.

Workplace wellbeing insights

- **Observation:** No organisations scored a Nesta level 5 categorisation and there was a low number of submissions above Nesta level 2.
  Comment: We consider there is a prime opportunity for provider and employer organisations alike to build their evidenced approaches. There is space for more leaders evidencing the health outcomes that employees gain.

- **Observation:** The case study collection period was short – the survey remained open for only five weeks. Despite this we received valid responses from 117 organisations.
  Comment: This shows that there are many organisations that recognise the importance of staff wellbeing. There is clearly a vibrant and diverse work-wellbeing sector.

- **Observation:** In this report we have seen that domestic violence, sleep and menopause are emerging target areas for workplace interventions. Despite their emerging nature we still received a number of interesting case studies.
  Comment: We hope that turning the spotlight on these areas in this report will lead to further development of approaches that will increase access by large segments of the working age population to much required support.

- **Observation:** We have seen that the size of an organisation does not always reflect the level of evidence collated, with smaller organisations often taking steps to collect evidence about their intervention.

Comment: We emphasise that small and medium-sized organisations should feel reassured that evaluation is achievable and to learn from their peers to find approaches that match their size and aspirations.

- Observation: We saw a tendency across relevant submissions to rely solely on the knowledge and awareness-raising of participants directly before and after any training.
  Comment: The increasing focus on workplace wellbeing provision should not come at the expense of ensuring effective and good practice workplace management practices, themselves an integral element of staff wellbeing. We would challenge those delivering training approaches to consider who the end beneficiaries of the training are and whether they receive benefits from the training. For example, in the case of line manager training, often the intended beneficiaries are those being line managed, rather than solely the line managers who attend the training. In some cases we saw little to suggest there was either sustained or immediate improvement evaluated in end beneficiary cohorts. Some organisations also found it useful to look at business indicators such as absence rates, but it should be borne in mind that such indicators may not necessarily act as direct proxies for the health and wellbeing of staff; for example, without wider consideration of the context, it may be difficult to understand the risk that reduced absence rates are, in fact, encouraging presenteeism amongst staff.

- Observation: Submissions focusing on mental health and stress were the most common type of submission, with 25 of 117 submissions focusing on this area.
  Comment: Many case study submissions aimed to support both physical and mental wellbeing. Through the lens of this study, the integrated approach to wellbeing is still very much an active ingredient in the workplace health improvement of England.

The provider and employer relationship

- Observation: A third of submissions were from employers, rather than providers. Providers demonstrated a stronger evidence base in general than those employing organisations delivering their own intervention.[229]
  Comment: While more organisations are developing their own workplace wellbeing capabilities, there remains a place for the use of selected provider solutions to support the provision of evidence-based health and wellbeing interventions.

- Observation: Few organisations were graded at level 2 or above.
  Comment: We suggest small and large organisations alike consider their evaluation approaches further. This will support differentiation in the marketplace. It will also reassure employer organisations that what they are providing is having a positive impact on the health of employees.

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[229] Nine providers were rated Nesta level 2 or above whereas no employers achieved this evidence level.

Managing integration and workplace culture

- **Observation**: The study found that almost half of submissions (n=58) were classified within 'holistic', 'organisational capacity' or 'health assessment and education' submission types. Many more were integrated alongside other wellbeing initiatives. With the exception of three of submissions at level 2, the majority (55) did not reach above Nesta level 1.
  Comment: There is recent evidence to suggest integrated approaches drive improved wellbeing outcomes.[230] We have also found in other studies[231] that organisations that see organisational wellbeing as a measure of success have lower levels of work impairment. This suggests that although there are many organisations deploying integrated and cultural approaches, the majority of them could conduct stronger evidence-based approaches. We highlight this to allow organisations to gauge the difference they're making to organisational and individual health and wellbeing outcomes.

- **Observation**: Some case studies used external measures or charters to support their evidenced submissions.
  Comment: It is also important to understand how individual intervention types relate to the wider health and wellbeing offer within an organisation, including different provision for different health and wellbeing conditions. Many resources are available to workplaces to help them implement health and wellbeing offers, from structured assessments such as the Workplace Wellbeing Charter[232] and Better Health at Work Award[233] to individual topic-specific guidance from NICE, sector associations and not-for-profit organisations. Additionally, organisations may benefit from benchmarking and measuring their holistic wellbeing and improvement. Some organisations cited survey results such as those from Vitality's Britain's Healthiest Workplace to support their organisational wellbeing benchmarking and outcomes.

Data collection and evaluation

- **Observation**: In their review of the submissions, the panel noted that organisations that set aims, evaluated tightly against those aims and ensured a focus on outcomes relevant to the organization's working population, often provided clearer evidence bases.

  Comment: The design and implementation of approaches should be borne in mind from the outset to ensure clearer articulation and understanding as to the 'why' as well as the 'what' and 'how' of interventions.

- **Observation**: In the submissions there were examples of how digital platforms could support access and evidence data collection.
  Comment: Using such an approach may be especially relevant where organisations are deploying holistic or integrated programmes at scale and accessible by all staff.

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[227] Osilla (2014); Hassan (2009)

[228] Hafner et al (2015)

[232] See (as of 4 June 2018): http://www.wellbeingcharter.org.uk/index.html

[233] See (as of 4 June 2018): http://www.betterhealthatworkne.org/

- • **Observation**: In this study many organisations have responded that engagement is a key aim of their wellbeing approach.
  Comment: In accounting for evidence of health outcomes, recognition should also be given to the engagement benefits of implementing a wellbeing approach.

- • **Observation**: Many of the submissions that collected data about the effectiveness of their intervention (other than through open feedback sheets) did so using quantitative measures of change (such as weight loss or amount of physical activity undertaken).
  Comment: The workplace setting is a complex environment, with different employees experiencing different responses to sources of stress and ill-health in their work and personal life, performing different job roles, and with different baseline levels of health and wellbeing. Qualitative and subjective evaluation methods of feedback, as well as quantitative and objective data sets, may provide a more holistic understanding of the actual and perceived experiences of employees and organisational cultures.

Beginning on the road to evaluation

Organisations should not be put off from using basic evaluation tools to begin with. There is no 'one size fits all', but it has been suggested that in workplace wellbeing 'what gets measured gets done'.[234]

Understanding the routes to impact – that is, how and why an intervention will result in a particular outcome – is an important first step in designing a data collection or evaluation strategy for an initiative. This means, foremost, thinking clearly about the mechanisms by which the intervention will lead to a particular outcome and articulating the actual outcomes that are hoped for.

Data capture is key in any evaluation. Submitting organisations have used a variety of methods to successfully acquire data and evidence. These have reflected the nature and type of both the intervention and of the organisation deploying the intervention. Measures have ranged from basic training evaluation and attendance sheets for measuring participation and confidence levels to more sophisticated digital platforms and tracking devices to measure defined behavioural change outcomes.

In considering more robust evidence-based approaches, certain study designs such as RCTs may produce greater confidence about particular aspects of an intervention, for instance the impact on health outcomes and cost-effectiveness. Satisfaction with the service and process of service delivery may at other times be better explored through qualitative studies that provide a stronger understanding of the reality and perceptions of implementation 'on the ground'. Seeking guidance from academic and research institutions may often be beneficial and could even lead to funding or access to researchers who could evaluate the approach as part of their academic programme.

There are ethical and privacy issues that may arise in relation to the collection and storage of personal, health and wellbeing data and organisations should make themselves aware of these. Relevant functions

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[234] Hafner et al. (2015), 30.

such as legal, human resources and data protection staff should be consulted as appropriate throughout the evaluation process.

Importantly, we recognise that small and medium-sized organisations manage unique pressures and often have limited resources. We suggest further consultation with small and medium-sized enterprises to test their views on the feasibility of different evaluation methods and approaches.

Final comment

Whilst conducting this survey we have been mindful that organisations deploy wellbeing interventions to engage staff as much as to support their direct health outcomes. Because of this, the value of health can often be seen as secondary to the value of employee engagement. We hope this study has made a small step towards a big change in the evolution of England's workplace wellbeing. We have shown that there are some strong and innovative approaches but that there is still much distance to travel. England's business and employer communities have an exciting and unrivalled opportunity to create a step change in how they support and evidence not only the health and productivity of their workforce, but also, by so doing, the health of the nation as a whole.

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Appendix A: Infographics

Promising Practices for Health and Wellbeing at Work
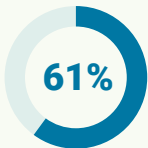
MENTAL HEALTH

1 in 5

working age people in England has a mental health condition at a given point in time[1]

Every year mental health issues in the workforce cost UK employers up to

£42 billion[2]

ARE EMPLOYERS DOING ENOUGH TO SUPPORT STAFF?

61% 61% of CEOs and managing directors believe that employees' mental health is being looked after...

40% ...compared with just 40% of non-managers[3]

The 2017 Stevenson / Farmer Review of mental health in the workplace proposed six core standards for all employers to facilitate a supportive environment for mental health:[4]

- Produce, implement and communicate a mental health at work plan

- Develop mental health awareness among employees

- Encourage open conversations about mental health and the support available when employees are struggling

- Provide employees with good working conditions

- Promote effective people management

- Routinely monitor employee mental health and wellbeing

EXAMPLE CASE STUDIES WITH (ASSOCIATED) NESTA CRITERIA

Be Mindful

A digital training programme that guides users through all the elements of mindfulness-based cognitive therapy and mindfulness-based stress reduction.

Nesta level: **3**
Independent evaluations have been undertaken, investigating and validating the effect Be Mindful has on anxiety, sleep quality and work-related fatigue and rumination.

Reach: **11,000**
The organisation is implemented by approximately 17 organisations and reaches approximately 11,000 individuals annually. It is not limited to a workplace setting.

Available: **Nationally**

Mental Health First Aid England

Training delivered by instructors accredited by the Royal Society for Public Health that provides participants with the knowledge and skills to recognise the signs and symptoms of common mental health issues.

Nesta level: **3**
Multiple evaluations have been undertaken showing an increase in confidence, attitudes and behaviour in the international context, although at the time of writing fewer studies consider outcomes relating to improved mental health outcomes.

Reach: **245,000+**
Over 245,000 people have undergone the MHFA England training to date, including 70,000 in 2017. Individuals can also be trained by MHFA England to deliver the programme and are then able to act as independent instructors. It is not limited to a workplace setting.

Available: **Nationally**

[1] Department for Work & Pensions and Department of Health (2016).
[2] Department for Work & Pensions and Department of Health (2017b).
[3] Business in the Community (2017).
[4] Department for Work & Pensions and Department of Health (2017b).

Promising Practices for Health and Wellbeing at Work
PHYSICAL ACTIVITY

As the UK economy has become more focused on the provision of services, **more jobs have become sedentary and offer very little physical activity**[1]

20% The UK is **20% less active** than it was in the early 1960s...

35% ...and this is expected to **rise to 35% by 2030** if no action is taken[2]

1 in 6 deaths
is caused by physical inactivity[3]

Prolonged inactivity is associated with a higher risk of numerous detrimental severe health outcomes including:[4]

Cancer

Type 2 diabetes

Heart disease

Premature death

EXAMPLE CASE STUDIES WITH (ASSOCIATED) NESTA CRITERIA

Workplace Challenge

Employees complete a digital activity log over the course of 8 weeks, with workplaces and employees competing for prizes with other organisations at a national and local level.

Nesta level: **2**
An independent evaluation has demonstrated positive change with regard to physical activity for previously inactive participants.

Reach: **10,000 – 24,999**
The programme is implemented by over 500 organisations and reaches between 10,000 and 24,999 individuals annually. It is designed for the workplace setting.

Available: **Nationally**

StepJockey

A behavioural change programme aimed at increasing the use of stairs in multistorey office buildings.

Nesta level: **2**
An external evaluation was undertaken with results indicating a positive change in the level of physical activity levels (stair-climbing) 'following the introduction of prompts.

Reach: **25,000+**
In the range of 100–249 organisations have implemented the programme, which reaches over 25,000 individuals annually. It is not limited to a workplace setting.

Available: **Nationally**

Virgin Pulse Global Challenge

A 15-week programme to encourage physical activity in the workplace whereby, in teams of seven, employees are provided with wearable activity trackers as they attempt to reach their daily target of 10,000 steps a day, while competing with thousands of other employees worldwide.

Nesta level: **2**
Data have been collected that demonstrate positive change amongst participants of the Global Challenge on activity levels and health outcomes.

Reach: **25,000+**
The programme is implemented by over 500 organisations and reaches over 25,000 individuals annually. It is designed for the workplace setting only.

Available: **Nationally and internationally**

[1] ukactive. 2015. ukactive's Blueprint For An Active Britain. As of 4 June 2018: http://www.sportsthinktank.com/research,117936.html
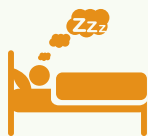[2] Ng & Popkin (2012).
[3] PHE. 2014b, 4.
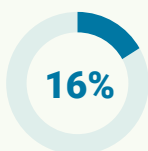[4] Schmid & Leitzmann (2014); NHS Choices (2016).

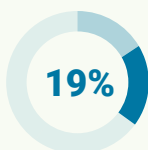# Promising Practices for Health and Wellbeing at Work
SLEEP

It is recommended that working aged adults, 18–64 years old, sleep between **seven and nine hours a night**[1]

Evidence shows that **sleep plays an important** role in determining cognitive performance and workplace productivity[4]

16%

However, around 16% of adults in the UK get **fewer than six hours of sleep a night...**

'Employees sleeping fewer than six hours a night lose the equivalent of around

6 working days per year[2]

19%

...and a further 19% sleep for **six to seven hours per night**[2]

Those sleeping six to seven hours lost on average

3.7 working days per year[2]

Factors affecting sleep loss include:[3]

- Weight
- Smoking status
- Commute
- Financial concerns
- Work routine
- Job stress

Insufficient sleep was found to cost the United Kingdom up to

£36 billion a year

which accounts for **1.86% of GDP**[2]

EXAMPLE CASE STUDIES WITH (ASSOCIATED) NESTA CRITERIA

Sleepio

A digital training programme that aims to improve participants' sleep and in turn their wider mental health, using CBT.

Nesta level: 4
Robust independent evaluations have been undertaken, investigating and validating the effect Sleepio has on sleep quality outcomes.

Reach: 25,000+
In the range of 20–49 organisations have implemented the programme, which reaches over 25,000 individuals annually. It is not limited to a workplace setting.

Available: **Internationally** (English-speaking countries only)

Sleep Well, Work Well

Westfield Health, a health insurance provider, has developed a programme in collaboration with James Wilson (the 'Sleep Geek'), delivering education seminars that utilise a range of behavioural change techniques to improve sleep health.

Nesta level: 1
An external evaluation of the programme is in progress in collaboration with the Advanced Wellbeing Research Centre at Sheffield Hallam University.

Reach: 1,000 – 4,999
In the range of 6–19 organisations have implemented the programme and the intervention reaches between 1,000 and 4,999 individuals on an annual basis. It is not limited to a workplace setting.

Available: In pilot stage

[1] National Sleep Foundation (2015).
[2] Hafner et al. (2016).
[3] Nishitani, Sakakibara & Akiyama (2013); Park et al. (2013); and Heo et al. (2013).
[4] Nuckols et al. (2009); and Pack et al. (1995).

Promising Practices for Health and Wellbeing at Work
ALCOHOL & DRUG MISUSE

1.6 million adults in England show some sign of alcohol dependence[1]

2.7 million adults use illegal drugs annually[2]

60% 60% of employers have experienced problems due to staff drinking alcohol[3]

ALCOHOL AND DRUG MISUSE HAVE MULTIPLE IMPACTS[4,5,6]

Short-term impacts include:

- Nervous system
- Slow reaction time
- Alcohol poisoning
- Wakefulness
- Blood pressure
- Overdose

Long-term impacts include:

- Stroke
- Liver disease
- Depression
- Cancer
- Mental illness
- Heart disease

Workplace impacts include:

- Absenteeism
- Presenteeism
- Labour conflicts
- Work accidents
- Company image problems
- Equipment damage

Through lost productivity alone, the business cost in England of alcohol-related harm is **£7 billion**[7]

EXAMPLE CASE STUDIES WITH (ASSOCIATED) NESTA CRITERIA

Dry January

A public health campaign/programme run by Alcohol Concern that urges people to abstain from alcohol throughout the month of January, encouraging individuals to start conversations that are hoped to lead to a healthier relationship with alcohol.

Nesta level: 2
An independent evaluation has been conducted (although not necessarily in a workplace context) which has shown positive behavioural change amongst the users of their intervention.

Reach: 25,000+
In the range of 6–19 organisations have implemented the programme, that reaches over 25,000 individuals annually. It is not limited to a workplace setting.

Available: Nationally

[1] PHE (2014a).
[2] PHE (2014a).
[3] TUC (2010).
[4] NHS choices (2015a).
[5] National Institute on Drug Abuse (2017).
[6] EurWORK (2012).
[7] PHE (2018).

Promising Practices for Health and Wellbeing at Work
MUSCULOSKELETAL HEALTH

Musculoskeletal (MSK) conditions include a range of ailments that cover **injury, damage or disorder of the joints or other tissues in the upper/lower limbs or the back**[1]

From 2014 to 2017, the industries with the highest rates of work-related MSK conditions were:[2]

- Agriculture
- Transportation and storage
- Forestry and fishing
- Human health
- Construction
- Social work

22% In 2016, **22% of all working days lost were due to MSK-related conditions**[3]

In 2008 the prevalence of MSK conditions in the workforce was

6.5 million...

...and by 2030 this is expected to rise to

7 million[4]

MSK-related conditions are associated with:[5]

- Sedentary positions
- Continual repetition of movement
- Concentrated force on specific areas of the body
- A pace of work that does not allow employees sufficient recovery time

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EXAMPLE CASE STUDIES WITH (ASSOCIATED) NESTA CRITERIA

ESCAPE-pain

A rehabilitation programme that includes both an education component to learn about the causes of chronic pain and coping strategies, as well as a tailored exercise programme.

Nesta level: **3**
Independent controlled evaluations have been undertaken, investigating and validating the effect ESCAPE-pain has on physical functioning.

Reach: **500–999**
In the range of 50–99 organisations have implemented the programme, which reaches between 500 and 999 individuals annually. It is not limited to a workplace setting.

Available: **Nationally**

Arthritis Research UK MSK health initiatives

Arthritis Research UK submitted five interventions that they provide to their employees, outlining the integrated organisational approach being taken to improve MSK.

Nesta level: **1**
Arthritis Research UK demonstrates an innovative, integrated and consistent approach to championing MSK in the workplace at multiple organisation touchpoints, and is basing its current office redesign on a key industry charter.

Reach: **Arthritis Research UK employees**
The wellbeing initiatives are provided to all Arthritis Research UK employees.

Available: **Arthritis Research UK's workplace**

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[1] See (as of 4 June 2018): http://www.hse.gov.uk/msd/
[2] HSE (2017).
[3] Office for National Statistics (2016a).
[4] Public Health England Health and work infographics Spotlight on musculoskeletal conditions (MSK). See (as of 4 June 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/618541/Health_and_work_infographics.pdf
[5] HSE (2017).

Promising Practices for Health and Wellbeing at Work
MENOPAUSE

4.3 million
women aged 50 years and over are in employment in the UK...

29% ...which **accounts for around 29%** of the entire female workforce[1]

Menopause symptoms can include:[2]

- Hot flushes
- Headaches
- Night sweats
- Changes in energy
- Difficulty sleeping
- Aches and pains

The Faculty of Occupational Medicine of the Royal College of Physicians suggests the following workplace steps to facilitate a supportive environment for menopausal women:[3]

- Provide training for managers and employees to raise awareness of the topic and potential employee needs

- Facilitate communication about symptoms and needs

- Review the physical workplace environment, including adapting temperature and ventilation, providing cold drinking water and washroom facilities at all workplace locations

- Consider adapting working hours or shifts to the needs of the individual, for example if sleep is disturbed

EXAMPLE CASE STUDIES WITH (ASSOCIATED) NESTA CRITERIA

KCL Menopause at work

A brief self-help booklet involving information, exercises and homework tasks based on CBT principles, aimed at helping women in the workplace manage problematic menopausal symptoms, as well as raising awareness.

Nesta level: **3**
An RCT of the programme has been conducted, demonstrating benefits of the intervention on problematic menopausal symptoms and other outcomes.

Reach: **N/A**
A trialled intervention.

Available: **N/A**
(The intervention is at the trial stage)

Simply Hormones

Workshops to discuss the impact of the menopause in the workplace. The content is adjusted depending on the audience, with programmes tailored to three main groups: line/HR managers, occupational health nurses and managers, and women's groups.

Nesta level: **1**
It has clearly been articulated why Simply Hormones workshops are likely to relate to positive impacts with respect to managing the menopause in the workplace, and the intervention is based on relevant literature.

Reach: **1,000 – 4,999**
In the range of 20–49 organisations have implemented the programme and the intervention reaches between 1,000 and 4,999 individuals on an annual basis. It is not limited to a workplace setting.

Available: **Internationally**
(English-speaking countries only)

Promising Practices for Health and Wellbeing at Work
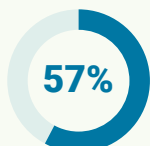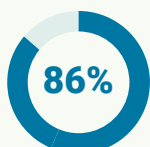# DOMESTIC VIOLENCE

1.4 million women & 700,000 men

suffer violence at the hands of a partner or ex-partner every year[1]

57% Of those experiencing domestic violence **57% have had to take time off work**...

86% ...and as many **as 86% report their work performance was affected**[2]

One of the conclusive findings of 30 years of research into domestic violence is that **employment is critical to reducing the effects of violence**[3]

Many people suffering from violence maintain commitment to their job and to the quality of their work as it is one of the **few safe spaces where they can be physically separate from their abuser**[4]

The Department of Health teamed up with Safe Lives to provide guidance for employers on how to recognise the signs of domestic abuse:[5]

Unexplained injuries

Frequent lateness or absence

Decreased productivity

Changes in behaviour

EXAMPLE CASE STUDIES WITH (ASSOCIATED) NESTA CRITERIA

Bristol Zero Tolerance

A new initiative that works with local employers to raise awareness of to gender-based violence issues with their employees and customers. Once a business pledges 'Zero Tolerance', Bristol Women's Commission helps create a tailored plan of action aimed at tackling domestic violence.

Nesta level: **1**
The Bristol Zero Tolerance initiative has an external evaluation planned for 2018.

Reach: **10,000 – 24,999**
In the range of 50–99 organisations have implemented the programme, which reaches between 10,000 and 24,999 individuals annually. It is designed for the workplace setting only.

Available: **Southwest England**

ManKind Initiative

A one-day domestic abuse training course aimed at supporting male victims. The training is provided on-site by qualified domestic abuse professionals.

Nesta level: **1**
The submission has articulated why the ManKind training course is likely to have positive outcomes, and the intervention has received CPD accreditation.

Reach: **1,000 – 4,999**
In the range of 50–99 organisations have implemented the programme, which reaches between 1,000 and 4,999 individuals annually. It is not limited to a workplace setting.

Available: **Nationally**

[1] PHE (2015).
[2] TUC (2014).
[3] Kahui et al. (2014).
[4] PHE (2015).
[5] Department of Health and SafeLives (2018).
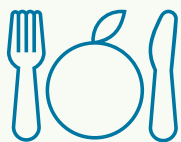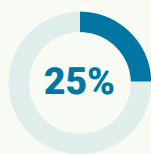
Promising Practices for Health and Wellbeing at Work
NUTRITION

25% Only around a quarter of adults **ate the recommended five or more portions of fruit and vegetables a day** in 2015[1]

58% of women & 68% of men
are overweight or obese in the UK...

...with obesity prevalence rising from **15% in 1993 to 27% in 2015**[2]
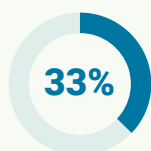
33% Individuals **consume a third of their daily calories at work**, highlighting the potential for businesses to have a significantly positive impact on the diet and weight of their employees[3]

Public Health England have put together guidance for employees to support and encourage healthier eating in the workplace, which includes:[4]

Put in place a healthy eating policy/statement to maximise opportunities for staff to make healthier choices

Share information on the benefits of healthy eating

Provide staff with access to a clean eating space away from work areas and restrict access to cakes and snacks where possible

Encourage staff to take regular breaks during the working day so they have opportunities to eat well

Choose healthy catering services and venues when considering staff away days and business lunches

EXAMPLE CASE STUDY WITH (ASSOCIATED) NESTA CRITERIA

OurPath

A six-week digital and coaching programme aimed at encouraging behavioural change through four areas: education, peer group support, personalised private health mentoring and results tracking technology.

Nesta level: 2
Data collected via a pre-post survey demonstrated positive change with respect to overall weight.

Reach: 500 – 999
In the range of 6–19 organisations have implemented the programme, which reaches between 500 and 999 individuals annually. It is not limited to a workplace setting.

Available: **Nationally**

[1] NHS Digital (2017).
[2] NHS Digital (2017).
[3] Workplace Wellbeing Charter. Undated. Healthy Eating at Work: a guide for employers. Accessed: http://www.wellbeingcharter.org.uk/media/Healthly%20Eating%20Topic%20Guide.pdf.
[4] http://www.wellbeingcharter.org.uk/media/Healthly%20Eating%20Topic%20Guide.pdf

Promising Practices for Health and Wellbeing at Work
HOLISTIC WORKPLACES

While numerous individual interventions are available to employers, many organisations will choose to implement multiple workplace wellbeing programmes across a range of topics, to provide a holistic programme to meet varied employee needs.

A review of the literature on workplace wellness programmes and a survey of employers in the US context identified five key facilitators of successful wellbeing programmes:[1]

Broad outreach and clear messaging from organisational leaders

Making wellness activities convenient and accessible for all employees

Making wellness an organisational priority among senior leaders

Leveraging existing resources and building relationships with health plans to expand offerings at little to no cost

Approaching wellness with a continuous quality improvement attitude, and soliciting feedback from employees to improve programmes

EXAMPLE CASE STUDIES WITH (ASSOCIATED) NESTA CRITERIA

Forster Well

Each employee of Forster Communications receives a 'wellness card' with which to collect stamps across five areas of wellbeing. Completion of the card within a financial quarter is rewarded with an extra hour off work or a £25 voucher.

Nesta level: 1
Although no formal evaluations have taken place, the submission articulated a clear underlying logic and the company, despite its small size, has taken steps to collect data and feedback from participants on health and wellbeing outcomes.

Reach: 10 – 49
Forster Communications is an SME with between 10 and 49 employees.

Available:
Implemented internally by Forster Communications

University of Sheffield 'Juice'

This platform includes the ability to book on-site exercise classes and health checks and access online health resources, as well as activities such as an annual walking competition and social groups such as the Book Group and needlework.

Nesta level: 1
Although no formal evaluations have taken place, the submission articulated a clear underlying logic.

Reach: 8,000+
The programme reaches 8,000+ employees internally.

Available:
Implemented internally by the University of Sheffield

[1] Mattke et al. (2013).

Promising Practices for Health and Wellbeing at Work
ORGANISATIONAL CAPACITY

Submissions in this category comprised those that focused on improving the capacity of organisations to understand, assess and address the health and wellbeing needs of their staff.

EXAMPLE CASE STUDIES WITH (ASSOCIATED) NESTA CRITERIA

Better Health at Work Award

A certification scheme implemented to recognise employers who have taken action to encourage health and wellbeing amongst their workforce. The award is certified at Bronze, Silver and Gold level, depending on the level of activities and policies in place.

Nesta level: 2
Internal and external evaluations have been undertaken, demonstrating that the BHAWA is viewed favourably by participating organisations with regard to workplace health and wellbeing. Additional in-depth qualitative analysis has provided understanding of the mechanisms of impact and reality of implementation.

Reach: 25,000+
In the range of 250–499 organisations have implemented the programme, which reaches over 25,000 individuals annually. It is designed for the workplace setting only.

Available:
North East England & Cumbria

NHS Employers Creating Healthy Workplaces Toolkit

A series of online toolkits to provide guidance to support employers in ensuring healthy working environments for their employees.

Nesta level: 1
The toolkits are based on NICE guidance and endorsed by NICE.

Reach: online
The toolkits are openly available online.

Available:
Nationally (online)

Promising Practices for Health and Wellbeing at Work
HEALTH ASSESSMENT & EDUCATION

Submissions in this category comprised those that focused on educating individuals about their health and wellbeing.

Free health checks are offered on the NHS to anyone aged 40–74 on the grounds that the benefits of checks are likely to outweigh the risks that these checks could result in under- or over-treatment by misidentifying risk factors, or cause undue concern to individuals.[1]

EXAMPLE CASE STUDIES WITH (ASSOCIATED) NESTA CRITERIA

Sheffield Hallam University in Partnership with Yorkshire and Humber Academic Health Science Network

An hour-long service is provided to employees directly by SHU or through employers that have been trained by the university. The programme provides a combination of a health and fitness assessment alongside behavioural change techniques.

Nesta level: 2
Widespread data has been collected to determine the effects of SHU Workplace Wellness, which has shown change amongst the users of the intervention.

Reach: 7,000 – 8,000
In the range of 20 organisations have implemented the programme, which has so far produced baseline assessments of over 7,500 individuals. It is designed for the workplace setting only.

Available: **Yorkshire, North East England**

Wellpoint Health Kiosks

The Wellpoint Group provides health screening kiosks for the workplace and public spaces. The health kiosks measure and provide information on participants' health, such as weight, blood pressure and body fat.

Nesta level: 2
Data from external evaluations has demonstrated positive change amongst users of the kiosks with regard to reductions in body weight, fat, BMI and heart health.

Reach: 25,000+
In the range of 100–249 organisations have implemented the programme, which reaches over 25,000 individuals annually. It is not limited to a workplace setting.

Available: **Nationally**

[1] See (as of 4 June 2018): https://www.nhs.uk/conditions/nhs-health-check/pages/pros-and-cons-of-the-nhs-health-check.aspx

Appendix B: Full list of submissions

The following section provides the full list of submissions to the portal which are not included as case studies above. A small number requested omission from any public listings. All submissions graded as Nesta 2 or above were included as case studies in the main report. We thank all organisations for their time and contribution to this research project.

Interventions graded at level 1

- AMC Consultancy - Individual Wellbeing Assessment
- Busy Bees Nursery - NHS Better Health at Work Programme
- Carers UK - Employers for Carers
- Carlisle City Council - Workplace Wellbeing Initiatives
- Central and North West London NHS Foundation Trust – Staying Well at Work Service
- Curel CIC – Workplace Wellness
- Devon Partnership NHS Trust – Mindful Employer
- Department for Environment, Food & Rural Affairs – Defra Group Wellbeing Forum
- East Sussex Healthcare NHS Trust – Staff Wellbeing Initiatives
- Edge Hill University – Staff Wellbeing
- FirstCare – Day 1 Absence Management
- Forster Communications – Peddle Points
- Gazelle Partners – Personalised Wellbeing Programme
- Health Innovation Network – HealthyHIN
- HMRC – Advocacy service
- Horsham District Wellbeing – Workplace Wellbeing MOT
- Justhealthchecks – Preventative Health Screens
- Knowsley Chamber of Industry & Commerce – Working Well
- Mates in Mind – Mates in Mind
- Mind – Workplace Wellbeing Index
- Nestlé UK & I – Nestlé approach to employee wellbeing
- NHS Employers – Emotional Wellbeing Toolkit – How are you feeling today?
- NHS Employers – Everything you need to know about sickness absence
- Northamptonshire County Council – Healthy, Happy, Here
- Oldham Council – Fit for Oldham
- Physiotherapy Matters – Better Health at Work
- Pladis UK & Ireland – In-house OH Provision

- Rethink Mental Illness – Critical Incident Stress Debriefing
- Rightway Wellbeing Ltd – Wellbeing Champion Programme
- Rightway Wellbeing Ltd – Mental Health Supporters Training
- Rightway Wellbeing Ltd – Wellness Coaching
- Royal Liverpool and Broadgreen University Hospitals Trust – The Employment Passport
- Sleep Unlimited Ltd – The R.E.S.T. Programme
- South Tyneside NHS Foundation Trust – South Tyneside NHS Foundation Trust Wellbeing Team
- Teesside University – Festival of Wellbeing
- The British Dietetic Association – BDA Work Ready
- The Resilience Doughnut – The Resilience Doughnut
- University of Sunderland – Annual Wellbeing Action Plan and Events Calendar
- University of the West of England – Feel Good February
- University of the West of England – UWE Go
- University of the West of England – Feel Good Focus
- Vala - Vala
- Vehicle Certification Agency - Wellbeing room
- Westfield Health - Sleep Well, Work Well
- Work Care – WorkCare
- Yellow Brick Road Solutions Ltd - Lead Well

One organisation – Beat the Seat – was categorised as level 1 based on the available data at the time of writing, but has since been the subject of an RCT focusing on the intervention. This has not been reviewed in the course of this project. The RCT is available at:

- Maylor BD, Edwardson CL, Zakrzewski-Fruer JK, Champion RB, Bailey DP. Efficacy of a Multi-Component Intervention to Reduce Workplace Sitting Time in Office Workers: A Cluster Randomized Controlled Trial. *J Occup Environ Med*. 2018 May. .doi:10.1097/jom.0000000000001366. PMID: 29851741.

Given the scope and timescales of the research we were unable to approach all submitting organisations for further information. The research team considered there to be insufficient information in the submission to come to a proper judgement at the time on the appropriate representation for the following interventions. This should not be taken as a reflection on the level of evidence that may underpin these interventions. We have referenced these cases as 'requiring further information' (RFI):

- Alison Judah Consultant Osteopath – Osteopathic Ergonomic Assessments
- Atkins – Mindfulness
- B.Braun Medical – B.Healthy B.Braun
- BackCare – BackCare publications
- Bamboo Workplace Mental Health – The Bamboo Beehive and Employer Review
- Breaking the Silence – Breaking the Silence
- Club Soda – Mindful Drinking Movement – Sober Sprint and 8 weeks to Mindful Drinking
- Crystal Palace Physio Group – Lifestyle Management

- Discover Your Bounce For Business – Engage!
- Dixons Carphone – Ultimate Workforce
- EJH Consulting Ltd – Wellbeing Workshops
- Faculty of Sport and Exercise Medicine
- Future Lives Consulting and Coaching Ltd – Enhancing Wellbeing Through Mindfulness and Resilience
- Healthy Performance Ltd – Employee Wellbeing Programmes
- Healthywork Ltd – Ergonomic Assessments & Info
- Healthy Working Futures - unnamed submission
- HiMotiv – HiMotiv
- Humbleworks - Standing desks and laptop stands
- IntoAlignment – Stress to Strength Resilience Programme
- Justhealthchecks – Nutrition Advice
- Kings College Hospital NHS Foundation Trust – A Healthier Kings
- Larking Gowen – Total Wellbeing Programme
- Laughology – Menopause awareness
- Living Pain Free Ltd – Living Pain Free Workshops
- Medway Council – Medway Healthy Workplaces Programme
- Menopause Support – Understanding Menopause
- Metrostress – Stressbusters
- Passport to Wellbeing – Passport to Wellbeing
- RehabWorks – Mental Health and Wellbeing provision
- Rightway Wellbeing Ltd - Manage Well - Leadership skills for enhancing wellbeing
- Siemens Rail Automation – Mental Health Strategy
- SportAssure Cardiac Screening Ltd – Corporate cardiovascular screening
- Staywell Occupational Health – Know Your Numbers Medicals
- SuperWellness 3-month nutrition challenge
- The Well+ Group – Well+ Dynamics
- Thriving Workplaces – Thriving Workplaces
- Wellbeing People – Various interventions
- Work and Well-Being Ltd – Impact Analysis
- WorkingWell Ltd – Stress Risk
- Your Homes Newcastle - Support for officers with mental health

Appendix C: Methods

The study took place between September 2017 and January 2018.

Survey design

The project team designed a survey (see Appendix D) through which organisations could submit details of their interventions, including the opportunity to upload files to substantiate the detail provided about their evidence base. Employers and providers were directed to their respective branch of the survey after an initial routing question, in order to ensure that questions were relevant to each type of respondent.

Survey release and promotion

The survey was uploaded on the Smart Survey platform with an open link to allow providers and employers to submit details of their interventions. The survey was open for five weeks in September and October 2017, and promoted widely through email alerts, online articles and social media.

A communications campaign was undertaken to promote the survey. Regular tweets and social media posts were distributed by RAND Europe, and a dedicated RAND Europe website page was created, providing information about the survey. An article to promote the survey was placed in the Institute of Occupational Safety and Health magazine and an email alert was sent out to the conference mailing list of the Health at Work Conference. An alert was also disseminated amongst the personal networks of PHE, RAND Europe and the academic and expert review panel. Targeted searches within key topic areas selected by Public Health England were also performed to identify prominent, market-leading or innovative approaches, and direct invitations to participate sent to these organisations.

Incentives were offered to organisations in an attempt to maximise the number of submissions. The alert noted the opportunity to be selected as a case study, and feedback on the submission was offered to all submitting organisations. The alert stated that all submissions would be listed in the final report.

Sifting

Some 123 full interventions were submitted to the portal, following removal of dud entries and duplicates. Of these, two submissions were identified as not applicable (one was from Northern Ireland and one did not relate to workplace wellbeing). Two further submissions were directly related to another submission (for example, a workplace implementing an intervention that had been independently submitted) and were considered together. Ultimately 117 submissions were entered into the review by the project team.

During the initial sifting process, submissions were also coded as relating to one of 13 key topic areas (as outlined in Chapter 3), based on the initial key issue areas selected by Public Health England. Coding was based on the judgement of the researcher, and was judged on the stated aims and intent of the intervention form the survey response. In the case of multiple relevant categories (for example, a mental health intervention that also aimed to improve sleep quality), the primary outcome used in the process of collecting data was chosen.

Analysis and grading

All entries were reviewed by the project team in order to determine an initial categorisation against the Nesta levels. The Nesta Standards of Evidence (as discussed in Chapter 1 and depicted in Figure 4) provide a stepped hierarchy of evidence relating to the impact of the social intervention.

Figure 4. Nesta Standards of Evidence

Source: Puttick & Ludlow (2013).

Nesta's Standards of Evidence were originally developed to provide a benchmarking of evidence to guide Nesta's own investments in social interventions. As such, Nesta Standards are not intended to be an arbitrary measure of evidence, but should be considered 'dynamic and developmental':

> *The Standards of Evidence recognise the need to ensure that demand for evidence is appropriate for different stages of product or service development, that it doesn't hamper innovation, and that it is realistic and proportionate.* (Puttick & Ludlow 2013)

In this spirit, we adapted the Nesta Standards for the purposes of this study. The interventions under consideration are a heterogeneous set of interventions, covering a range of delivery modes (such as EAPs, software programmes and training courses). In developing criteria to map practices against the Nesta Standards, the study team sought both to consider what makes sense with reference to the specific

workplace wellbeing context, and to represent what is pragmatic in light of the study design and heterogeneous nature of the interventions. For this reason, judgement in categorising each intervention was exercised with reference to the type and nature of the intervention at hand:

Nesta level 1: '*You can give an account of impact. By this we mean providing a logical reason, or set of reasons, for why your intervention could have an impact and why that would be an improvement on the current situation.*'

Interpretation in this study: Practices categorised as **level 1** were those that can show at least an emerging commitment to data collection and thoughtful implementation, for example by providing a clear articulation of expected inputs and outputs or are in the process of external evaluation. These practices were:

- Submissions that provided a clear articulation of reason-inputs-expected outputs;
- Submissions that are collecting rudimentary data relating to intervention outcomes or impact, but not enough to reach level 2;
- Submissions that clearly detailed the background research or inputs that underpin the design of their intervention;
- Commitment to formal data collection, interpreted as initiatives currently in the process of being independently evaluated, even if no data are yet available

Although a large number of submissions indicated that they were collecting positive feedback from participants, submissions that collected only this data were not classed as level 1 due to concerns about the quality of such data.

Nesta level 2: '*You are gathering data that shows some change amongst those receiving using your intervention.*'

Interpretation in this study: Practices categorised as **level 2** were those that are collecting data which shows change amongst the users of their intervention.

The data must:

- Show *change* (i.e. pre-post data collection) or extensive collection of outcomes data (e.g. a comprehensive evaluation);
- Be of high quality;
- Be collected in a formal, systematic way;
- Comprise a sample of sufficient size, bearing in mind the size of the implementing organisation/reach;
- Relate specifically to outcomes relevant to the intervention (e.g. participation rates would not be adequate).

Nesta level 3: '*You can demonstrate that your intervention is causing the impact, by showing less impact amongst those who don't receive the product/service.*'

Interpretation in this study: Practices categorised as **level 3** were those that can demonstrate causality to show that their intervention is having the observed effect.

This may include:

- A control-group trial of sufficient sample size;

- A longitudinal study of sufficient sample size;

- A comprehensive qualitative evaluation with sufficient data collection regarding the relationship of inputs to outcomes.

Nesta level 4: '*You are able to explain why and how your intervention is having the impact you have observed and evidenced so far. An independent evaluation validates the impact. In addition, the intervention can deliver impact at a reasonable cost, suggesting that it could be replicated and purchased in multiple locations.*'

Interpretation in this study: Practices categorised as **level 4** were those that can demonstrate robust, independent collection of data which confirm causality by replicating results or providing a comprehensive account of the nature and reasons for the impact.

To be included in this category, practices must:

- Have data and processes relating to consistency; AND

- Have multiple evaluations which replicate results, of which at least one was conducted independently; OR

- Have a robust independent evaluation with sufficient data collection relating to outcomes in addition to investigation of the underlying causal mechanisms.

Nesta level 5: '*You can show that your intervention could be operated up by someone else, somewhere else and scaled up whilst continuing to have positive and direct impact on the outcome, and whilst remaining a financially viable proposition.*'

Interpretation in this study: Practices categorised as **level 5** were those that have shown themselves to be scalable, affordable, and with consistent outcomes in different implementation settings. This includes:

- Multiple independent evaluations that demonstrate a strong understanding of causal mechanisms through comprehensive qualitative evaluation or multiple control-group trials.

- Evaluations consider outcomes in different scenarios, including alternative populations, dosage, and in context of practical implementation.

- [If relevant] Evidence of long-term enduring impact.

No submissions were categorised as level 5 in this study.

We also developed a typology both to reflect the adapted standards and to simplify the categorisation for readers unfamiliar with evidence hierarchies (as depicted in Figure 5).

Figure 5. Nesta evidence standards in this study

Established evidence base
- **Level 5**: Has comprehensively confirmed nature and level of impact, including understanding of implementation in real-world context

Maturing evidence base
- **Level 3**: Can demonstrate causal nature of impact
- **Level 4**: Can verify nature of impact amongst at least one population group

Emerging evidence base
- **Level 1**: Can show basic data collection or understanding of pathways to impact
- **Level 2**: Can provide basic data which shows positive change on relevant outcomes

The submissions were reviewed against the standards outlined above by one researcher, and a sample reviewed by a second researcher for validation. Cases that were considered marginal (for example, those that met most but not all of the criteria for a particular level, or those for which categorisation was considered to depend on the quality of the study) were referred to the expert panel.

Given the scope and timescales of the research we were unable to approach all submitting organisations for further information. The research team considered there to be insufficient information in the submission to come to a proper judgement on the appropriate Nesta level for a subset of submissions. We referenced these cases as 'requiring further information' (RFI).

Expert panel

A sample of the submissions (including marginal cases) was also moderated by an expert panel. This panel was consulted during two teleconferences and over the course of a full moderation day, held in October 2017. Over the course of this full day, the panel reviewed a random sample of submissions from each Nesta level (including all level 3+ submissions received to date); selected and reviewed a 'wildcard' from each Nesta level; and reviewed all marginal cases received to date. Where the judgement of the panel differed from the categorisation of the research team, this was discussed in order to establish clear principles for categorisation, which were then applied to the wider set of interventions.

The panel members were:

- Professor Tarani Chandola, University of Manchester

- Professor Sara Connelly, University of East Anglia and What Works Wellbeing Centre
- Professor Kevin Daniels, University of East Anglia and What Works Wellbeing Centre
- Dr Joanna Crawford, Institute of Occupational Medicine
- Steve Bevan, Institute for Employment Studies
- Dr Steve Boorman, Empactis
- Shaun Subel, Vitality
- Dr Christian van Stolk, RAND Europe.

Any further marginal cases following the panel moderation meeting were circulated to the panel by email for comment.

Reporting

All submissions categorised as level 2 based on the data provided were written up as case studies. This was considered a reasonable number in light of the resources available for the study. The evidence level was presented on the basis of the data supplied in the submission. The websites of case study organisations were reviewed in order to identify any further information of relevance. Short topic summaries were also developed for each topic area in order to set the case studies in the policy context and signpost readers to additional resources or information of use.

Limitations

This study has a number of limitations. Firstly, the case studies are a self-selecting collection of practices, and do not provide a comprehensive, systematic overview of the health-at-work landscape. For this reason, while we consider our results to be illustrative of interesting trends and the use of data collection relating to health and wellbeing interventions in the workplace, the figures and data provided here should not necessarily be considered fully representative of the wider sector.

Secondly, our categorisation of practices has taken place against a study-specific interpretation of the Nesta Standards of Evidence (as outlined above). Submissions have not been subject to an in-depth assessment of impact or exploration of the Theory of Change.[235] The quality and extent of data and text provided by submitting organisations also varied. As a result, not all submissions were considered to have provided sufficient information for a categorisation decision to be made. Strong interventions may have been overlooked as a result.

Thirdly, in the process of developing the case studies, we have made use of data collected and evaluations conducted by third parties. These studies may be subject to their own limitations, which were considered during the review period. However, while such limitations have in part informed the categorisation of practices below, we urge interested readers to seek out the original source where possible in order to consider the full context within which the findings are presented.

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[235] A Theory of Change is a '*tool to help you describe the need you are trying to address, the changes you want to make (your outcomes), and what you plan to do (your activities). The approach can be used for organisations of all shapes and sizes—from service-delivery charities, to campaigning organisations, to funders. A theory of change is often represented in a diagram or chart, but a full theory of change process involves more than this. It should help you consider and articulate the assumptions and enablers that surround your work and explain why you think your activities will lead to the outcomes you want. It should also challenge you to develop clear aims and strategies and explore whether your plans are supported by evidence*' (Harries, Noble and Hodgson 2014).

Finally, in the same vein, many of the evidence sources provided by participating organisations for this project consist of self-reported data. There is a risk that some data may have been reported incorrectly, or that some negative results have been withheld. It was beyond the scope of this study to independently verify the results, nor verify whether additional unpublished data have been collected. Our conclusions should be considered in this light.

Appendix D: Survey

Are you:
- An employer offering health and/or wellbeing intervention(s)? / A provider or developer of health and/or wellbeing intervention(s)?

About your intervention [If organisation has indicated they are a provider]

Did your organisation develop this intervention/programme?
- Yes / No / Other (please specify)

What is the name of the intervention, practice or programme you offer?

Please describe your intervention.
- [Text box]

How would you describe the type of the intervention/programme you offer? Please select all that apply.
- Training course / Health Assessments/Screening / Workplace risk assessments / Task, job, team or work system redesign to promote health, safety or wellbeing / Communications/promotion support/campaigns / Other (please specify)

How long has the intervention/programme been available?
- It is still under development/being piloted / Less than 1 year / 1–2 years / 3–5 years / 6–9 years / 10 years +

Which area does your intervention/programme aim to address? Please select all that apply.
- Diet & nutrition / Weight Issues / Physical inactivity / Drug misuse / Alcohol misuse / Smoking / Common mental health issues / Musculoskeletal health / Stress / Sleep issues / Menopause / Domestic violence / Financial resilience / Line management / Other (please specify)

What is the aim of the intervention? Please select all that apply.
- To support sick or absent employees to remain in, or return to work / To improve employee health and/or wellbeing / To improve employee engagement / To reduce absenteeism and/or presenteeism / To meet regulatory requirements in health and wellbeing / To improve the capacity of organisations to understand staff health and wellbeing needs / To manage chronic or long term conditions / To improve employee productivity / Other (please specify)

How would you describe the core delivery approach of the intervention/programme? Please select all that apply.

- The intervention/programme is delivered through a digital platform (e.g. computer programme, app, email) / The intervention/programme is delivered through literature (e.g. leaflets, booklets) / The intervention/programme is delivered via the telephone / The intervention/programme is delivered face-to-face in a group setting / The intervention/programme is delivered face-to-face with individuals / Other (please specify)

Is the intervention/programme designed for workplace settings only?

- Yes / No, it is accessible by the wider public

Where else is the intervention/programme available?

- The intervention/programme is accessible through the NHS / Individuals can access the intervention/programme for free / Individuals can pay to access to intervention/programme directly / Other (please specify)

What size of organisation does the intervention/programme target?

- The intervention/programme can be implemented by organisations of all sizes / Small or micro organisations (1–49 employees) / Medium organisations (50–250 employees) / Large organisations (250+ employees)

Which staff groups is the intervention/programme aimed at? Please select all that apply.

- Whole workforce / Chief executives and top management/executive teams / Line managers / Non-management staff roles / Specific sub-populations of employees based on health or modifiable lifestyle needs (please specify) / Specific sub-populations of employees based on profile (e.g. women, BAME staff) (please specify) / Specific staff roles (please specify) / Other (please specify)

Where is your intervention/programme available? Please select all that apply.

- South West / Greater London / Scotland / West Midlands / North East / East Midlands / Wales / North West / South East / Northern Ireland / Yorkshire / Other non-UK countries (please specify)

How many people does the intervention/programme currently reach on an annual basis? If you do not know exact figures, please provide a rough estimate.

- Up to 24 / 25–99 / 100–249 / 250–499 / 500–999 / 1,000–4,999 / 5,000–9,999 / 10,000–24,999 / 25,000+ / Don't know

How many organisations currently implement this intervention? If you do not know exact figures, please provide a rough estimate.

- Up to 5 / 6–19 / 20–49 / 50–99 / 100–249 / 250–499 / 500+ / Don't know

Do you charge organisations or participants for the use or implementation of your intervention/programme?

- Yes, organisations pay a fee to access the intervention/programme / Yes, participants pay a fee to access the intervention/programme / Yes, both organisations and participants pay a fee / No, the intervention/programme is free / No, the intervention/programme is purchased or sponsored by an external body (e.g. government, charity, local commissioning bodies, etc.) / Other (please specify)

If applicable, please provide information about the costs to organisations or individuals for your intervention/programme here, or provide a link.

- [Text box]

Do you have measures in place to ensure that the intervention/programme can be accessed by diverse groups? For example, people of different ages, ethnicities, sexual orientation, staff grade, working patterns or persons with disabilities.

- Yes (please specify) / No / Not applicable

<u>Data and evidence</u>

Why do you believe the intervention/programme has a positive impact? Please select all that apply.

- The intervention/programme is based on existing academic research in the field / The intervention/programme has received some kind of formal accreditation from a recognised public health or wellbeing organisation / The intervention/programme has received some kind of formal accreditation from another body / The intervention/programme is based on a programmes which has been successfully implemented elsewhere / The intervention is based on advice from government or professional bodies (e.g. NHS, National Institute for Health and Care Excellence [NICE], Chartered Institute of Personnel and Development [CIPD]) / Data or feedback has been collected showing a positive impact of the intervention/programme / At least one internal evaluation has been conducted showing positive impact / At least one external evaluation (an evaluation conducted by an independent evaluator) has been conducted showing positive impact / Other (please specify)

Please provide further detail about the reasons why you think your intervention/programme has a positive impact: If you have indicated in the previous question that you have collected data on the impact of the intervention and/or conducted evaluations, you will be asked about this in the next section.

- [Text box]

<u>Data continued</u> [If organisation has indicated they collect data only]

Has your organisation measured the effectiveness of the intervention/programme based on the following criteria? Please select all that apply.

- Programme participation rates / Change in the number of sick days / Change in the incidence of cases identified by the intervention/programme (e.g. body weight overweight or obesity, blood pressure, blood glucose etc.) / Change in the number of cases of long-term sickness absence (more than two consecutive weeks) / Change in the number of cases of short-term absence (less than two consecutive weeks) / Change in the number of absences returning to work / Change in the proportion of annual staff turnover

What other types of data do you collect about the impact of the intervention/programme? Please select all that apply.

- Data about participant views of the programme (e.g. interviews, focus groups, surveys, feedback questionnaires) / Data about staff engagement with the intervention/programme (e.g. attendance) / Measures of staff emotional/mental wellbeing (e.g. levels of anxiety) / Measures of staff physical health (e.g. BMI, weight, conditions) / Measures of lifestyle or nutrition (e.g. healthy eating, level of exercise) / Measures of staff engagement with the wider workplace setting / Measures of productivity / Absence statistics / Other (please specify)

If you have answered yes to any of the above, please provide the data you have collected or provide a summary of the findings: Please specify how you measured or captured the data, the outcomes under examination, and the impact recorded.

- [Text box]

If you would like to upload a file, please do so here.
- [Option to upload file]

Do you measure the changes or progression in participant's lifestyle or behaviour as a result of the programme (i.e. goal setting and achievement, changes after training, changes from a benchmarked measurement)? Please specify how you measure this.
- [Text box]

Have you measured whether the impact of the programme varies across different groups? For example, whether programme access or outcomes vary across people of different gender, age, disability, race/ethnicity, religion, sexual orientation, staff grade or seniority, or working patterns.
- Yes / No

If possible, please provide the data you have collected on access or uptake across different groups, or provide a summary of the findings.
- [Text box]

Is there any other information you would like to provide about how you capture and manage evidence and data about the intervention?
- [Text box]

Plans for evaluation [If organisation has indicated they have not evaluated the practice]

Does your organisation have plans to conduct or commission a formal evaluation? An evaluation is a structured assessment of the impact or implementation of an intervention/programme against set criteria, such as participant outcomes or economic return. An evaluation can be conducted by the implementing organisation (internal evaluation) or by an independent organisation (external evaluation).
- No / Yes, an evaluation is planned [Please provide details] / Yes, an evaluation is under way [Please provide details]

Evaluation [If organisation has indicated they have evaluated the practice]

An evaluation is a structured assessment of the impact or implementation of an intervention/programme against set criteria, such as participant outcomes or economic return.

An internal evaluation is defined as an evaluation conducted by your own organisation or by your own staff. An external evaluation is an evaluation conducted by independent evaluators who are not directly employed (but could be commissioned) by your organisation.

How many evaluations have been conducted of this intervention/programme?
- 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10

You will be asked about each evaluation separately on the following pages.

Evaluation 1 [This section recurs for each evaluation indicated in previous question]

How was the evaluation conducted?
- Internally / Externally / Other (please specify)

Did the evaluation involve a control group?
- Yes / No / Unsure/Don't know

Please provide a link or reference details for the evaluation.
- [Text box]

If you would like to upload files, please do so here.
- [Option to upload file]

Replication and consistency

We are interested in how easy it is to implement your intervention/programme in different settings. Please indicate which of the following apply to your intervention/programme:
- The intervention/programme is a standard format (e.g. a website): Yes / No
- Manuals and guidance are available for organisations to implement in different settings: Yes / No
- The intervention/programme is delivered by a person external to the implementing organisation: Yes / No
- The intervention/programme is provided by someone employed by the implementing organisation who has been trained to deliver it (e.g. 'train the trainer approach'): Yes / No
- The intervention/programme was developed or tailored for a particular setting: Yes / No

Do staff implementing the intervention/programme require formal qualifications, accreditation or training?
- No / Yes (please specify)

Please specify any other methods which you use to support consistency and implementation across different settings (i.e. trained teams to deliver, licensing agreements, CPD for staff, exclusive venues for delivery etc.).
- [Text box]

Have you ever measured the return on investment (ROI) of your intervention/programmes?
- Yes / No / Unsure/Don't know

How do you measure the rate of return on investment? Please select all that apply, and please specify the values if selected.
- We measure this in GBP (£) gained per GBP (£) spent / We measure this through other factors such as reduced absenteeism, productivity, engagement etc. / Other (please specify)

If there is any other information you would like to share with us, please provide it below.
- [Text box]

About your intervention [If organisation has indicated they are an employer]

What is the size of your organisation?
- Micro organisation (1–9 employees) / Small organisation (10–49 employees) / Medium organisation (50–250 employees) / Large organisation (250+ employees)

Please specify your industry or sector.

- [Text box]

Which of the below best describes your organisation?

- Commercial organisation / Non-profit charity / Non-profit social enterprise / Statutory public sector organisation / Other (please specify)

What is the name of the intervention, practice or programme you offer?

- [Text box]

Please use the box below to describe your intervention.

- [Text box]

Did your organisation develop this intervention/programme?

- Yes / No

If no, please provide the name of the organisation which developed or provides this intervention/programme.

- [Text box]

How would you describe the type of the intervention/programme you offer? Please select all that apply.

- Training course / Health Assessments/Screening / Workplace risk assessments / Task, job, team or work system redesign to promote health, safety or wellbeing / Communications/promotion support/campaigns / Other (please specify)

How long has the intervention/programme been available?

- It is still under development/being piloted / Less than 1 year / 1–2 years / 3–5 years / 6–9 years / 10 years +

Which area does your intervention/programme aim to address? Please select all that apply.

- Diet & nutrition / Weight Issues / Physical inactivity / Drug misuse / Alcohol misuse / Smoking / Common mental health issues / Musculoskeletal health / Stress / Sleep issues / Menopause / Domestic violence / Financial resilience / Line management / Other (please specify)

What is the aim of the intervention? Please select all that apply.

- To improve employee productivity / To reduce absenteeism and/or presenteeism / To support sick or absent employees to remain in, or return to work / To improve the capacity of organisations to understand staff health and wellbeing needs / To improve employee engagement / To improve employee health and/or wellbeing / To meet regulatory requirements in health and wellbeing / To manage chronic or long term conditions / Other (please specify)

How would you describe the core delivery approach of the intervention/programme? Please select all that apply.

- The intervention/programme is delivered through a digital platform (e.g. computer programme, app, email) / The intervention/programme is delivered through literature (e.g. leaflets, booklets) / The intervention/programme is delivered via the telephone / The intervention/programme is delivered face-to-face in a group setting / The intervention/programme is delivered face-to-face with individuals / Other (please specify)

Which staff groups is the intervention/programme aimed at? Please select all that apply.

- Whole workforce / Chief executives and top management/executive teams / Line managers / Non-management staff roles / Specific sub-populations of employees based on health or modifiable lifestyle needs (please specify) / Specific sub-populations of employees based on profile (e.g. women, BAME staff) (please specify) / Specific staff roles (please specify) / Other (please specify)

Is the intervention/programme part of a wider offer of staff wellbeing initiatives and benefits?

- Yes / No

Do you provide this intervention/programme across all of your organisation sites or at a single site?

- The organisation operates only at one site / Single site / Multiple sites (including across a supply chain) / Other (please specify)

How do you ensure that the intervention is delivered in a consistent way across different sites? Please select all that apply.

- The intervention is a standard format (e.g. a website) / Manuals and guidance are available for different sites to implement the intervention / The intervention is delivered by a person external to my organisation / The intervention is provided by someone employed by my organisation who has been trained to deliver it (e.g. 'train the trainer approach') / The intervention is not delivered in a consistent way across different sites / Other (please specify)

Could the intervention/programme be easily implemented in another organisation? Please select all that apply.

- Yes, it could easily be replicated in another setting / No, the intervention is specifically designed for my organisation / Other (please specify)

Please specify any other methods which you use to support consistency and implementation across different settings (i.e. trained teams to deliver, licensing agreements, CPD for staff, exclusive venues for delivery etc.).

- [Text box]

Please indicate your current level of annual spend for the intervention/programme:

- Prefer not to answer / Don't know / GBP: [text box]

Please indicate the approximate amount of set-up cost for the intervention/programme (e.g. capital expenditure, equipment purchase/hire etc.):

- Prefer not to answer / Don't know / GBP: [text box]

Please indicate the approximate amount of staff cost for the intervention/programme in the last 12 months (e.g. downtime cost for staff to participate in the programme, internal costs for staff allocated time to administer/deliver the programme, training cost etc.):

- Prefer not to answer / Don't know / GBP: [text box]

Please indicate the approximate amount of non-staff recurring cost for the intervention/programme in the last 12 months (e.g. upgrade costs, expenses for external intervention/programme facilitators and consultants, miscellaneous cost, travel cost etc.):

- Prefer not to answer / Don't know / GBP: [text box]

Do you have measures in place to ensure that the intervention/programme can be accessed by diverse groups? For example, people of different ages, ethnicities, sexual orientation, staff grade, working patterns or persons with disabilities.

- Yes (please specify) / No / Not applicable

Data and evidence

Why do you believe the intervention/programme has a positive impact? Please select all that apply.

- The intervention/programme is based on existing academic research in the field / The intervention/programme has received some kind of formal accreditation from a recognised public health or wellbeing organisation / The intervention/programme has received some kind of formal accreditation from another body / The intervention/programme is based on a programmes which has been successfully implemented elsewhere / The intervention is based on advice from government or professional bodies (e.g. NHS, National Institute for Health and Care Excellence [NICE], Chartered Institute of Personnel and Development [CIPD]) / Data or feedback has been collected showing a positive impact of the intervention/programme / At least one internal evaluation has been conducted showing positive impact / At least one external evaluation (an evaluation conducted by an independent evaluator) has been conducted showing positive impact / Other (please specify)

Please provide further detail about the reasons why you think your intervention/programme has a positive impact: If you have indicated in the previous question that you have collected data on the impact of the intervention and/or conducted evaluations, you will be asked about this in the next section.

- [Text box]

Plans for evaluation [If organisation has indicated they have not evaluated the practice]

Does your organisation have plans to conduct or commission a formal evaluation? An evaluation is a structured assessment of the impact or implementation of an intervention/programme against set criteria, such as participant outcomes or economic return. An evaluation can be conducted by the implementing organisation (internal evaluation) or by an independent organisation (external evaluation).

- No / Yes, an evaluation is planned [Please provide details] / Yes, an evaluation is under way [Please provide details]

Data continued [If organisation has indicated they collect data only]

Has your organisation measured the effectiveness of the intervention/programme based on the following criteria? Please select all that apply.

- Programme participation rates / Change in the number of sick days / Change in the incidence of cases identified by the intervention/programme (e.g. body weight overweight or obesity, blood pressure, blood glucose etc.) / Change in the number of cases of long-termsickness absence (more than two consecutive weeks) / Change in the number of cases of short-term absence (less than two consecutive weeks) / Change in the number of absences returning to work / Change in the proportion of annual staff turnover

What other types of data do you collect about the impact of the intervention/programme? Please select all that apply.

- Data about participant views of the programme (e.g. interviews, focus groups, surveys, feedback questionnaires) / Data about staff engagement with the intervention/programme (e.g. attendance) / Measures of staff emotional/mental wellbeing (e.g. levels of anxiety) / Measures of staff physical health (e.g. BMI, weight, conditions) / Measures of lifestyle or nutrition (e.g. healthy eating, level of exercise) / Measures of staff engagement with the wider workplace setting / Measures of productivity / Absence statistics / Other (please specify)

If you have answered yes to any of the above, please provide the data you have collected or provide a summary of the findings.
Please specify how you measured or captured the data, the outcomes under examination, and the impact recorded.

- [Text box]

If you would like to upload a file, please do so here.

- [Option to upload file]

Do you measure the changes or progression in participant's lifestyle or behaviour as a result of the programme (i.e. goal setting and achievement, changes after training, changes from a benchmarked measurement)? Please specify how you measure this.

- [Text box]

Have you measured whether the impact of the programme varies across different groups? For example, whether programme access or outcomes vary across people of different gender, age, disability, race/ethnicity, religion, sexual orientation, staff grade or seniority, or working patterns.

- Yes / No

If possible, please provide the data you have collected on access or uptake across different groups, or provide a summary of the findings.

- [Text box]

Is there any other information you would like to provide about how you capture and manage evidence and data about the intervention?

- [Text box]

Evaluation [If organisation has indicated they have evaluated the practice]

An evaluation is a structured assessment of the impact or implementation of an intervention/programme against set criteria, such as participant outcomes or economic return.

An internal evaluation is defined as an evaluation conducted by your own organisation or by your own staff. An external evaluation is an evaluation conducted by independent evaluators who are not directly employed (but could be commissioned) by your organisation.

How many evaluations have been conducted of this intervention/programme?

- 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10

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You will be asked about each evaluation separately on the following pages.

<u>Evaluation 1</u> [This section recurs for each evaluation indicated in previous question]

How was the evaluation conducted?
- Internally / Externally / Other (please specify)

Did the evaluation involve a control group?
- Yes / No / Unsure/Don't know

Please provide a link or reference details for the evaluation.
- [Text box]

If you would like to upload files, please do so here.
- [Option to upload file]

Do staff implementing the intervention/programme require formal qualifications, accreditation or training?
- No / Yes (Please provide details)

Have you ever measured the return on investment (ROI) of your intervention/programme?
- Yes / No / Don't know

<u>ROI continued</u>

How do you measure the rate of return on investment? Please select all that apply, and please specify the values if selected.
- We measure this in GBP (£) gained per GBP (£) spent / We measure this through other factors such as reduced absenteeism, productivity, engagement etc. / Other (please specify)

Please specify the values.
- [Text box]

If there is any other information you would like to share with us, please provide it below.
- [Text box]

Appendix E: Conflict of interest declarations

RAND Europe operated conflict of interest protocols as part of this project. All assessors and expert review panel members declared conflicts of interests at the outset and at further touchpoints across the project. Membership groups for final scoring or moderation were managed accordingly, opting out members from certain parts of the process where relevant.