

Workplace health interventions and accreditation schemes

A rapid evidence review and global mapping exercise

The Work Foundation



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Through its rigorous research programmes targeting organisations, cities, regions and economies, now and for future trends; The Work Foundation is a leading provider of analysis, evaluation, policy advice and know-how in the UK and beyond.

The Work Foundation addresses the fundamental question of what Good Work means: this is a complex and evolving concept. Good Work for all by necessity encapsulates the importance of productivity and skills needs, the consequences of technological innovation, and of good working practices. The impact of local economic development, of potential disrupters to work from wider-economic governmental and societal pressures, as well as the business-needs of different types of organisations can all influence our understanding of what makes work good. Central to the concept of Good Work is how these and other factors impact on the well-being of the individual whether in employment or seeking to enter the workforce.

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Executive summary

Public Health England (PHE) commissioned the Work Foundation to review employer-led action to improve employee health and wellbeing, including mapping of global workplace charter schemes and the views of employers on public health workplace health offers. The evidence could be used to potentially inform decisions on whether to develop new and safe healthy workplace standards.

The study

The research was carried out in three interdependent stages:

1. Review evidence of employer-led action to improve employee health and wellbeing
2. Map global workplace charter/accreditation schemes
3. Explore employers' views on public health workplace health offers, specifically local accreditation schemes

To meet the first and second aim, we carried out a rapid evidence review. Evidence of employer-led action was sought, primarily, from existing systematic reviews and meta-analyses in the published academic and 'grey' literature. The mapping exercise identified schemes from these sources as well as individual studies and insights gained from members of PHE's Health and Work Advisory Board. The third, and final, aim was met through qualitative research involving a roundtable with 10 employers.

Findings

Employer-led action to improve employee health and wellbeing

The rapid evidence review found 100 eligible studies (i.e. systematic reviews or meta-analyses), revealing a wide range of workplace-based interventions designed to improve employee health and wellbeing. Primarily, interventions are concerned with addressing specific health conditions, e.g. obesity, musculoskeletal (MSK) conditions and mental health problems.

A significant minority look at health behaviours, e.g. smoking, alcohol consumption, and physical inactivity. In all cases interventions aim to reduce employees' exposure to such lifestyle factors, often through counselling or medical interventions, e.g. screening or pharmacological treatment. Such interventions are rarely effective unless the recipient is either personally motivated or incentivised to make a change. This contrasts with the relative success of approaches to reducing, for example, MSK conditions through mechanical interventions, which require little motivation on the recipient's part.

Some interventions, rather than focus on a specific condition or behaviour, simply look at ways to reduce absenteeism and presenteeism. Such interventions typically comprise a range of approaches, e.g. health risk screening, supervised exercise programmes, wellbeing initiatives, etc.

A further category focuses on 'general' health and wellbeing (i.e. they take a holistic – rather than biomedical – approach to employee health). These tend to focus on improving the psychosocial quality of work and report positive findings.

Findings from several reviews suggest that co-produced interventions (i.e. with input from both the employee and the employer and, if applicable, a relevant health practitioner) can be more effective. Buy-in from senior management is also important. Furthermore, interventions seeking to modify both the employee's behaviour and the work environment tend to be more effective and more likely to achieve sustained change.

No individual intervention emerges as the 'gold standard' and there is no 'one-size-fits-all' approach applicable all 'occupational settings', e.g. to both small and large organisations operating in different sectors and to workers of varying socioeconomic status. This is partly due to the fact that businesses' needs depend to a large extent on their size and their sector, but also because there is a lack of data on small organisations and 'blue-collar' sectors, and low income workers in particular. More generally – across all the areas we reviewed – there are too few well-reported, high quality intervention studies that describe, in sufficient detail, the nature of the intervention and its effect – and whether effects are sustained long term. Reviews reporting positive effects are typically accompanied by caveats alerting the reader to either the lack of available studies or their relatively poor quality.

While the evidence review we carried out is subject to some limitations (outlined in the main report), our findings suggest there is a need for more research in this area. It would, therefore, be difficult for PHE to make recommendations via a standard based on the evidence available.

Global workplace charter/accreditation schemes

The global mapping exercise identified 17 charters/schemes through secondary and primary research. For each we collected a range of information, including: the provider, primary health focus, scheme 'type', common components, schemes' evidential basis, evidence of impact, engagement levels, etc.

Most schemes are provided by government (i.e. national, devolved or local). UK central government schemes are typically owned and provided by non-department public bodies, have national coverage and are well-established. A significant number of schemes provided at the regional level (often by local authorities) have been established more recently.

The majority have a 'general' health focus, which encompasses a wide range of employee health and wellbeing issues. Several schemes have a more specific focus, often mental health (particularly more recent schemes e.g. from the mental health charity Mind) health and safety (e.g. the well-established Management Standards from Health and Safety Executive or the International Labour Organisation's international standards). We also found schemes with a broader focus, which have an indirect impact on employee wellbeing, including the standards from Investors in People and Disability Confident.

The type of scheme we identified also varied. Most can be described as 'conventional' in that they comprise a set of standards, assessment process, award process and an award. However, several only comprise a set of standards (without an award), while others are primarily benchmarking tools.

Regarding common elements – many are shared by the identified schemes. The most common element was 'best practice and idea sharing', enabling organisations to adopt and adapt best practice from other, comparable (i.e. of a similar size or sector) organisations. The second most common was 'tailored reports/feedback'. Tailored reports are particularly useful

as they allow organisations to see what they are doing well and where investment needs to be prioritised. Also, they demonstrate that the business is at least committed to doing 'something' about employee health and wellbeing, which may have reputational benefits. 'Awards' (e.g. award ceremonies) was the third most common. This acts as an incentive for organisations to undertake the accreditation process, potentially offering reputational benefits.

Most schemes use evidence on the 'general' benefits and costs of employee health and wellbeing as their evidential basis. However, a smaller number use more specific evidence (e.g. the Health and Safety Executive's Management Standards drawing on evidence about the impact of the psychosocial work environment on health) or cite specific public health guidance from the National Institute for Health and Care Excellence (e.g. Cornwall's Healthy Workplace Programme).

In general, the number of evaluations and the quality of evidence regarding the effectiveness of identified schemes is poor, with the majority being 'average' and 'lacking'. Where it is available (e.g. for larger schemes such as the standards from Investors in People and a US scheme: Total Worker Health), the evidence suggests they do have a positive impact. For the vast majority, however, we only have either a very small number of formal evaluations to rely on or evidence/case studies compiled by the scheme providers themselves (which are not necessarily reliable and could be biased).

Finally, levels of take-up appear to be generally quite low. Available evidence suggests that schemes typically cover (at most) 1 per cent of businesses in the area they are active in (e.g. national or regional). In addition, the average take-up for all schemes is fewer than 2,000. As one would expect, it is higher for national schemes (1,103) than it is for regional ones (323).

Employers' views on public health workplace health offers

We conducted a roundtable comprising 10 employers employing between 14 and 1,500 people (based in Cornwall in South West England). We then asked six questions, covering employers' awareness of public health workplace health schemes, their engagement with and wider perception of them.

The participants are highly engaged with the local public health workplace health offer (the Cornwall Healthy Workplace Programme). The frequent updates, emails and bulletins were highly valued and singled out for praise, as well as the regular events and opportunities to network with other businesses. It is unclear whether this is representative of all organisations in the region or indeed the UK in general. Given how well funded the Cornwall scheme is, it may not be representative of engagement levels across the UK.

An attractive feature of the Cornwall scheme is its flexibility. Participating organisations are not over-burdened by bureaucracy (as may be the case with other schemes we identified) enabling organisations to shape it to their particular needs. Onsite training was another popular feature. Whether a less well-funded scheme could provide such a service is unlikely.

In general, participants considered PHE a trustworthy provider of reliable information and an authority on workplace health. Furthermore, the majority of participants valued a workplace health needs assessment, but one thought it can act as a deterrent to some – particularly small – businesses if it is required by a scheme.

Overall, this stage of the research offered useful insights into what makes for an effective workplace health offer, including: regular updates, bulletins, events, award ceremonies, information and idea sharing, relevant training, onsite training, flexible/adaptable standards, senior management buy-in, a workplace health needs assessment (in some cases). However, much of this is dependent on whether the scheme is well funded and the resources it can draw on. The Cornwall scheme is particularly well funded and well established, having been in operation for more than 10 years, with three dedicated part time staff. Whether this could be replicated nationwide across other regions is not clear.

Conclusions and recommendations

Although subject to a number of limitations (outlined in the main report) our findings suggest that the potential development of any new national public health workplace health standards would be faced with a number of challenges. Perhaps most importantly, participation rates are low (even for well-resourced schemes like Cornwall's) given the size of the target populations. There are also question marks around the effectiveness of schemes (due to a lack of evaluations) and – more broadly – workplace health interventions in general (due to a need for more robust evaluations with organisations of different sizes and sectors, etc.). Furthermore, while a workplace health needs assessment has value – helping businesses prioritise areas for investment – insistence on it can deter organisations. An additional problem is that, having completed one, the next steps are not necessarily obvious given the lack of high quality robust studies on what interventions are effective.

Schemes that have a comprehensive set of general health and wellbeing standards that must be rigidly adhered to – Investors in People for example has 39 that all organisations must meet – can be perceived as overly bureaucratic and may have limited appeal – particularly amongst small organisations. Businesses may also question the value of trying to meet extensive criteria if it is based on primarily 'general' evidence of the health and wellbeing benefits of investing in workplace health (which the majority of schemes are). A relatively vague payoff on an uncertain timescale may not be appealing.

It is also difficult to develop an inclusive set of standards that are relevant and appeal to a range of businesses varying in size, sector, workforce type, industry, etc. (which will probably have different needs as a result of these differences). A 'catch-all' scheme runs the risk of being too 'high-level', general, abstract, and therefore potentially not particularly relevant to any organisation. On the other hand, a scheme that is very specific and targeted at a certain organisation/population type will have more limited appeal. It is difficult to strike a balance between universality and specificity. The Healthy Working Wales scheme has attempted to deal with this issue by having a different set of standards for different sized organisations. It is clear that, given these difficulties, a 'menu' of interventions that participating organisations can choose from may be preferable to long list of requirements – standards – that all organisations must comply with.

The overall aim of this research was to help inform a decision on whether to develop new national public health workplace health standards, i.e. whether they are valued and make a difference. Our qualitative work suggests that, if executed properly, with adequate funding and resource, they are valued. However, the low level of take-up for schemes in general raises question marks over how much businesses value them. Furthermore, the lack of evidence and evaluations regarding their effectiveness makes it difficult to determine how much of a positive

difference they actually make. An additional problem is the lack of robust evaluations on workplace health interventions in general. While the limitations of this research must be kept in mind, our findings suggest it might be difficult for PHE to make recommendations via a standard based on the available evidence.

PHE could therefore concentrate on developing 'commissioning guidance'. This could enable/help local authorities design their own accreditation schemes that cater to their local businesses' needs. Our (albeit limited, qualitative) evidence suggests employers consider PHE a reliable and trustworthy authority on this topic. PHE might therefore choose to focus on being a repository for best practice and knowledge that local authorities can draw on in order to develop their own offers.

Furthermore, there is a role for further research to play. A more ambitious systematic review, perhaps focused on a specific health topic, could address the limitations of the rapid evidence review presented here. In addition, there appears to be a need for more robust research – e.g. an impact assessment – of employer standards on their effects on participating organisations and their employees.

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1. Introduction

1.1. Research purpose

Public Health England (PHE) has commissioned the Work Foundation to conduct a review of employer-led action to improve employee health and wellbeing, including mapping of global workplace charter schemes and the views of employers on public health workplace health offers, specifically local accreditation schemes. The evidence could be used to potentially inform decisions on whether to develop new and safe healthy workplace standards.

1.2. Research aims and methods

The research was carried out in three interdependent stages; each stage has its own individual aim:

1. Review evidence of employer-led action to improve employee health and wellbeing
2. Map global workplace charter/accreditation schemes
3. Explore employers' views on public health workplace health offers, specifically local accreditation schemes

To meet the first and second aim, we carried out a rapid evidence review. Evidence of employer-led action was sought, primarily, from existing systematic reviews and meta-analyses in the published academic and 'grey' literature. The mapping exercise identified schemes from these sources as well as individual studies and insights gained from members of PHE's Health and Work Advisory Board. The third, and final, aim was met through qualitative research involving a roundtable with 10 employers.

Further information is provided in the following chapter.

1.3. This report

The structure of the report is as follows:

- **Chapter Two** gives an overview of the methods used in this research;
- **Chapter Three** outlines findings from the rapid evidence review of employer-led action to improve employee health and wellbeing;
- **Chapter Four** presents the findings from the global mapping of charter/accreditation schemes;
- **Chapter Five** reports on the employer roundtable, which involved 10 businesses employing between 14 and 1,500 people in South West England; and
- **Chapter Six** provides concluding comments and recommendations based on the evidence.

2. Methodology

In this chapter we give an overview of the methods used in this research. We combined secondary, desk-based methods with primary, qualitative research.

2.1. Stage One

The first aim – and stage – of the research was to:

1. Review evidence of employer-led action to improve employee health and wellbeing

To meet this aim, we carried out a rapid evidence review. We conducted a 10-year, retrospective analysis of reviews on interventions designed to improve employee health and wellbeing and their effectiveness. The search strategy was based on similar existing reviews^{1,2}. The following electronic databases, covering a range of fields and disciplines relevant to employee health and wellbeing, were searched:

- Scopus: the largest abstract and citation database of peer-reviewed literature;
- PubMed, which indexes citations from MEDLINE, PreMEDLINE, and other journals in the field of medicine and life sciences;
- Web of Science, which indexes most science journals;
- The Cochrane Database of Systematic Reviews; and
- The Health and Safety Executive's 'Research Report Series'.

For an inventory of search terms used, please see Appendix 1.

In addition to the above sources, 'grey' literature was searched, mainly through the Internet using Google and Google Scholar search engines. Sources included academic institutions, public sector organisations, workplace health partnerships, research companies, workplace health companies, and company websites. The search involved use of the main term 'workplace health and wellbeing', cross-referenced with a number of related terms outlined in Appendix 1.

2.1.1. Eligibility criteria

For reasons of expediency and efficiency³, the rapid evidence review focused only on existing systematic and meta-analytic reviews. Meta-analyses are useful because they (i) include a consolidated and quantitative review of a large, often complex, body of literature, and (ii) provide a more precise estimate of the effect of treatment or risk factor for disease, or other outcomes, than any individual study contributing to the pooled analysis⁴. Similarly, systematic

¹ Hill, D., Lucy, D., Tyres, C. & James, L. (2007). What works at work? Retrieved 28 March, 2018 from https://www.virk.is/static/files/7_What%20works.pdf

² Cavill, N., Coffey, M., Parker, M. & Dugdill, L. (2014). Best Practice in Promoting Employee Health and Wellbeing in the City of London. Retrieved from <https://www.cityoflondon.gov.uk/business/economic-research-and-information/research-publications/Documents/research-2014/employee-health-and-wellbeing-in-the-city-of-London-final.pdf>

³ Owing to the constrained nature of the timeline and budget for this project

⁴ Haidich, A. B. (2010). Meta-analysis in medical research. *Hippokratia*, 14(Suppl 1), 29–37. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3049418&tool=pmcentrez&rendertype=abstract>

reviews allow the reader to account for a range of findings from research on a particular topic, and whether they are generalisable across different populations and settings⁵ However, they are both subject to limitations: for example, the summaries of the literature they provide are only as reliable as the methods used to estimate the effect by the studies they comprise, i.e. problems inherent in the individual study designs are not necessarily overcome by the systematic or meta-analytic review⁶.

Additional criteria included:

- published in English;
- published in the last ten years;
- comprised a literature review of relevant health and wellbeing studies; and
- evaluated by individuals independent of the employer.

Furthermore, we did not limit the review to a particular study design (e.g. randomised controlled trials) – all types of employee health and wellbeing intervention were potentially included.

2.2. Stage Two

Having conducted the rapid evidence review, the second aim, and stage, was to:

2. Map global workplace charter/accreditation schemes

To map workplace accreditation schemes, we reviewed the existing academic and grey literature, using the sources mentioned above, but with additional search terms (provided in Appendix 1). Schemes brought to our attention by PHE's Health and Work Advisory Board were also considered.

We prioritised schemes with a direct health focus, e.g. those covering 'general health and wellbeing' or specific health conditions. We also included schemes with a broader, more 'holistic' focus, covering aspects of the work environment that have the potential to impact on and influence employees' mood, feelings and ultimately their wellbeing. This included schemes that promote diversity and inclusion, for example.

At the very least, schemes included in the mapping exercise either required or encouraged employers to meet, or work towards, a set of criteria designed to positively impact on employees' health and wellbeing in some way. The more comprehensive schemes comprised a set of standards, an assessment process, an award process and award.

Furthermore, the mapping exercise considered examples from within and outside the UK, as well as schemes with international, national and regional coverage (i.e. 'global').

2.3. Stage Three

The third and final stage of the project used qualitative methods, aiming to:

⁵ Garg, A. X., Hackam, D., & Tonelli, M. (2008). Systematic review and meta-analysis: When one study is just not enough. *Clinical Journal of the American Society of Nephrology*.

⁶ Ibid.

3. Explore employers' views on public health workplace health offers, specifically local accreditation schemes

Unlike the previous stages this involved primary research. We selected Cornwall in the South West. The local authority has been running the well-funded Healthy Workplace Programme for over 10 years with relatively high levels of engagement. We therefore expected participants to be fairly knowledgeable about the subject at hand, and, as such, able to provide rich qualitative data.

We conducted a roundtable comprising 10 employers employing between 14 and 1,500 people. We then asked six questions, covering employers' awareness of public health workplace health schemes, their engagement with and wider perception of them. The list of questions asked are available in the Appendix 1.

Responses were sought from all employers to each question before moving onto the next. This helped mitigate a risk associated with focus groups whereby the discussion is dominated by one or two participants.

Although the sample, due to its qualitative nature, cannot be considered representative of employers' views generally – or even those in Cornwall specifically – we deliberately selected cases with 'maximum variation'⁷ (i.e. employers of different sizes) to help ensure we had a range of views.

⁷ Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Administration and Policy in Mental Health*, 42(5), 533–44.

3. Employer-led action to improve employee health and wellbeing

Key reflections

- Generally speaking, interventions to improve employee health and wellbeing are more effective when they are 'co-produced', i.e. designed by the employee working with the employer and, if applicable, a relevant health practitioner.
- As well as employee input into the design of an effective intervention, senior management buy-in – or more importantly perceived authentic management buy-in – is essential.
- Multi-faceted interventions that are directed at both the individual employee and the employer – or the work environment – tend to be more effective. Interventions solely focused on the individual imply the fault lies with the employee – not the organisation or the environment. Sustained improvement is more likely when interventions address individual and organisation-wide factors, e.g. improving employees' control over their work alongside complementary changes in company policy (i.e. holistic).
- There is no individual intervention that emerges as the 'gold standard' for improving employee health and wellbeing. There is limited evidence available to support the establishment of evidence-based guidelines applicable to a number of industrial sectors – i.e. there is no 'one-size-fits-all' approach.
- There is a lack of well-reported, high quality intervention studies that describe, in sufficient detail, the nature of the intervention and its effect – and whether they are sustained long term.
- There is a lack of evidence from studies involving smaller sized organisations operating in 'blue-collar' (i.e. manual labour) sectors and low income workers.
- Interventions designed to reduce tobacco and alcohol consumption, and increase physical activity/reduce weight, are rarely effective unless the individual is personally motivated or incentivised to do so.

3.1. Introduction

The aim of this stage of the research was to review the existing evidence of employer-led action to improve employee health and wellbeing. In addition, it set out to answer the following research questions:

- What health conditions do interventions typically address?
- Are there any identifiable common elements which make it more likely that an intervention will succeed?
- Is there a 'gold standard'?

In the following section we outline the evidence review's findings, followed by some concluding comments.

3.2. Findings

The rapid evidence review found 100 eligible studies (i.e. systematic reviews or meta-analyses of workplace-based employee health and wellbeing interventions)⁸. They varied according to the type of intervention used and the outcome variable studied. Generally speaking, the intervention type is informed by what it is trying to change. For example, interventions designed to address excess weight and obesity often seek to change employee behaviour by either improving diet, or by promoting physical activity through education and counselling. Interventions designed to improve the psychosocial work environment, however, focus on improving employees' 'quality' of work (i.e. give them more control over their work or flexibility at work).

The review's findings are described below, divided into sections according to the outcome variable studied. This includes reviews of interventions on weight loss, cardiovascular disease, musculoskeletal conditions, smoking, mental health, absenteeism and presenteeism, alcohol, and, finally, general health and wellbeing. This is followed by a section on what makes for a successful intervention. Then, we offer concluding comments, as well as the limitations of this part of the research.

3.2.1. Weight loss

A relatively large number of studies (16) reviewed interventions that aimed to address excess weight and obesity. Primarily, they used nutrition- or diet-based interventions. For example, Allan et al.⁹ found, from 22 studies, that more than half (13) reported significant changes in primary measures of eating behaviour (i.e. increased fruit/veg consumption, increased sales of healthy options and reduction in calories purchased). However, only one study produced a small significant improvement in weight/body mass index. These studies sought to change employee behaviour through environmental – 'choice-architecture' – interventions which change properties or contents of the environment.

A smaller – though still relatively large – number of studies focused on physical activity interventions to address overweight and obesity. Benedict & Arterburn¹⁰ identified 11 randomised controlled trials (RCTs), most of which focused on education and counselling to increase physical activity. Although the overall methodological quality of the studies was reportedly 'poor', intervention groups lost significantly more weight than controls.

Anderson et al.¹¹ assessed the effectiveness of worksite nutrition and physical activity interventions. They found evidence from nine RCTs that studies combining informational and behavioural strategies to influence diet *and* physical activity – rather than focusing on just one element or the other – may be more effective.

⁸ A list of all the reviews and meta-analyses found by the rapid evidence review is provided in Appendix 2

⁹ Allan, J. L., Querstret, D., Banas, K., & de Bruin, M. (2017). Environmental interventions for altering eating behaviours of employees in the workplace: a systematic review. *Obesity Reviews*, 18(2), 214–226.

¹⁰ Benedict, M. A., & Arterburn, D. (2008). Worksite-Based weight loss programs: A systematic review of recent literature. *American Journal of Health Promotion*, 22(6), 408–416.

¹¹ Anderson, L. M., Quinn, T. A., Glanz, K., Ramirez, G., Kahwati, L. C., & Johnson, D. B. (2009). The effectiveness of worksite nutrition and physical activity interventions for controlling employee overweight and obesity: A systematic review. *American Journal of Preventive Medicine*, 37(4), 340–357.

Most reviews were united in their call for the need for further research¹², particularly “more rigorous, well-reported studies”¹³ that include “clear reporting of intervention strategies”¹⁴.

3.2.2. Cardiovascular disease

A relatively small number of reviews (3) were focused on interventions targeted at improving cardiovascular disease (CVD) outcomes. Aneni et al.¹⁵, for example, examined the effectiveness of internet-based employee cardiovascular wellness and prevention programmes. They found evidence, based on 29 studies, that such interventions secure modest improvements in weight-related outcomes, but not physical activity outcomes. Although the studies were generally high quality (18 RCTs and 11 follow-up studies), only a few were conducted with people at risk of CVD – and none with blue-collar or low income workers. They concluded that more research is needed on the effectiveness of internet-based programmes but acknowledged their ‘promise’ for improving cardiovascular wellness.

In part compensating for the limitations of the above study, Groeneveld et al.¹⁶ found evidence that populations at risk of CVD benefit the most from lifestyle-focused interventions in the workplace which aim to reduce CVD risk. From 31 RCTs (of which 18 were ‘high quality’), they concluded that there is “strong evidence” for the effectiveness of a range of interventions (including counselling, group education, or supervised exercise) on body fat – one of the strongest CVD predictors.

All three studies highlighted gaps in the current evidence base, and how to fill them. For example, more generally there is a need for further research in this area (specifically with low income workers)¹⁷ as well as better reporting¹⁸. Furthermore, little is known about the long-term impact of interventions on CVD, i.e. whether positive effects are sustained¹⁹.

3.2.3. Musculoskeletal conditions

Several reviews (9) looked at interventions designed to prevent/help manage musculoskeletal (MSK) conditions. Boocock et al.²⁰, for example, reviewed 31 studies. They found evidence to support the use of mechanical interventions (e.g. changing the computer mouse or keyboard) but not for the benefits of production systems/organisational culture interventions (e.g. team

¹² Tam, G., & Yeung, M. P. S. (2018). A systematic review of the long-term effectiveness of work-based lifestyle interventions to tackle overweight and obesity. *Preventive Medicine*, 107, 54–60.

¹³ Allan et al. (2017).

¹⁴ Hutcheson, A. K., Piazza, A. J., & Knowlden, A. P. (2018). Work Site–Based Environmental Interventions to Reduce Sedentary Behavior: A Systematic Review. *American Journal of Health Promotion*, 32(1), 32–47.

¹⁵ Aneni, E. C., Roberson, L. L., Maziak, W., Agatston, A. S., Feldman, T., Rouseff, M., ... Nasir, K. (2014). A Systematic Review of Internet-Based Worksite Wellness Approaches for Cardiovascular Disease Risk Management: Outcomes, Challenges & Opportunities. *PLOS ONE*, 9(1), e83594.

¹⁶ Groeneveld, I. F., Proper, K. I., van der Beek, A. J., Hildebrandt, V. H., & van Mechelen, W. (2010). Lifestyle-focused interventions at the workplace to reduce the risk of cardiovascular disease—a systematic review. *Scandinavian Journal of Work, Environment & Health*, 36(3), 202–215.

¹⁷ Reed, J. L., Prince, S. A., Elliott, C. G., Mullen, K.-A., Tulloch, H. E., Hiremath, S., ... Reid, R. D. (2017). Impact of workplace physical activity interventions on physical activity and cardiometabolic health among working-age women. *Circulation: Cardiovascular Quality and Outcomes*, 10(2).

¹⁸ Groeneveld et al. (2010).

¹⁹ Aneni et al. (2014).

²⁰ Boocock, M. G., McNair, P. J., Larmer, P. J., Armstrong, B., Collier, J., Simmonds, M., & Garrett, N. (2007). Interventions for the prevention and management of neck/upper extremity musculoskeletal conditions: a systematic review. *Occup Environ Med*, 64(5), 291–303.

building and increased worker participation in the problem-solving of workplace production). The review identified no single-dimensional or multi-dimensional strategy for an intervention that was considered effective across occupational settings.

Carroll et al.²¹ reviewed nine trials from Europe and Canada involving employees with MSK conditions. It concluded that interventions where employees, health practitioners and employers worked together to implement work modifications for the employee – i.e. co-produced – were more effective than other types (e.g. exercise). Early intervention was also found to be effective.

Some support for the findings from Boocock et al.²² is found in a review by Kennedy et al.²³. Based on 36 studies of ‘occupational health and safety interventions’, they supported evidence for the effectiveness of mechanical interventions, e.g. arm supports and workstation adjustments. Psychological interventions, e.g. cognitive behavioural therapy (CBT), however, were not found to be effective.

Many reviews highlighted the “paucity” of high quality interventions²⁴ and the need for “more rigorous studies”²⁵. Durand et al.²⁶ in particular stressed the need for better, more accurate, reporting of the specific components of the interventions, and to identify whether they were temporary or permanent.

3.2.4. Smoking

A small number of reviews (3) focused on workplace-based smoking cessation interventions. Cahill & Lancaster²⁷, for example, found “strong evidence” that group counselling and pharmacological treatment to overcome nicotine addiction increased the likelihood of quitting smoking. Self-help interventions and social support, however, were considered less effective. Their conclusions were based on 57 studies of generally moderate to high quality. They highlighted the need for further research to understand why group counselling and pharmacological treatments have more relative success.

An American review of 14 studies found support for the use of interventions that ‘reward’ individuals or teams on the basis of participation or success in a specified smoking behaviour

²¹ Carroll, C., Rick, J., Pilgrim, H., Cameron, J., & Hillage, J. (2010). Workplace involvement improves return to work rates among employees with back pain on long-term sick leave: A systematic review of the effectiveness and cost-effectiveness of interventions. *Disability and Rehabilitation*, 32(8), 607–621.

²² Boocock et al. (2007).

²³ Kennedy, C. A., Amick III, B. C., Dennerlein, J. T., Brewer, S., Catli, S., Williams, R., ... Rempel, D. (2010). Systematic Review of the Role of Occupational Health and Safety Interventions in the Prevention of Upper Extremity Musculoskeletal Symptoms, Signs, Disorders, Injuries, Claims and Lost Time. *Journal of Occupational Rehabilitation*, 20(2), 127–162.

²⁴ Ibid.

²⁵ Padula, R. S., Comper, M. L. C., Sparer, E. H., & Dennerlein, J. T. (2017). Job rotation designed to prevent musculoskeletal disorders and control risk in manufacturing industries: A systematic review. *Applied Ergonomics*, 58, 386–397.

²⁶ Durand, M. J., Vézina, N., Loisel, P., Baril, R., Richard, M. C., & Diallo, B. (2007). Workplace interventions for workers with musculoskeletal disabilities: A descriptive review of content. *Journal of Occupational Rehabilitation*, 17(1), 123–136.

²⁷ Cahill, K., & Lancaster, T. (2014). Workplace interventions for smoking cessation. The Cochrane Database of Systematic Reviews, 2(2), CD003440.

change intervention²⁸. It found worksite-based incentives and competitions – when implemented together – can effectively increase the number of workers quitting smoking. However, there is insufficient evidence to say whether these methods are effective when implemented in isolation. A recent literature review from Fishwick et al.²⁹ (based on six recent reviews and meta-analyses of workplace smoking cessation programmes), found that simply providing programmes and interventions is not sufficient for change. Instead, they suggested that smoking cessation programmes at work are only useful for workers who already wish to stop smoking.

3.2.5. Mental health

A relatively large amount of reviews (21) looked at studies of workplace interventions to improve mental health, ranging from common mental disorders, e.g. anxiety and depression^{30,31}, to more severe mental illness^{32,33}. One, based on 21 RCTs, reported that occupational digital mental health interventions significantly improve psychological wellbeing and work effectiveness³⁴. Such interventions comprise online programmes, which help increase resilience, develop positive mental health, and address emerging or established distress.

There is also evidence – from 140 studies reviewed by Joyce et al.³⁵ – that enhancing employee control (i.e. creating ‘good’ work), and promoting physical activity, reduces the risk of developing depression and anxiety disorders. Stronger evidence was found for CBT-based stress management interventions – but not group counselling. Similar findings are reported in a literature review of 23 studies³⁶. Improving the psychosocial quality of work (i.e. increasing workers’ control, access to support, etc.) can contribute to recovery for people with mental illness. Interventions affecting both the individual and the organisation are more effective than ‘single target’ approaches. Involving the worker in the design of the intervention also increases

²⁸ Leeks, K. D., Hopkins, D. P., Soler, R. E., Aten, A., & Chattopadhyay, S. K. (2010). Worksite-Based Incentives and Competitions to Reduce Tobacco Use. A Systematic Review. *American Journal of Preventive Medicine*, 38(2 SUPPL.).

²⁹ Fishwick, D., Carroll, C., McGregor, M., Drury, M., Webster, J., Bradshaw, L., ... Leaviss, J. (2013). Smoking cessation in the workplace. *Occupational Medicine*, 63(8), 526–536.

³⁰ Joyce, S., Modini, M., Christensen, H., Mykletun, A., Bryant, R., Mitchell, P. B., & Harvey, S. B. (2016). Workplace interventions for common mental disorders: a systematic meta-review. *Psychol Med*, 46(4), 683–697.

³¹ Nigatu, Y. T., Liu, Y., Uppal, M., McKinney, S., Rao, S., Gillis, K., & Wang, J. (2016). Interventions for enhancing return to work in individuals with a common mental illness: systematic review and meta-analysis of randomized controlled trials. *Psychol Med*, 46(16), 3263–3274.

³² Kinoshita, Y., Furukawa, T. A., Kinoshita, K., Honyashiki, M., Omori, I. M., Marshall, M., ... Kingdon, D. (2013). Supported employment for adults with severe mental illness. *The Cochrane Database of Systematic Reviews*, 9(9), CD008297.

³³ Suijkerbuijk, Y. B., Verbeek, J. H., van Mechelen, J., Ojajärvi, A., Anema, J. R., Corbiere, M., & Schaafsma, F. G. (2015). Interventions for obtaining and maintaining employment in adults with severe mental illness, a network meta-analysis. *Cochrane Database of Systematic Reviews*, 2015(9).

³⁴ Carolan, S., Harris, P. R., & Cavanagh, K. (2017). Improving employee well-being and effectiveness: Systematic review and meta-analysis of web-based psychological interventions delivered in the workplace. *Journal of Medical Internet Research*, 19(7).

³⁵ Joyce et al. (2016).

³⁶ Robinson, M., Raine, G., & South, J. (2010). Mental Health and Employment Evidence Review. Retrieved March 2, 2018, from <http://www.altogetherbetter.org.uk/SharedFiles/Download.aspx?pageid=4&mid=112&fileid=92>

its chance of success. Thus, the findings from these reviews suggest that workplace interventions can help prevent common mental health conditions.

Further support for the positive impact on common mental health disorders like depression and anxiety comes from Martin et al.³⁷. Reviewing 22 studies, they found interventions comprising CBT, and those focused on building resilience, reduced depression and anxiety symptoms. Similar findings are reported in a 2016 systematic review of six studies for CBT³⁸.

A review from Davenport et al.³⁹, focused on mental health in the workplace, took a different approach to the above studies. It sought to develop 'expert' consensus regarding practical, actionable strategies that organisations can implement to promote positive mental health in the workplace. Endorsed strategies covered the topics of: a mental health and wellbeing strategy, a work environment that promotes positive mental health, positive leadership styles, effective communication, designing jobs for positive mental health, recruitment and selection, supporting and developing employees, work-life balance, and positive mental health and well-being initiatives.

Though there are fewer of them, some studies have looked at the effectiveness of interventions for people with severe mental illness. A 2017 meta-analysis, for example, found evidence that supported employment and augmented employment are effective ways of helping people with severe mental illness obtain and maintain employment⁴⁰. Although these findings are based on 48 RCTs comprising over 8,000 participants, the available evidence was considered to be either of 'moderate' or 'low' quality. The authors therefore caution that future studies with a lower risk of bias could produce different results. Another review, based on 14 RCTs and over 2,000 participants, reported similar findings.

Overall, there is more and better quality evidence for the effectiveness of interventions to improve common mental disorders (e.g. stress, anxiety and depression), than there is for more severe forms of mental illness. This may to some extent be expected due to the more significant impact that the latter tends to have on people's health.

Many of the reviews we found outlined the need for more research⁴¹. For example, a 2010 review on the effectiveness of workplace counselling for people with common mental health conditions called for more "high-quality research" to reinforce the evidence base⁴². This is

³⁷ Martin, A., Sanderson, K., & Cocker, F. (2009). Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms. *Scandinavian Journal of Work, Environment & Health*, 35(1), 7–18.

³⁸ Naidu, V. V., Giblin, E., Burke, K. M., & Madan, I. (2016). Delivery of cognitive behavioural therapy to workers: A systematic review. *Occupational Medicine*, 66(2), 112–117.

³⁹ Davenport, L. J., Allisey, A. F., Page, K. M., LaMontagne, A. D., & Reavley, N. J. (2016). How can organisations help employees thrive? The development of guidelines for promoting positive mental health at work. *International Journal of Workplace Health Management*, 9(4), 411–427.

⁴⁰ Suijkerbuijk et al. (2017).

⁴¹ Nieuwenhuijsen, K., Faber, B., Verbeek, J. H., Neumeyer-Gromen, A., Hees, H. L., Verhoeven, A. C., ... Bültmann, U. (2014). Interventions to improve return to work in depressed people. *Cochrane Database of Systematic Reviews*, 2014(12).

⁴² McLeod, J. (2010). The effectiveness of workplace counselling: A systematic review. *Counselling and Psychotherapy Research*, 10(4), 238–248.

echoed by Robinson et al.⁴³. Furthermore, Suijkerbuijk et al.⁴⁴ highlighted the need for more research on people with severe conditions, highlighting the lack of high quality evidence.

3.2.6. Absenteeism and presenteeism

Several reviews (12) looked at absenteeism and presenteeism directly, rather than looking at a specific health condition, and at interventions that can help manage and reduce both. A review of 14 studies found some evidence of the positive effects of some workplace health programmes on improving presenteeism in workers⁴⁵. These included programmes which offered organisational leadership, health risk screening, individually tailored programs, and a supportive – psychosocial – workplace culture.

A more recent review looking at studies of absenteeism found moderate evidence to support the effectiveness of supervised exercise programmes, cognitive behavioural programmes and multidisciplinary wellbeing initiatives for reducing sickness absence⁴⁶. However, no one individual intervention emerged as the ‘gold standard’ for supporting employee health and wellbeing and reducing sickness absence.

Some reviews looked specifically at return to work, and whether interventions can expedite it. The evidence, however, suggests that the effects are limited. A 2016 meta-analysis comprising 136 RCTs found that interventions aimed at people with mental health problems did not improve return to work (RTW) rates relative to controls⁴⁷. Similarly, a 2017 systematic review of 14 studies comprising over 12,000 workers found no evidence that RTW programmes (designed to tackle MSK and/or mental health problems) improved RTW rates⁴⁸.

3.2.7. Alcohol

A small number of reviews (2) have assessed the evidence on alcohol interventions in the workplace. For example, a recent systematic review of eight studies reported that a number of interventions, including alcohol screening, alcohol testing, brief interventions, peer care or peer-based support intervention, do show positive outcomes – particularly for those identified as ‘risky drinkers’⁴⁹. General health and wellbeing promotion activities, however, do not appear to have an impact on drinking rates.

⁴³ Robinson et al. 2010

⁴⁴ Suijkerbuijk et al. 2017

⁴⁵ Cancelliere, C., Cassidy, J. D., Ammendolia, C., & Côté, P. (2011). Are workplace health promotion programs effective at improving presenteeism in workers? A systematic review and best evidence synthesis of the literature. *BMC Public Health*, 11.

⁴⁶ Chetty, L. (2015). Effective interventions that support employee health and wellbeing and its implications for reducing sickness absence: Systematic review of the literature. *Physiotherapy (United Kingdom)*, 101, eS236-eS237

⁴⁷ Nigatu, Y. T., Liu, Y., Uppal, M., McKinney, S., Rao, S., Gillis, K., & Wang, J. (2016). Interventions for enhancing return to work in individuals with a common mental illness: systematic review and meta-analysis of randomized controlled trials. *Psychol Med*, 46(16), 3263–3274.

⁴⁸ Vogel, N., Schandelmaier, S., Zumbunn, T., Ebrahim, S., de Boer, W. E. L., Mousavi, S. M., ... Kunz, R. (2015). Return to work coordination programmes for improving return to work in workers on sick leave. *Cochrane Database of Systematic Reviews*, 2015(3).

⁴⁹ Lee, N. K., Roche, A. M., Duraisingam, V., Fischer, J., Cameron, J., & Pidd, K. (2014). A Systematic Review of Alcohol Interventions Among Workers in Male-Dominated Industries. *Journal of Men's Health*, 11(2), 53–63.

Another systematic review of 18 studies was only able to conclude that, although prevalent, “brief” interventions generally yielded non-significant results⁵⁰.

3.2.8. General health and wellbeing

Several reviews (12) assessed studies of interventions designed to improve employees’ ‘general’ health and wellbeing. Several involved psychosocial interventions designed to improve the ‘quality’ of work (i.e. employees’ control over work and their level of workplace flexibility). Joyce et al.⁵¹, for example, found that there was tentative evidence to suggest that flexible working interventions, that increase worker control and choice, are likely to have a positive effect on health outcomes. Egan et al.⁵² report similar findings. Their systematic review suggests that some organisational-level participation interventions may benefit employee health (as predicted by Karasek’s ‘demand-control’ model⁵³). In particular, interventions that increase employees’ control over their work are found to be effective.

In addition to the above, a 2015 review looked at the impact of psychosocial interventions, specifically improving social support in the workplace and supervisory quality⁵⁴. Based on 10 papers, the authors found ‘moderate’ and ‘limited’ evidence that interventions to improve support (e.g. supportive counselling or specific workplace policies) and supervisory quality (e.g. supervisory training or improved workplace structure) improve work- and health-related outcomes.

Unlike the reviews outlined above, a 2012 systematic review looked at return to work as a health intervention in itself⁵⁵ (based on the notion that, generally speaking, work is considered good for one’s health and wellbeing⁵⁶). The review found 15 studies, one of which was an RCT, showing the beneficial effects of returning to work on health: either demonstrated by health improvements following reemployment, or deterioration following sustained unemployment.

⁵⁰ Kolar, C., & von Treuer, K. (2015). Alcohol Misuse Interventions in the Workplace: A Systematic Review of Workplace and Sports Management Alcohol Interventions. *International Journal of Mental Health and Addiction*, 13(5), 563–583.

⁵¹ Joyce, K., Pabayo, R., Critchley, J. A., & Bambra, C. (2010). Flexible working conditions and their effects on employee health and wellbeing. *The Cochrane Database of Systematic Reviews*, (2. Art. No.: CD008009), 1–88.

Joyce et al. (2016).

⁵² Egan, M., Bambra, C., Thomas, S., Petticrew, M., Whitehead, M., & Thomson, H. (2007). The psychosocial and health effects of workplace reorganisation. 1. A systematic review of organisational-level interventions that aim to increase employee control. *Journal of Epidemiology and Community Health*, 61(11), 945–54.

⁵³ Karasek, R. (1979). Job Demands, Job Decision Latitude, and Mental Strain: Implications for Job Redesign. *Administrative Science Quarterly*, 24(2), 285.

⁵⁴ Wagner, S. L., White, M. I., Schultz, I. Z., Williams-Whitt, K., Koehn, C., Dionne, C. E., ... Wright, M. D. (2015). Social support and supervisory quality interventions in the workplace: A stakeholder-centered best-evidence synthesis of systematic reviews on work outcomes. *International Journal of Occupational and Environmental Medicine*, 6(4), 189–204.

⁵⁵ Rueda, S., Chambers, L., Wilson, M., Mustard, C., Rourke, S. B., Bayoumi, A., ... Lavis, J. (2012). Association of returning to work with better health in working-aged adults: a systematic review. *Journal of Public Health*, 102(3), 541–556.

⁵⁶ Waddell, G., & Burton, A. (2006). *Is Work Good for Your Health and Well-Being?* London: The Stationery Office.

Many of the reviews looking at general health and wellbeing highlighted the need for better quality evidence. Joyce et al.⁵⁷, for example, suggested results should be interpreted with caution due to the limited evidence base. Egan et al. specifically called for more research with low income workers⁵⁸. The lack of existing evidence was highlighted by other reviews, too^{59,60}.

3.2.9. Common elements of successful interventions

Many of the reviews we found lamented the lack of well-reported, rigorous studies. As such, it is difficult to say, definitively, what makes for a ‘successful’ intervention. That said, there are a number of identifiable common elements that – generally speaking – increase the chances of an intervention succeeding. This does not, however, mean that any intervention with these components will be effective, and that any intervention without them will not.

Findings from several reviews^{61,62,63} suggest that co-produced interventions (i.e. with input from both the employee and the employer and, if applicable, a relevant health practitioner) can be more effective. For example, Carroll et al.⁶⁴ concluded, on the basis of 14 studies, that MSK-related interventions were more effective when the employer, employee and health practitioner worked together to find a solution. In addition, buy-in from senior management was considered important by several reviews^{65,66,67}. A review exploring ‘success factors’ for interventions addressing tobacco, physical activity, nutrition, stress and alcohol identified ‘senior management involvement’ as crucial⁶⁸. Another review went as far to say that buy-in from top management is “essential” to drive health and wellbeing interventions⁶⁹. Finally,

⁵⁷ Joyce et al. (2010).

⁵⁸ Egan et al. (2007).

⁵⁹ Robertson, L., Yeoh, S. E., & Kolbach, D. N. (2013). Non-pharmacological interventions for preventing venous insufficiency in a standing worker population. *Cochrane Database of Systematic Reviews*.

⁶⁰ Neil-Sztramko, S. E., Pahwa, M., Demers, P. A., & Gotay, C. C. (2014). Health-related interventions among night shift workers: a critical review of the literature. *Scandinavian Journal of Work, Environment & Health*, 40(6), 543–556.

⁶¹ Bull, F., Adams, E. & Hooper, P. (2008). Well@Work: Promoting active and healthy workplaces. Retrieved March 3, 2018, from <http://www.ssehsactive.org.uk/userfiles/Documents/WWEVALUATIONAPPENDICES.pdf>

⁶² Carroll, C., Rick, J., Pilgrim, H., Cameron, J., & Hillage, J. (2010). Workplace involvement improves return to work rates among employees with back pain on long-term sick leave: A systematic review of the effectiveness and cost-effectiveness of interventions. *Disability and Rehabilitation*, 32(8), 607–621.

⁶³ Hill, D., Lucy, D., Tyres, C. & James, L. (2007). What works at work? Retrieved from https://www.virk.is/static/files/7_What%20works.pdf

⁶⁴ Carroll et al. (2010).

⁶⁵ Bellew, B. (2008). Primary prevention of chronic disease in Australia through interventions in the workplace setting: a rapid review. Retrieved from https://www.saxinstitute.org.au/wp-content/uploads/29_Primary-prevention-chronic-disease....workplace-setting.pdf

⁶⁶ Bull et al. (2008).

⁶⁷ Cavill, N., Coffey, M., Parker, M. & Dugdill, L. (2014). Best Practice in Promoting Employee Health and Wellbeing in the City of London. Retrieved from <https://www.cityoflondon.gov.uk/business/economic-research-and-information/research-publications/Documents/research-2014/employee-health-and-wellbeing-in-the-city-of-London-final.pdf>

⁶⁸ Bellew. (2008).

⁶⁹ Cavil et al. (2014).

several reviews^{70,71,72,73} stress the importance of an integrated and comprehensive approach to improving employee health and wellbeing, i.e. interventions that address both individual- and organisation-level factors. In particular, organisational interventions combined with complementary individual interventions have been shown to be effective⁷⁴, e.g. improving individual employees' control and autonomy over their work – e.g. task discretion or the pace of work – alongside complementary changes in company-wide policy.

⁷⁰ Hill et al. (2007).

⁷¹ Goldgruber, J., & Ahrens, D. (2010). Effectiveness of workplace health promotion and primary prevention interventions: A review. *Journal of Public Health*, 18(1), 75–88.

⁷² Cooklin, A., Joss, N., Husser, E., & Oldenburg, B. (2017). Integrated Approaches to Occupational Health and Safety: A Systematic Review. *American Journal of Health Promotion : AJHP*, 31(5), 401–412.

⁷³ Robroek, S. J. W., van Lenthe, F. J., van Empelen, P., Burdorf, A., & van, E. P. (2009). Determinants of participation in worksite health promotion programmes: A systematic review. *International Journal of Behavioral Nutrition and Physical Activity*, 6(1479–5868 (Electronic)), 26.

⁷⁴ Hill et al. (2007).

Table 3.1 – Overview of the evidence on workplace health interventions

Intervention topic	Intervention type(s)	Quality*	Overall findings	Notes
Weight loss (16 reviews)	Nutrition/diet-based; Education and counselling to physical activity; Informational and behavioural strategies to influence diet <i>and</i> physical activity	**	Physical activity interventions are more effective than nutrition/diet-based ones but interventions combining both are superior	More “rigorous, well-reported” studies needed
Cardiovascular disease (CVD) (3 reviews)	Internet-based cardiovascular wellness and prevention programmes; ‘Lifestyle focused’ (including counselling, group education, or supervised exercise)	***	Wellness and prevention programmes lead to “modest” improvements in weight but not physical activity; “Strong evidence for ‘lifestyle’ interventions on body fat (strong CVD predictor)	More research needed, particularly with people at risk of CVD and blue collar/low income workers
Musculoskeletal (MSK) conditions (9 reviews)	Mechanical (changing computer mouse, keyboard); Workplace culture (team building, more worker participation in decisions); Psychological (CBT)	**	Mechanical interventions are effective, but workplace culture ones and psychological interventions are ineffective	Many reviews highlighted the lack of high quality interventions
Smoking (3 reviews)	Group counselling and pharmacological treatment; Self-help and social support; Reward-based behaviour change	**	“Strong evidence” that group counselling and pharmacological treatment increase chance of quitting; Self-help and social support ineffective; Reward-based behaviour change effective	Simply providing programmes is insufficient, recipients need personal motivation or incentives
Mental health (21 reviews)	Online programmes to develop resilience; Psychosocial (more ‘good work’ i.e. greater employee control, etc.); CBT-based stress management;	***	Improving resilience (through online programmes or CBT) reduces anxiety, depression, as do interventions to improve the psychosocial quality of work; Comparatively little evidence on more several mental health conditions	More research – particularly high quality research – needed, for both common and severe mental disorders (though primarily the latter)
Absenteeism and presenteeism (12 reviews)	‘Health programmes’ (organisational leadership, health risk screening, supportive – psychosocial – workplace culture); Supervised exercise, CBT	*	“Some” evidence to support effectiveness of health programmes; “Modest” evidence to support supervised exercise and CBT; No evidence for improved return to work	No ‘gold standard’ intervention for tackling absenteeism and presenteeism; Return to work evidence lacking
Alcohol (2 reviews)	Screening, testing, peer-based support/care; Promoting general health and wellbeing	*	Screening, testing and peer-based support/care shows “positive outcomes”; General health and wellbeing promotion ineffective	Lack of studies; Those identified as ‘risky drinkers’ see greatest beneficial impact
General health & wellbeing (12 reviews)	Psychosocial to improve quality of work (e.g. more employee control)	**	“Tentative” evidence that flexible working is effective; Increasing control is effective	Lack of studies; Better quality evidence needed

*Quality = High (***) several randomised controlled trials (RCT), evidence from Cochrane Reviews, many case control studies; Medium (**) some RCT/Cochrane Reviews, several case control studies; Low (*) general lack of studies, none or few RCT/Cochrane Reviews, mainly case control studies

3.3. Conclusions

The evidence review revealed a wide range of workplace-based interventions designed to improve employee health and wellbeing. Table 1 (above) provides an overview of this evidence. Primarily, interventions are concerned with addressing specific health conditions, e.g. obesity, MSK conditions and mental health problems. It is probable that the focus on these conditions is at least partly attributable to the fact that they – the latter two in particular – are responsible for the vast majority of long-term sickness absence in the UK⁷⁵. Furthermore, the focus on obesity is arguably a reflection of the UK's broader public health priorities⁷⁶.

Despite an overall focus on specific conditions, a significant minority look at health behaviours, e.g. smoking, alcohol consumption, and physical inactivity. In all cases interventions aim to reduce employees' exposure to such lifestyle factors, often through counselling or medical interventions, e.g. screening or pharmacological treatment. Such interventions are rarely effective unless the recipient is either personally motivated or incentivised to make a change. This contrasts with the relative success of approaches to reducing, for example, MSK conditions through mechanical interventions, which require little motivation on the recipient's part.

Some interventions, rather than focus on a specific condition or behaviour, simply look at ways to reduce absenteeism and presenteeism. Such interventions typically comprise a range of approaches, e.g. health risk screening, supervised exercise programmes, wellbeing initiatives, etc.

A further category includes interventions with a focus on 'general' health and wellbeing (i.e. they take a holistic – rather than biomedical – approach to employee health). Many of these focus on improving the psychosocial quality of work and tend to report positive findings.

There are a number of identifiable common elements that can increase the chances of an intervention being successful. Findings from several reviews suggest that co-produced interventions (i.e. with input from both the employee and the employer and, if applicable, a relevant health practitioner) can be more effective. Buy-in from senior management is also considered important. Furthermore, interventions seeking to modify both the employee's behaviour and the work environment can be more effective and more likely to achieve sustained change.

Unsurprisingly, no individual intervention emerges as the 'gold standard' and there is no 'one-size-fits-all' approach that is applicable all 'occupational settings', e.g. to both small and large organisations operating in different sectors and to workers of varying socioeconomic status. This is partly due to the fact that businesses' needs depend to a large extent on their size and their sector, but also because there is a lack of data on small organisations, 'blue-collar' sectors, and low income workers in particular.

More generally – across all the areas we reviewed – there are too few well-reported, high quality intervention studies that describe, in sufficient detail, the nature of the intervention and

⁷⁵ Henderson, M., & Madan, I. (2013). Mental health and work. In N. Mehta, O. Murphy, & C. Lillford-Wildman (Eds.), *Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence* (pp. 157–169). London: Department of Health.

⁷⁶ Stuckler, D., & Basu, S. (2013). Getting serious about obesity. *BMJ (Online)*, 346(7900).

its effect – and whether effects are sustained long term. Reviews reporting positive effects are typically accompanied by caveats alerting the reader to either the lack of available studies or their relatively poor quality. While there are some exceptions to this it is generally the case – as has been pointed out in this field previously – that “the body of publications is in stark contrast to the widespread use of such programs”⁷⁷, i.e. the quality of the evidence underpinning the effectiveness of employer-led action to improve employee health and wellbeing does not fully justify how common they are. Our conclusions are therefore similar to those put forward in a recent case study review of health promotion practices in the workplace: it is difficult to understand exactly the impact that these approaches are having. As a result, it is difficult for PHE to make recommendations via a standard based on the evidence available.

3.3.1. Limitations of the rapid evidence review

The above conclusions must be considered in light of the review’s limitations. It was outside the scope of this research to conduct a full systematic review of the literature. It is therefore possible that some potentially relevant studies could have been missed. To, in part, compensate for this, our rapid review focused exclusively on systematic and meta-analytic reviews. This allowed us to consider a wide range of relevant literature. However, our findings are necessarily only as accurate as the summaries provided by the reviews we found.

Future reviews on this topic could focus on a particular health condition or intervention type or occupational setting – rather than all health and wellbeing interventions in workplaces. This could potentially lead to different findings and a better understanding of what interventions are effective and why in different settings.

⁷⁷ Osilla, K. C., Van Busum, K., Schnyer, C., Larkin, J. W., Eibner, C., & Mattke, S. (2012). Systematic review of the impact of worksite wellness programs. *The American Journal of Managed Care*, 18(2), e68-81.

4. Global workplace charter/accreditation schemes

Key reflections

- Most schemes are provided by government (i.e. national, devolved or local). UK central government schemes are typically owned and provided by non-department public bodies, have national coverage and are well-established. A significant number of schemes provided at the regional level (often by local authorities) have been established more recently.
- Most schemes have a 'general health and wellbeing' focus covering several aspects of employee health and wellbeing, including: physical health, mental health, diet, exercise, smoking cessation, alcohol use monitoring, sickness absence monitoring; health and safety, etc.
- Around a third of identified schemes have a specific or targeted health focus, which is either mental health, health and safety or stress.
- We identified a diverse range of schemes. Most can be described as conventional in that they comprise a set of standards, assessment process, award process and an award. However, several only comprise a set of standards.
- Identified schemes shared many common elements. The most common was 'best practice and idea sharing', followed by 'tailored reports/feedback', and then 'awards'.
- For most schemes, the accreditation process involves self-assessment, external validation, an award at one of several 'levels' followed by (often annual) awards ceremonies.
- The majority of schemes use evidence on the 'general' benefits and costs of employee health and wellbeing as their evidential basis. However, a smaller number use more specific evidence (e.g. the Health and Safety Executive drawing on evidence about the impact of the psychosocial work environment) or cite specific NICE public health guidance (e.g. Cornwall's Healthy Workplace Programme).
- In general, the number of evaluations and the quality of evidence regarding the effectiveness of identified schemes is fairly poor.
- Levels of take-up are generally quite low.

4.1. Introduction

The aim of this stage of the research was to map global workplace charter/accreditation schemes. It also set out to answer the following research questions:

- What aspects of employee health and wellbeing do existing charters/schemes cover?
- What are the commonalities or common elements shared by existing charters/schemes?
- What evidence is there showing the effectiveness of existing charters/schemes?

In the following section we outline the findings from the global mapping exercise. We assess and analyse what aspects of health and wellbeing the schemes cover, their common elements, and evidence of their effectiveness and take-up. This is followed by a section outlining our concluding comments and the mapping exercise's limitations.

4.2. Findings

For each charter/scheme identified we collected a range of information (see Box A). In total, we identified 17 charters/schemes through secondary and primary research (see Table 2 for identified schemes and their owner/provider).

Table 4.1– Identified schemes and their owner/provider

Scheme	Owner/provider
Better Health at Work Award	TUC & North East councils
Britain's Healthiest Workplace	Vitality
Certificate in Internal Workplace Mediation	ACAS
Cornwall Workplace Health Programme	Cornwall Council
Disability Confident	UK government
European standards – Safety and health at work	EU-OSHA
Healthy Working Wales	Healthy Working Wales team
Healthy Workplace Charter	Greater London Authority
Investors in People	Investors in People
Management Standards	Health and Safety Executive
Standards on Occupational Safety and Health	International Labour Organisation
Time to Change Employer Pledge	Mind & Rethink Mental Illness
Total Worker Health	NIOSH
West Midlands Workplace Wellbeing Commitment	West Midlands Combined Authority
Workplace Equality Index	Stonewall
Workplace Wellbeing Charter	Health@Work
Workplace Wellbeing Index	Mind

Below, we discuss the schemes we identified in accordance with the information we collected (set out in Box A), with reference to the research questions outlined above.

Box A: Charter/scheme key information

- Charter/scheme owner/provider
- Year of establishment
- Geographical coverage
- Eligible organisations
- Primary health focus
- Charter/scheme 'type' (e.g. set of standards; benchmarking tool; certification scheme)
- Common components
- Accreditation process/framework
- Evidential basis
- Evidence of effectiveness/impact (i.e. evaluations)
- Engagement levels (e.g. take-up)

4.2.1. Charter/scheme owner/provider type

The majority of the schemes we identified are owned/provided by government (9). Of these, most (5) are provided by central government. It should be pointed out that three of the four UK central government schemes (i.e. Certificate in Internal Workplace Mediation, Health and

Safety Executive’s Management Standards and Investors in People standard⁷⁸) are (or were in the case of IIP) provided by non-departmental public bodies operating at arm’s length from ministers. The exception to this is Disability Confident. The other central government scheme is Total Worker Health, which is provided by the National Institute for Occupational Safety and Health in the US.

Table 4.2 – Charter/scheme owner/provider type

Owner/provider type	% of sample	Number of schemes ⁷⁹
Central government	27.8	5
Charity	22.2	4
Local government	22.2	4
International agency	11.1	2
Devolved government	5.6	1
Trade union	5.6	1
Private company	5.6	1

The four schemes provided by local government include Cornwall Council’s Workplace Health Programme, the Greater London Authority’s (GLA) Healthy Workplace Charter, the West Midlands Workplace Wellbeing Commitment from the West Midlands Combined Authority and the Better Health at Work Award (also owned by the TUC).

Four schemes are provided by UK charities. The mental health charity Mind provides the Workplace Wellbeing Index and, in partnership with Rethink Mental Illness (an England-based mental health charity), the Time to Change employer pledge. Stonewall (a UK lesbian, gay, bisexual and transgender rights charity) provides the Workplace Equality Index and Liverpool-based charity, Health@Work (with expertise in health, safety and wellbeing) offers the Workplace Wellbeing Charter.

4.2.2. Year of establishment

The average ‘age’ of the schemes we identified⁸⁰ is just over 10 years. However, this is skewed significantly by the Standards on Occupational Safety and Health from the International Labour Organisation (ILO) and the Investors in People (IIP) Standard (established in 1981 and 1991 respectively). In fact, the vast majority of organisations were established within the last 10 years, with 7 out of 16 organisations (44%) being established within the last six. Thus, it is fair to say that most of the schemes identified are relatively young. This could have been prompted, in part, by the publication of Dame Carol Black’s 2008 report, *Working for a Healthier Tomorrow*⁸¹, which highlighted the substantial costs of sickness absence in the UK. Indeed, many of the schemes explicitly reference this influential report.

⁷⁸ The Investors in People (IIP) standard has been categorised as being provided by central government as it was owned by the UK Government for the vast majority of its lifespan (1991-2017). It is now a Community Interest Company.

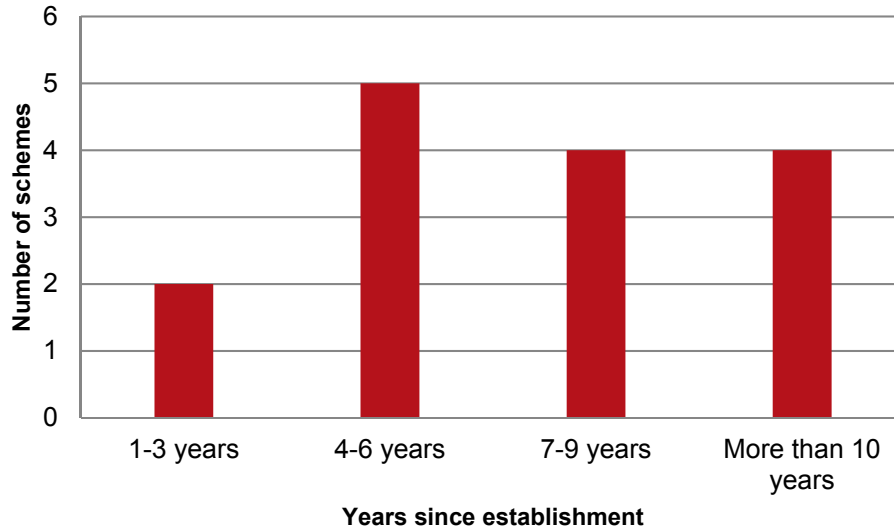
⁷⁹ Total is 18 because the Better Health at Work Award is owned by both the TUC and North East councils

⁸⁰ No data for the European Agency for Safety and Health at Work’s ‘European standards – Safety and health at work’ scheme

⁸¹ Black, C. (2008). *Working for a healthier tomorrow*. London: The Stationery Office.

It is worth noting that the ‘youngest’ schemes are those with a regional geographical focus (typically provided by local governments). This may at least partly be a result of the Localism Act 2011 which facilitated the devolution of decision-making from central to local government.

Figure 4.1 – Year of establishment



4.2.3. Geographical coverage

The majority of schemes (10) have national coverage. Six cover the UK, two England, one Wales and one the US. As might be expected, all of the schemes provided by central government have nationwide coverage and all of the local government schemes have regional coverage (4)⁸². Only three identified schemes have international coverage.

Table 4.3 – Geographic area covered by schemes

Coverage	% of sample	Number of schemes
National	58.8	10
Regional	23.5	4
International	17.6	3

4.2.4. Eligible organisations

With only one exception, all of the identified schemes are open to any size organisation. Britain’s Healthiest Workplace, from insurance company Vitality, is only open to organisations employing more than 20 people.

4.2.5. Primary health focus

Most schemes (7) have a ‘general’ health and wellbeing focus, i.e. they cover several aspects of employee health and wellbeing, including: physical health, mental health, diet, exercise, smoking cessation, alcohol use monitoring, sickness absence monitoring; health and safety, etc. Around a third of identified schemes have a specific or targeted health focus, which is either mental health (3), health and safety (2) or stress (1). A minority have a broader, or holistic, health and wellbeing focus: inclusivity (2), business performance (1) and conflict

⁸² This includes: Cornwall & Isles of Scilly, London, North East & Cumbria, and the West Midlands

resolution (1). These categories and the schemes that populate them are discussed in turn, below.

Table 4.4 – Scheme primary health focus category

Health focus category	% of sample	Number of schemes
General ⁸³	41.2	7
Specific/targeted ⁸⁴	35.3	6
Broad/holistic ⁸⁵	23.5	4

4.2.5.1. *General health focus*

The GLA’s Healthy Workplace Charter (HWC) is a good example of a scheme with a general health and wellbeing focus. It is also fairly representative of this type of scheme⁸⁶ (with one exception – discussed below). Like other schemes in this category, it can be described as a ‘conventional’ accreditation scheme. It comprises a set of standards, an assessment process, an award process and an award (the different types of schemes identified are discussed in more detail in Section 3.2.6). Participating organisations must meet these standards to receive accreditation. The HWC, for example, uses the following criteria⁸⁷:

- **Corporate support for wellbeing** – is the working environment conducive to health?
- **Attendance management** – how is information used to reduce sickness absence?
- **Health and safety requirements** – what systems are used to monitor and improve health and safety?
- **Mental health and wellbeing** – how does the organisation promote and protect employees’ mental health and wellbeing?
- **Tobacco and smoking** – does the organisation go beyond the minimum legal requirement?
- **Physical activity** – does the organisation actively promote benefits of exercise?
- **Healthy eating** – does the organisation enable staff to eat healthily?
- **Problematic use of alcohol and other substances** – how does the organisation promote sensible use of alcohol?

Depending on how well an organisation meets these criteria, they will be accredited at one of three ‘levels’. This system is typical of such schemes – we discuss accreditation frameworks in more detail in Section 3.2.8. The HWC uses the following: ‘Commitment’, ‘Achievement’ and ‘Excellence’ (in ascending order). An organisation’s level of accreditation is normally determined by some form of self-assessment, often completed by the employer (and, in the case of Vitality’s Britain’s Healthiest Workplace, an optional employee-led self-assessment). For example, the Cornwall Workplace Health Programme uses online self-assessment, followed by an ‘assessment team’ visiting the organisation to talk through the results and next

⁸³ Covering several aspects of employee health and wellbeing, including: physical health, mental health, diet, exercise, smoking cessation, alcohol use monitoring, sickness absence monitoring; health and safety, etc.

⁸⁴ For example: mental health; health and safety; stress

⁸⁵ Areas not considered to be strictly ‘health and wellbeing’, e.g. business performance; conflict resolution; inclusivity.

⁸⁶ The others being: Healthy Working Wales, the Workplace Wellbeing Charter, Britain’s Healthiest Workplace, the Cornwall Workplace Health Programme and the Better Health at Work Award.

⁸⁷ Greater London Authority. (2015). London Healthy Workplace Charter self-assessment. London: Greater London Authority.

steps. This approach allows organisations to identify what they are doing well and where improvement is needed.

Although it also has a general health and wellbeing focus, Total Worker Health, from the US National Institute for Occupational Safety and Health (NIOSH), differs to the other schemes in this category. It does provide a set of standards but does not have an assessment or award process. Furthermore, it is very clear about how organisations should approach employee health and wellbeing. The first priority – for all organisations – is addressing physical risks and hazardous conditions. Only once these are addressed can ‘wellness programmes’ (i.e. the ‘softer’ side of employee health and wellbeing) be implemented⁸⁸. The other schemes in this category do not insist on such a rigid approach. For example, the Trade Union Congress’s (TUC) Better Health at Work Award and the Cornwall Workplace Health Programme both offer participating organisations flexibility around the standards they must adhere to depending on the particular needs of their business.

4.2.5.2. *Specific/targeted health focus*

Six of the identified schemes had a specific health focus. Three focused on mental health: Mind’s Workplace Wellbeing Index (WWI), the West Midlands Workplace Wellbeing Commitment (WMWWC) and the Time to Change (TTC) employer pledge. The WWI can be described as a conventional scheme. However, the TTC employer pledge and (though to a lesser extent) the WMWWC are distinct. In the case of the former, participating organisations are required to submit an ‘action plan’ rather than undertake a form of self-assessment. Once approved, they signed the pledge. The pledge simply requires that organisations show a ‘commitment’ to “normalising the conversation about mental health in the workplace”, in accordance with seven ‘key principles’⁸⁹. Similarly, the WMWWC encourages employers to “demonstrate their commitment to the mental health and wellbeing of their staff”⁹⁰.

The WWI is more demanding. Participating organisations are required to submit their policies for review and complete an employer assessment. These are assessed for how well they address mental health and whether they effectively support and promote employee wellbeing. Employees also fill out a staff survey regarding their working conditions, and their impact on mental health, covering the following areas: organisational policy; job design; preventative measures; people management; physical workplace; support tools; health literacy; anti-stigmatisation.⁹¹

The other three schemes in this category focus, primarily, on health and safety: the standards from the European Agency for Safety and Health at Work (EU-OSHA), the ILO’s Standards on Occupational Safety and Health and the HSE’s Management Standards (which also focuses on workplace stress). The standards from EU-OSHA and ILO share obvious similarities. They are both international and put emphasis on the importance of occupational health. For example, the former stresses the need for a “coherent national occupational safety

⁸⁸ National Institute for Occupational Safety and Health. (2012). NIOSH Total Worker Health Program. Washington, DC: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health.

⁸⁹ Time to Change. (2018). Employer pledge. Retrieved March 3, 2018, from <https://www.time-to-change.org.uk/get-involved/get-your-workplace-involved/employer-pledge>

⁹⁰ West Midlands Combined Authority. (2018). Mental Health Commission. Birmingham: West Midlands Combined Authority.

⁹¹ Mind. (2017). Workplace Wellbeing Index. London: Mind.

and health policy” as well as the establishment of “enterprise-level occupational health services”⁹². HSE’s standards are distinct in that they are UK-wide and also put emphasis on workplace stress and its relationship with poor health, lower productivity and increased accident and sickness absence rates. The standards cover six ‘key areas’ of work design. They focus on the quality of the psychosocial work environment, i.e. how much control and support employees have at work, and the demands placed on them, etc. A large body of evidence shows that these aspects of work are related to both physical and mental health outcomes^{93, 94}.

4.2.5.3. *Broad/holistic health focus*

Although not necessarily directly related to employee health in the strictest sense, the following four schemes focus on aspects of the work environment that have the potential to impact on and influence employees’ mood, feelings and ultimately their wellbeing.

Two of the four schemes with a broader health focus are dedicated to promoting inclusivity in the workplace. The Workplace Equality Index (WEI) from Stonewall focuses on inclusivity for sexual and gender identities, while the UK government scheme, Disability Confident, is concerned with the recruitment and retention of people with disabilities. The former is primarily a benchmarking tool. Participating organisations benefit from guidance to help them make their workplace inclusive. Disability Confident differs in that it is a certification scheme, but its aims are similar to the extent that they are about changing workplace attitudes, removing prejudice and increasing understanding.

Another UK government certification scheme, provided by Acas, focuses on conflict resolution. It offers a five day course, equipping participants with workplace mediation skills and an understanding of workplace conflict causes. The rationale for this is that differences between workers can lead to absences and lost productivity⁹⁵. It also can impact negatively on their wellbeing⁹⁶

Finally, IIP’s standard, which was recently re-modelled, is primarily focused on business performance. Amongst other things, it stresses the importance of fostering a culture of trust and ownership in the organisation where people feel empowered to make decisions and act on them⁹⁷. Furthermore, it puts emphasis on the structure of work with the aim of ensuring that roles are designed to deliver organisational objectives and create interesting work for people,

⁹² International Labour Organization. (2018). International Labour Standards on Occupational Safety and Health. Geneva: International Labour Organization.

⁹³ Karasek, R. (1979). Job Demands, Job Decision Latitude, and Mental Strain: Implications for Job Redesign. *Administrative Science Quarterly*, 24(2), 285.

⁹⁴ Kivimäki, M., & Kawachi, I. (2015). Work Stress as a Risk Factor for Cardiovascular Disease. *Current Cardiology Reports*, 17(9), 74.

⁹⁵ Institute for Employment Studies. (2014). An evaluation of the impact of the internal workplace mediation training service. Brighton: Institute for Employment Studies.

⁹⁶ Sonnentag, S., Unger, D., Nägel, I. J., (2013). Workplace conflict and employee well-being: The moderating role of detachment from work during off-job time. *International Journal of Conflict Management*, 24: 2, 166-183.

⁹⁷ Investors in People. (2018). Explore the Standard. Retrieved April 29, 2018, from <https://www.investorsinpeople.com/iip-standard>

whilst encouraging collaborative ways of working. Poorly defined roles, where employees are unsure about their responsibilities, impact negatively on wellbeing⁹⁸.

4.2.6. Charter/scheme 'type'

At the very least, all of the schemes included in the mapping exercise either required or encouraged employers to meet, or work towards, a set of criteria designed to positively impact on employees' health and wellbeing in some way.

Most of the schemes (7) can be described as 'conventional' in the sense that they comprise four key components (see Box B). A significant minority (4) include one of these key components – a set of standards – but no others (EU-OSHA, ILO, NIOSH and HSE). This is partly explained by the nature of these schemes. They are 'high level' in the sense that they have either international or national coverage, which would make an assessment process and award process difficult from a practical point of view. Furthermore – and to a greater extent than the other identified schemes – these schemes appeal to organisations' legal obligation to make work safe for employees. Awarding employers for complying with legal requirements would of course be inappropriate.

Box B: Key components of 'conventional' schemes

- A **set of standards** that participating organisations must meet
- An **assessment process** all organisations must go through (typically involving a form of self-assessment)
- An **award process** (following self-assessment, organisations are normally subject to some form of external validation from the scheme provider)
- The **award** (typically, this is 'tiered', i.e. participating organisations are awarded 'levels', e.g. 'bronze', 'silver' or 'gold')

A further minority (2) are primarily certification schemes – Acas's Certificate in Internal Workplace Mediation and Disability Confident – and are both UK-government backed. Another two (the Workplace Wellbeing Index and Workplace Equality Index) are primarily benchmarking tools, allowing organisations to compare themselves to similar organisations with rankings compiled by the providers.

4.2.7. Common components

The most common feature shared by almost half of identified schemes (41%) is 'best practice and idea sharing'. The findings from our employer roundtable involving 10 organisations in South West England (see Chapter Four for more details) suggested that employers value this feature as it gives them an opportunity to learn from similar organisations. For example, the TTC employer pledge gives pledged organisations access to an 'Employers Accelerator Programme', which includes invitations to a series of 'masterclasses' with sessions run by employers and examples of good practice, as well as support and introductions to enable participating organisations to build connections with other employers⁹⁹.

⁹⁸ Sonnentag, S., Unger, D. & Nägel, I. J. (2013). Workplace conflict and employee well-being: The moderating role of detachment from work during off-job time. *International Journal of Conflict Management*, 24: 2, 166-183.

⁹⁹ Time to Change. (2018). Employer pledge. Retrieved March 3, 2018, from <https://www.time-to-change.org.uk/get-involved/get-your-workplace-involved/employer-pledge>

The second most common component, offered by more than a third (35%) of identified schemes, is ‘tailored reports/feedback’. Schemes typically offer organisations in-depth reports or detailed feedback once they have completed some form of assessment. This enables organisations to see what they are doing well and where improvement is needed. Britain’s Healthiest Workplace, for example, provides participating organisations with a comprehensive report outlining employees’ health needs, benchmarking information, and practical suggestions to improve employee health and productivity¹⁰⁰.

Another common component, provided by almost a quarter of schemes (24%) is the provision of a dedicated health specialist or practitioner. For example, Healthy Working Wales offers participating organisations a free visit from a ‘workplace health practitioner’. They help review management arrangements for health, safety and wellbeing and discuss particular issues that are relevant to individual businesses’ needs¹⁰¹. The Better Health at Work Award, from the TUC, provides a similar service: offering organisations a dedicated ‘workplace health improvement specialist’ to help participating organisations conform to the standard¹⁰².

Table 4.5 – Common scheme components

Component	% of sample	Number of schemes
Best practice and idea sharing	41.2	7
Tailored reports/feedback	35.3	6
Awards	29.4	5
Benchmarking	23.5	4
Dedicated support person	23.5	4
Buy-in from senior management	23.5	4
Staff survey	17.6	3
Inter-organisation comparison	17.6	3
Free	17.6	3
Action plan development	17.6	3
Bespoke 1-2-1 support	11.8	2
Tools to measure progress	11.8	2
Mentoring	11.8	2
Risk assessment	11.8	2
Health needs assessment	5.9	1

It is noteworthy that a significant minority of organisations (24%) put emphasis on the importance of getting senior management buy-in. The TTC employer pledge, for example, lists this as the first of its seven ‘key principles’¹⁰³. This should, in theory, help maximise the positive impact of adherence to a set of standards; in Chapter Two we identified this as an important aspect of effective workplace health and wellbeing interventions.

¹⁰⁰ Vitality. (2018). Britain’s Healthiest Workplace. Retrieved April 20, 2018, from <https://www.vitality.co.uk/business/healthiest-workplace/>

¹⁰¹ Healthy Working Wales. (2015). About HWW. Retrieved March 25, 2018, from <http://www.healthyworkingwales.wales.nhs.uk/about-hww>

¹⁰² Better Health at Work Award. (2018). Bronze level. Retrieved April 10, 2018, from <http://www.betterhealthatworkne.org/index.php?page=226§ion=2>

¹⁰³ Time to Change. (2018). Employer pledge. Retrieved March 3, 2018, from <https://www.time-to-change.org.uk/get-involved/get-your-workplace-involved/employer-pledge>

Finally, it is also worth noting that only a minority of schemes (18%) are freely available. Furthermore, it is interesting to note that only one scheme offers a workplace ‘health needs assessment’. Carrying one out can help employers identify and prioritise their organisation’s health needs. Findings from our roundtable also suggest that employers value it (see Chapter Five). The low number of schemes offering such a service suggests they may not be meeting businesses’ demands. That said, the in-depth reports that many schemes offer may provide a similar function, i.e. identifying where businesses must prioritise health and wellbeing investment.

4.2.8. Accreditation process/framework

The typical accreditation process, which applies to the majority of identified schemes, is shown in Box C. This process does not apply to all schemes. The less conventional schemes (i.e. EU-OSHA, ILO, NIOSH and HSE), which essentially only comprise a set of standards, do not have an accreditation process or award. Others, e.g. the Certificate in Workplace Mediation and the TTC employer pledge, have an assessment and accreditation process but not an award¹⁰⁴. However, the majority – 10 schemes¹⁰⁵ – roughly follow all of these steps and seven of them offer accreditation at various ‘levels’, e.g. ‘gold’, ‘silver’ and ‘bronze’ in the case of the Workplace Wellbeing Index and the Cornwall Workplace Health Programme.

Box C: Typical accreditation process

1. Applying organisations complete some form of self-assessment about their organisation’s health
 - Some schemes (e.g. Britain’s Healthiest Workplace) also invite employees to complete a health assessment as well
2. An ‘assessment team’ will visit the organisation to ‘validate’ the self-assessment
 - In the case of Cornwall’s Healthy Workplace Programme, the team speaks to the applying organisation’s staff and collect evidence to inform whether – and at what level – an award will be given
3. If criteria are met sufficiently, the applicant is awarded with accreditation
 - In many cases the award is ‘tiered’ depending on what criteria are met
4. An awards ceremony is hosted, often on an annual basis, by the scheme to celebrate outstanding organisations

What level is awarded generally depends on several factors. For example, in the case of the Better Health at Work Award, to achieve ‘bronze’ level organisations must offer the workforce a health needs assessment, followed by three health campaigns or events based on the outcome of a health needs assessment. They must also promote positive mental health through employee support, make healthy food choices available, develop links with stop smoking services, etc. The next level – ‘silver’ – requires organisations to participate in more health campaigns, encourage physical activity, ‘embed’ health and wellbeing in company

¹⁰⁴ Although, in the case of the latter, it could be argued that the ‘pledge’ amounts to, or is at least similar to, an award

¹⁰⁵ Better Health at Work Award, Britain’s Healthiest Workplace, Cornwall Workplace Health Programme, Disability Confident, Healthy Working Wales, Healthy Workplace Charter, IIP, Workplace Equality Index, Workplace Wellbeing Charter & Workplace Wellbeing Index

structures, etc. As one would expect, the requirements become more difficult to meet at the higher levels (in this case ‘gold’ and ‘continuing excellence’).

Although this approach of increasingly demanding criteria to attain ascending levels is logical, its bureaucratic nature could deter some businesses from applying. Evidence collected on the impact of the Workplace Wellbeing Charter suggests this could be the case: implementation of health and wellbeing interventions required by the scheme (e.g. developing links with a stop smoking service) was described as “really onerous” and not sufficiently tailored to the needs of small businesses¹⁰⁶. Indeed, it is difficult to see how a very small organisation, with perhaps 1-5 employees, could carry out an *anonymous* workplace health needs assessment (which is required for the ‘bronze’ level of the Better Health at Work Award) while maintaining employees’ anonymity. Furthermore, these organisations simply may not have the resources to provide healthy eating options onsite or promote health topics in the ‘wider community’ (required for ‘gold’ level). It should be pointed out that the scheme provider states that ‘flexibility is given to organisations that need it’ regarding how they meet criteria but it is unclear how much or what it applies to.

One scheme provider – Healthy Working Wales – has come up with what seems to be an effective way of accommodating the needs of different sized businesses. Unlike the other schemes we identified, it offers different awards – and therefore subjects businesses to different requirements – based on their size. Organisations with 50 employees or fewer are eligible for the ‘Small Workplace Health Award’ (SWHA). Businesses with more than 50 employees can apply for the ‘Corporate Health Standard’ (CHS). Both awards have different levels: ‘bronze’, ‘silver’, ‘gold’ and (for the latter only) ‘platinum’. It recognises that an organisation’s health needs, and what – realistically – can be implemented, is in part determined by the size of the organisation. Essentially, the SWHA focuses on the creation of ‘activities’ to promote health and wellbeing, while the CHS is more focused on the development of ‘policies’ (which naturally lend themselves to larger, more corporate bodies).

The Workplace Wellbeing Index takes a slightly different approach. Unlike other schemes it does not have a set of standards with various levels that participating organisations must meet. Rather, it offers three ‘levels of participation’. At each level, organisations receive:

1. An employee survey and production of an assessment report
2. A ‘dedicated client support officer’ and a more detailed report
3. A ‘Mind consultant’ to conduct interviews with staff to gather qualitative data

What organisations receive depends on how much they pay. Using the collected data, Mind hand out ‘bronze’, ‘silver’ and ‘gold’ awards at a ceremony depending on “how well organisations address mental health and whether they effectively support and promote employee wellbeing”¹⁰⁷.

4.2.9. Evidential basis

The majority of schemes (9) draw on the ‘general’ benefits of investing in employee health and wellbeing as their evidence base for the sets of standards they provide. This typically includes

¹⁰⁶ RAND Europe. (2017). *Analysing the Impact of the Workplace Wellbeing Charter*. Cambridge: RAND Europe.

¹⁰⁷ Mind. (2017). *Workplace Wellbeing Index*. London: Mind.

evidence on the costs of sickness absence to the UK, as highlighted by Dame Carol Black's 2008 report, *Working for a Healthier Tomorrow*¹⁰⁸. The Workplace Wellbeing Index and the TTC employer pledge are good examples. Drawing on a range of recent reports (including a 2014 Mind YouGov survey on workplace stress¹⁰⁹, 2017 Office for National Statistics data¹¹⁰, and recent reports from the Centre for Mental Health¹¹¹, the Chartered Institute of Personnel and Development¹¹² and Soma Analytics¹¹³), they make the case that looking after employees' mental health makes 'business sense', and that tackling stigma can improve sickness absence rates, presenteeism levels, staff wellbeing, productivity, and retention¹¹⁴. This type of general-level evidence is typically used by the majority of schemes.

A smaller number of schemes (6) draw on more specific evidence. For example, HSE's Management Standards draw on evidence highlighting the risks to health – primarily due to stress – posed by excessive demands placed on the working person, especially when combined with low job control and insufficient social support at work¹¹⁵. Furthermore, they also make the legal case for employer action, highlighting the Management of Health and Safety at Work Regulations 1999 (the Management Regulations), which requires employers to assess the risk of stress-related ill health in the workplace, as well as the Health and Safety at Work etc Act 1974, which requires employers to manage that risk.

The Cornwall Healthy Workplace Programme, although it does draw on more general evidence, also draws on public health guidance from the National Institute for Health and Care Excellence (NICE). In particular, its standards are informed by public health guidelines, e.g. PH22: mental wellbeing at work. Based on extensive and rigorous evidence, the guidelines recommend that employers, amongst other things, should provide employees with opportunities for flexible working according to their need, strengthen the role of line managers in promoting the mental wellbeing of employees through supportive leadership style and management practices, and ensure that employees have 'voice' i.e. giving them a say in determining their working conditions¹¹⁶.

4.2.10. Evidence of effectiveness/impact (i.e. evaluations)

Evidence of effectiveness, i.e. impact associated with implementing a scheme, was available for 14 schemes. For the majority of them (8) the quality of evidence ranged from 'average' (5)

¹⁰⁸ Black, C. (2008). *Working for a healthier tomorrow*. London: The Stationery Office.

¹⁰⁹ Mind. (2014). YouGov survey of 1,251 workers in Britain

¹¹⁰ Office of National Statistics. (2017). Sickness absence in the labour market: 2016. London: Office for National Statistics.

¹¹¹ Centre for Mental Health. (2017). Mental Health at Work: The Business Costs 10 years on. London: Centre for Mental Health.

¹¹² Chartered Institute of Personnel and Development. (2016). Employee Outlook: Focus on Mental Health in the Workplace. London: Chartered Institute of Personnel and Development.

¹¹³ Soma Analytics. (2017). Mental Health and Wellbeing: FTSE 100 Report. London: Soma Analytics.

¹¹⁴ Time to Change. (2018). Employer pledge. Retrieved March 3, 2018, from <https://www.time-to-change.org.uk/get-involved/get-your-workplace-involved/employer-pledge>

¹¹⁵ Karasek, R. (1979). Job Demands, Job Decision Latitude, and Mental Strain: Implications for Job Redesign. *Administrative Science Quarterly*, 24(2), 285.

¹¹⁶ Kivimäki, M., & Kawachi, I. (2015). Work Stress as a Risk Factor for Cardiovascular Disease. *Current Cardiology Reports*, 17(9), 74.

¹¹⁶ National Institute for Health and Care Excellence. (2009). Mental wellbeing at work. Retrieved April 22, 2018, from <https://www.nice.org.uk/guidance/ph22/chapter/1-Recommendations#recommendation-1-strategic-and-coordinated-approach-to-promoting-employees-mental-wellbeing>

to 'lacking' (3). Thus, for the most part, there is a lack of good evidence/evaluations demonstrating the impact and effectiveness of these schemes on, for example, employee health and wellbeing and other health- and work-related outcomes.

Table 4.6 – Quality of evidence underpinning identified schemes' effectiveness

Quality of evidence*	% of sample	Number of organisations
Very good	21.4	3
Good	21.4	3
Average	35.7	5
Lacking	21.4	3

*Quality = 'Very good': several independent studies/evaluations of the scheme in the academic and grey literature; 'Good': one or two independent studies/evaluations of the scheme in the academic and grey literature; 'Average': studies/evaluations conducted by the scheme provider; 'Lacking': no credible evidence.

4.2.10.1. Schemes lacking evidence of impact

Schemes lacking any reliable evidence regarding their effectiveness include the Healthy Workplace Charter (HWC), the West Midlands Workplace Wellbeing Charter and the Workplace Equality Index. It must be pointed out that the West Midlands scheme has only been running since 2017, leaving very little time for any evaluations to be carried out. As for the HWC, the scheme providers claim that participating organisations benefit from a structure around which they can develop health, safety and wellbeing strategies, and enhanced brand and reputation¹¹⁷. It is unclear what these claims are based on and how credible they are given that they come from the scheme provider and, therefore, not impartial.

4.2.10.2. Schemes with 'average' quality evidence

The Workplace Wellbeing Index, the Cornwall Healthy Workplace Programme and Healthy Working Wales represent three schemes with 'average' evidence of their effectiveness underpinning them. For example, drawing on the findings from the first Workplace Wellbeing Index (2016-17), Mind found evidence that more open conversations around mental health in the workplace are needed and that there is asymmetry between managers' perception of how well they support staff and how well supported employees feel. Although reported by the scheme provider, the findings can be considered somewhat reliable because (i) they reflect those reported in the recent Business in the Community Mental Health at Work Report¹¹⁸, and (ii) are based on a sample size of over 15,000 employees. These findings help organisations prioritise areas for investment.

Both Healthy Working Wales and the Cornwall Healthy Workplace Programme draw on case studies to highlight the effectiveness of the schemes they provide. For example, the former highlights three case studies which provide albeit limited support for its effectiveness. One case study, a manufacturing company with 125 full-time staff, has introduced a number of initiatives to protect and promote employee health and wellbeing. These include: a stress policy with links to HSE's Management Standards; a drug and alcohol policy with random testing and referral mechanisms; and a physical activity policy, with a walking group,

¹¹⁷ Greater London Authority. (2015). London Healthy Workplace Charter self-assessment. London: Greater London Authority.

¹¹⁸ Business in the Community. (2017). Mental Health at Work Report. London: Business in ---the Community.

pedometer challenge and subsidised gym membership.¹¹⁹ Two further case studies involving large employers (250+) report similar findings, highlighting the successful implementation of initiatives designed to improve employees' physical and mental health, as well as their lifestyle behaviours.

The Cornwall Healthy Workplace Programme, which the majority of our employer roundtable participants (see Chapter Four) were signed up to, also draws on case study evidence. A participating organisation reported that sickness absence figures are 6.2% lower on the previous year and that long term absence is 18.5% lower¹²⁰. Furthermore, insights from our roundtable suggest that engagement with the local scheme is high, with organisations valuing "email updates, bulletins and the yearly calendar of campaigns", as well as enabling them to access Mental First Aid training and take opportunities to share ideas and best practice.

4.2.10.3. Schemes with 'good' quality evidence

Schemes with 'good' evidence regarding their effectiveness include the Better Health at Work Award and the Workplace Wellbeing Charter. In the case of the former, evidence collected from participating organisations indicates they benefitted from an average reduction in sickness absence of over three days in 2015-16¹²¹. It is also claimed that employers can benefit from improved morale and increased productivity. This is corroborated by the findings of an academic study which evaluated the scheme, concluding that it could be a cost-effective way of improving health and reducing sickness absence particularly in the public sector¹²². However, the authors cautioned that additional evaluations are needed.

Regarding the Workplace Wellbeing Charter, a recent study from research institute RAND Europe analysed its take-up and impact (when it was publicly available)¹²³. Though it was not an impact evaluation, the study identified a number of areas where participating organisations felt they had seen improvements. These included: the provision of wellbeing programmes by participating organisations, such as sickness absence, job satisfaction and staff morale. However, a causal link between the Charter and such improvements should not be assumed.

4.2.10.4. Schemes with 'very good' quality evidence

The best quality – 'very good' – evidence of effectiveness is available for HSE's Management Standards, Total Worker Health from NIOSH and IIP's standards. In the case of the latter, a series of reports produced by the UK Commission for Employment and Skills (UKCES), which strategically owned IIP between 2010 and 2017, focused explicitly on the impact of the scheme. The first report, from November 2010, was a comprehensive literature review aiming

¹¹⁹ Healthy Working Wales. (2018). Case Study 1. Retrieved April 12, 2018, from <http://www.healthyworkingwales.wales.nhs.uk/sitesplus/documents/1130/Case%20Study%201%20-%20Sandvik%20Osprey.pdf>

¹²⁰ Cornwall Council. (2012). A Guide to the Healthy Workplace Award Programme. Retrieved April 13, 2018, from https://www.behealthyatwork.org/documents/NHS_Workplace_Health.pdf

¹²¹ Better Health at Work Award. (2018). The Business Case. Retrieved 12.04.18 from <http://www.betterhealthatworkne.org/index.php?page=245§ion=2>

¹²² Braun, T., Bambra, C., Booth, M., Adetayo, K., & Milne, E. (2015). Better health at work? An evaluation of the effects and cost-benefits of a structured workplace health improvement programme in reducing sickness absence. *Journal of Public Health (United Kingdom)*, 37(1), 138–142.

¹²³ RAND Europe. (2017). Analysing the Impact of the Workplace Wellbeing Charter. Cambridge: RAND Europe.

to “develop an overarching picture of IIP”¹²⁴. It provided an overview of various metrics through which IIP’s ‘impact’ or ‘effectiveness’ can be assessed. One of the key points identified in the literature is the significant variations in scheme engagement depending on business size and sector – as well as the attitudes of different businesses to future ambitions and their culture around training and development. Within this, perceived business goals and benefits oriented around organisation performance were the primary reasons identified for why businesses are motivated to engage with IIP. A more critical review, however, suggests it is primarily about image and the desire to have “another plaque on the wall”¹²⁵. In reflecting on how the scheme impacts on employees, businesses, and policymakers, the report is careful to point out that evidence on how IIP accredited businesses compare to other non-accredited organisations is very limited in scope and offers only tentative conclusions regarding benefits.

One crucial thing the above report does point to is the number of organisations “walking away” from accreditation – and the lack of understanding as to why. A subsequent report investigated this, by “building an evidence base” through the use of qualitative interviews with employers. This research found that longer term IIP accredited employers held more positive views, while others felt it only offered “one-off benefits”. This discrepancy was a key finding of the report, and one that has significant implications for how we understand and assess impact. Despite this, “most of the organisations that had been assessed against the standard had a positive experiences of the assessment” – a key reason for which, according to the report, was the relationship between the assessor and the organisation. The close relationship between the IIP assessor and the organisation in question was deemed to be fundamental to the scheme’s success.

Beyond the research conducted by UKCES, a 2008 study from the Institute for Employment Studies¹²⁶ found that firms with IIP certification generate higher profitability than “would a randomly selected organisation”. The study estimated “the average non-IIP organisation would generate in the region of £176.35 per employee extra in gross profits per annum if it switched to an IIP regime”. The rationale for their study was a perception that “organisations that already have superior performance (and implicitly superior people management practices) simply choose to collect the badge and continue on their higher performance trajectory”. In their examination, they chose to use profitability per employee as the measure of whether there was a positive effect of being IIP certified.

Unsatisfied with simple arguments that IIP ‘improves’ organisations, another 2008 study, carried out by the Cranfield School of Management¹²⁷, used a combination of case studies, surveys and financial analysis to understand exactly *how* the IIP standards improve ‘business

¹²⁴ Institute for Employment Studies & UK Commission for Employment and Skills. (2010). Perspectives and Performance of Investors in People: A Literature Review. Retrieved April 20, 2018, from <http://webarchive.nationalarchives.gov.uk/20140108123815/http://www.ukces.org.uk/assets/ukces/docs/publications/evidence-report-24-perspectives-and-performance-of-investors-in-people.pdf>

¹²⁵ Hoque, K. (2003). All in All, it’s Just Another Plaque on the Wall: The Incidence and Impact of the Investors in People Standard. *Journal of Management Studies*, 40(2), 543–571.

¹²⁶ Institute for Employment Studies. (2008). Does IIP add value to businesses? Retrieved April 28, 2018, from http://www.oce.uqam.ca/wp-content/uploads/2014/11/1106_does_iip_add_value.pdf

¹²⁷ Bourne, M., Franco-Santos, M., Pavlov, A., Lucianetti, L., Martinez, V., & Mura, M. (2008). The Impact of the Investors in People Standard on People Management Practices and Firm Performance. *Management*. Retrieved April 1, 2018, from <http://dspace.lib.cranfield.ac.uk/handle/1826/4305>

performance'. The study found that a 'chain of impact' was generated by IIP accreditation, establishing a "positive Organisational Social climate... of trust, cooperation and people engagement", and a "Human Capital Flexibility – the skills and behaviours needed for an organisation to change". These 'non-financial' performance indicators, according to the report, were crucial to stimulating elevated financial performance levels.

More recent studies on IIP's impact include a 2014 paper by Smith et al.¹²⁸, which examined employees' awareness of IIP and its impact on training and development. Another, a 2016 study by de Waal¹²⁹, questioned the value of assessing IIP's standards given that it is primarily an evaluation tool rather than a vehicle for improvement. Both cases mount a strong critique of the notion that there is a causal connection between IIP accreditation and both training and development levels of employees and the resultant job satisfaction attained.

It should be pointed out that IIP have redesigned their standards after extensive consultation with business (in 2015). They have also moved away from being government-funded to a Community Interest Company. Thus, the findings and conclusions from studies pertaining to the old iteration of IIP must be considered with this in mind.

Turning our attention to Total Worker Health, provided by NIOSH in the US, the rationale behind the standard is that only when the more 'basic' or fundamental aspects of workplace health and safety have been addressed should organisations then consider more holistic 'wellness programmes' designed to protect and promote employees' wellbeing. To some extent, this is what separates TWH from other schemes – few take such a methodical, pragmatic approach.

Evaluations of the scheme suggest that this approach is effective. For example, a recent review of the relationships between work–life stress and health behaviours found that work–life stress serves as a negative occupational exposure relating to poor health behaviours, including smoking, poor food choices, low levels of exercise, and even decreased sleep time.¹³⁰ Thus, the authors concluded that interventions at both the occupational (health protection) and individual (health promotion) level may be helpful in mitigating effects of work–life stress, which is consistent with the Total Worker Health approach. Further support for the effectiveness of TWH's integrated approach in tackling adverse health behaviours (tobacco use, sedentary behaviour, poor diet, etc.) were reported in a recent systematic review.¹³¹

In addition to the above, there is evidence (from a recent review of 17 studies) that addressing both injuries and chronic diseases in an integrated way can improve workforce health effectively and more rapidly than the alternative of separately employing more narrowly

¹²⁸ Smith, M. S., Stokes, P., & Wilson, J. F. (2014). Exploring the impact of Investors in People. *Employee Relations*, 36(3), 266–279.

¹²⁹ de Waal, A. (2016). Does Investors in People affect organisational performance: a relevant question? *Employee Relations*, 38(5), 665–681.

¹³⁰ Hammer, L. B., & Sauter, S. (2013). Total worker health and work-life stress. *Journal of Occupational and Environmental Medicine*, 55(12 SUPPL.).

¹³¹ Feltner, C., Peterson, K., Weber, R. P., Cluff, L., Coker-Schwimmer, E., Viswanathan, M., & Lohr, K. N. (2016). The effectiveness of total worker health interventions: A systematic review for a national institutes of health pathways to prevention workshop. *Annals of Internal Medicine*, 165(4), 262–269.

focused programs to change the same outcomes in serial fashion.¹³² This suggests that not only is TWH's integrated approach effective, but it is potentially *more* effective than addressing the same workplace health issues in a disaggregated, 'siloed' way.

4.2.10.5. Summary

There is a good amount of robust evidence to suggest that a minority of schemes, e.g. IIP and Total Worker Health, are effective in what they promise to deliver. However, for the majority of identified schemes, this is not the case. While another three have 'good' evidence underpinning them – i.e. evidence from one or two formal evaluations – the remainder (which make up the majority) at best draw on their own research or case studies and testimonials from participating organisations. This inevitably raises questions about the reliability and impartiality of their claims. Thus, overall, it is reasonable to conclude that there is a general lack of reliable evidence underpinning the effectiveness of the schemes we've identified.

There are broader questions to be asked here. What constitutes 'effectiveness' for an accreditation scheme? Improvements in sickness absence rates are fairly easy to monitor and measure but capturing improvements in wellbeing can be difficult, not only because they are not always readily measurable but also due to the timescales involved – a positive impact on one's health and wellbeing takes time, often years or more, to manifest itself. Perhaps looking at something more tangible would be preferable, such as levels of take-up amongst businesses? We turn to this subject in the following section.

4.2.11. Engagement levels (e.g. take-up)

Overall, take-up of schemes is, in absolute terms, low¹³³. If we take some of the national schemes, e.g. the TTC employer pledge and Workplace Equality Index, they have the third and fourth highest take-up amongst identified schemes. They are, however, open to any type of business across the entire UK and government data suggests there are almost 5.7 million businesses active in the UK¹³⁴. Thus, the scheme covers a *very* small fraction of UK businesses. It is worth pointing out, however, that the vast majority of these businesses (76%) employ nobody (the only employee is the owner). Accreditation schemes are, of course, designed with businesses with employees in mind. There are only 1.4 million businesses with employees in the UK (and the vast majority of these are 'micro', employing between 0-9 people)¹³⁵. However, if we only include these businesses, coverage is still very low (significantly less than 1 per cent).

The Better Health at Work Award covers the North East and Cumbria and has the highest take-up of the four regional schemes (400). However, there are 142,000 businesses operating in this region¹³⁶. Although the data is not available, if we assume that 76% of businesses in the region employ nobody (mirroring national trends), this would mean the scheme covers just over 1 per cent of North East businesses with employees. Perhaps a better indicator is employee coverage. A recent academic study found that the Better Health at Work Award

¹³² Anger, W. K., Elliot, D. L., Bodner, T., Olson, R., Rohlman, D. S., Truxillo, D. M., ... Montgomery, D. (2015). Effectiveness of Total Worker Health interventions. *Journal of Occupational Health Psychology, 20*(2), 226-247.

¹³³ Take-up data is not available for all identified schemes

¹³⁴ Rhodes, C. (2017). Business statistics. London: House of Commons.

¹³⁵ Rhodes, C. (2017). Business statistics. London: House of Commons.

¹³⁶ Rhodes, C. (2017). Business statistics. London: House of Commons.

covers just over a fifth (21.4%) of the regional workforce (200,319). This provides a more generous reading of the Award's coverage.

Table 4.7 – Scheme take-up

Scheme	Employer take-up	Employee coverage
Investors in People	10,000	-
Disability Confident	5,500	-
Time to Change employer pledge	703	-
Workplace Equality Index	434	94,000
Workplace Wellbeing Charter	410	-
Better Health at Work Award	400	200,319 ¹³⁷
Cornwall Workplace Health Programme	373	-
Britain's Healthiest Workplace	370	124,000
Healthy Working Wales	275	-
Healthy Workplace Charter	195	319,000
Workplace Wellbeing Index	29	15,000

Another regional scheme, the GLA's Healthy Workplace Charter, covers 195 businesses across London. Looking at businesses with employees only, this amounts to less than 1 per cent of them. However, looking at employee coverage (again) provides a more generous reading: over 5% of London employees are covered.

IIP – the only scheme identified with global coverage – has the highest take-up (10,000). This was to some extent expected given its wider reach, but also because it is more established – it has been running for almost three decades (since 1991). In addition, it was UK-government backed for the vast majority of that period. Furthermore, IIP has a broader remit than the other schemes (most of which are solely focused on health and wellbeing). It covers broad workplace practices to drive better performance – health is only part of that offer – which may be more attractive to businesses.

The average take-up, for all schemes, is 1,699. Take-up is, for obvious reasons, related to coverage. The national schemes, on average, cover 1,103 businesses while regional schemes only 323.

The low levels of take-up prompt the question as to why this might be the case. Although answering that question definitively is beyond the scope of this study, it is possible to make some suggestions. Firstly, there is evidence to suggest that businesses perceive complying with standards as too onerous¹³⁸. Many schemes require participating organisations to comply with numerous, rigid criteria that may not be compatible with the needs or priorities of their business and therefore perceived as overly bureaucratic. IIP for example, although it has relatively high take-up, expects every organisation to meet 39 'evidence requirements'. This may not be feasible for all businesses – particularly small ones. Indeed, carrying out an anonymous health needs assessment (required by some schemes) in an office with 1-5 people is not possible. Furthermore, small organisations may not have the time or resources to meet an entire standard. Healthy Working Wales's approach of offering different awards based on

¹³⁷ Based on 232 participating organisations

¹³⁸ RAND Europe. (2017). *Analysing the Impact of the Workplace Wellbeing Charter*. Cambridge: RAND Europe.

organisation size appears to be a sensible way of dealing with this issue and more schemes should seek to emulate it.

4.3. Conclusions

The mapping exercise has uncovered a diverse range of 17 public health workplace health accreditation schemes. Most schemes are provided by government (i.e. national, devolved or local). UK central government schemes are typically owned and provided by non-department public bodies, have national coverage and are well-established. A significant number of schemes provided at the regional level (often by local authorities) have been established more recently. In terms of the aspects of employee health and wellbeing that the schemes cover – our first research question – most have a ‘general’ health focus. This encompasses a wide range of employee health and wellbeing issues. Second, targeted schemes with a more specific focus tend to concentrate on mental health (particularly the more recent schemes e.g. from Mind) health and safety (e.g. the well-established Management Standards from HSE or ILO’s international standards). We also found schemes with a broader focus, which have an indirect impact on employee wellbeing, including IIP and Disability Confident.

The type of scheme we identified also varied. Most can be described as conventional in that they comprise a set of standards, assessment process, award process and an award. However, several only comprise a set of standards. Regarding common elements – many are shared by the identified schemes. The most common was ‘best practice and idea sharing’, followed by ‘tailored reports/feedback’, and then ‘awards’. These elements – particularly the first two – were considered valuable by participants of our employer roundtable (discussed in the following chapter). Tailored reports are particularly useful as they allow organisations to see what they are doing well and where investment needs to be prioritised. Also, they demonstrate that the business is at least committed to doing ‘something’ about employee health and wellbeing, which may have reputational benefits.

For most schemes, the accreditation process involves self-assessment, external validation, an award at one of several ‘levels’ followed by (often annual) awards ceremonies. Most schemes use evidence on the ‘general’ benefits and costs of employee health and wellbeing as their evidential basis. However, a smaller number use more specific evidence (e.g. HSE drawing on evidence about the impact of the psychosocial work environment) or cite specific NICE public health guidance (Cornwall’s Healthy Workplace Programme).

In general, the number of evaluations and the quality of evidence regarding the effectiveness of identified schemes is poor. Where it is available (e.g. for IIP’s scheme and Total Worker Health), the evidence suggests these schemes have a measurable, positive impact. For the vast majority, however, we only have either a very small number of formal evaluations to rely on or evidence/case studies compiled by the scheme providers. Levels of take-up, which can be considered a form of impact measurement, are generally quite low.

4.3.1. Limitations of the mapping exercise

The conclusions outlined above must be considered with the following limitations in mind. The number of accreditation schemes found, at 17, is arguably quite low. The general lack of research on them in the academic and grey literature is one obvious cause of this. Furthermore, the vast majority of the schemes we identified are based in the UK. This was to some extent inevitable due to the fact our review was focused on English publications, and

that the networks we in part relied on to identify relevant schemes (e.g. PHE's Health and Work Advisory Board) are based in the UK. As such, the schemes found may not be representative of global schemes generally and, though to a lesser extent, those in the UK. As such, our conclusions necessarily only pertain to the schemes found by our mapping exercise.

5. Employers' views on public health workplace health offers

5.1. Introduction

The aim of this stage was to explore employers' views on public health workplace health offers, specifically local accreditation schemes, in a local area which runs its own scheme. We selected Cornwall in the South West. The local authority has been running the well-funded Healthy Workplace Programme for over 10 years with relatively high levels of engagement.

We conducted a roundtable comprising 10 employers employing between 14 and 1,500 people. We then asked six questions, covering employers' awareness of public health workplace health schemes, their engagement with and wider perception of them. We address these in turn below.

5.2. Employers' awareness of public health workplace health offers

In general, participants reported high levels of awareness. The local authority provides strong support, investing in a specific team for workplace health. They provide three part time staff who run the programme and are very proactive on social media, running events and offering businesses workshops, etc., as well as the popular Cornwall Healthy Workplace Awards annual event.

The programme was praised by participants for keeping them updated about local events, campaigns and workshops, e.g.:

"We feel that by being part of the Healthy Workplace Programme we know everything that is going on. If we weren't part of it I feel there would be a gap in understanding. A little lost without it, it is invaluable."

Participants found the regular email updates, bulletins and yearly calendars help to them plan ahead. It has also made them aware of training that they otherwise would probably not have accessed:

"There are financial constraints within the business but we are trying our best to do what we can ... the award has helped us immensely, it has helped us access Mental Health First Aid training and links us to everything."

It is apparent that our roundtable participants are highly aware of the local scheme and the benefits it brings their business. We cannot say if this is representative of all or even most organisations in the local area. Furthermore, how representative it is of other local schemes across the UK is also unclear. It is evident that the Cornwall scheme is well funded, as it has three dedicated staff who run events and keep participants updated. This may not be the case with the other local schemes we identified.

5.3. Employers' engagement with public health workplace health offers

To get a sense of employers' engagement with schemes, we asked them:

- (i) how engaged they have been in the development and take-up of them;
- (ii) what factors play a role in whether they sign-up or not; and
- (iii) the types of incentives/tools that can be used to encourage participation.

Although not involved in the development of the Cornwall Healthy Workplace Programme (CHWP) as such, the scheme providers collect feedback from participants and adapt it each year. Therefore, they do have an influence on it.

Two participants remarked that they were “very” engaged with the scheme, one having been involved with it since its inception and another remarking that engagement was increasing:

“Getting top line managers involved is essential. They see employees and they see the benefits, which increases engagement.”

Indeed, several participants stressed the importance of senior management buy-in. The importance of this was also reflected in the findings of our evidence review and mapping exercise.

A number of factors play a decisive role in whether participants chose to participate in the scheme. Several pointed to the fact that the programme is well supported across the local authority and public health team. Furthermore, the structure of the awards and the programme of events, which are well promoted, work effectively together. This suggests that local areas would need to invest dedicated resources to engage businesses and to support them.

Participants singled out the “support offered locally”, and the “really structured approach” of the scheme, as well as its “clear guidelines and criteria”. The regular updates from the scheme organisers were also praised:

“Emails and regular bulletins act as prompts so we are aware of what is happening and available. They help remind us and just ensure it’s always on the agenda. Also business forums are great for bringing businesses together, as well as the training days, e.g. Macmillan’s session on cancer at work, which was accessible and relevant.”

In addition to the regular updates, this participant valued the scheme as a platform for connecting with other businesses and sharing ideas (a common feature of the schemes we identified). They also highlighted the access that the scheme provides to relevant and helpful training.

Another participant valued the flexibility of the scheme:

“As we have been committed to employee health for a number of years there are activities (nutrition, getting active, back pain, mental health) that we cover ... so we may use information provided ... but not necessarily adopt the scheme as a whole.”

This offers some support for the view, outlined in the previous chapter, that overly bureaucratic schemes with rigid standards may deter organisations from participating, with businesses potentially perceiving them as overly onerous. Thus, organisations may prefer – as this one does – a ‘menu’ of options or interventions they can select from flexibly.

Another participant praised the scheme for helping their organisation deal with a particular problem it faced:

“We had many staff off sick with mental health issues and we as an organisation had a lack of knowledge. The training team has made a huge difference, we now have

Mental Health First Aid. Sickness absence levels have reduced and staff have returned to work sooner.”

This reinforces the need for schemes to offer a flexible approach. This organisation in particular wanted guidance on how to deal with mental health in the workplace. Some of the more rigid schemes with a general health and wellbeing focus, requiring organisations to look at several health issues, may have been inappropriate.

The types of incentives/tools considered effective related to networking and events as a means of sharing ideas and best practice. Peer to peer learning was also seen as important. The clear structure of the CHWP was also valued as it provides participants with a ‘template’ to follow which is then reinforced by regular events.

One participant singled out the value of onsite training:

“Them coming to us makes a huge difference and we can allow time to come off the phones to access a weigh-in, or some training – whatever it may be – and it always creates a real buzz in the office. It’s much cost effective for us.”

Again, whether a scheme can provide such a service does depend on the funding available and it is clear that the CHWP is particular well-funded and resourced.

5.4. Employers’ wider perception of public health workplace health offers

We asked employers what sources of public health workplace health information they found reliable, and specifically whether Public Health England (PHE) was perceived as an authority on this topic (and therefore well placed to potentially offer new national standards).

Generally speaking, the participants felt that PHE and NHS resources were reliable and trustworthy – and that PHE has credibility on the issue of workplace health.

We also asked participants whether they saw value in a ‘workplace health needs assessment’ (one is offered by PHE) and if one is needed before implementation of any scheme. Participants agreed that it is a useful tool to gather important information and how to prioritise investment:

“It makes you think about the health and wellbeing of staff. It is definitely a must.”

It’s really useful. It’s important to have staff views and a refresh on what to do within the company.”

One participant, however, saw value in it but felt that it should not be a prerequisite:

“Sometimes it can put employers off ... many organisations probably already use an engagement survey so it’s useful and valuable but not essential.”

This is an interesting finding in light of the fact that some of the schemes we identified (e.g. the Better Health at Work Award) insist on such an assessment. This may act as a deterrent in some cases.

5.5. Conclusions

It is fair to say that the participants of our employer roundtable are highly engaged with the local public health workplace health offer. It is unclear whether this is representative of all organisations in the region or indeed the UK in general. Given how well funded the Cornwall scheme is, it may not be representative of engagement levels across the UK. The frequent updates, emails and bulletins were highly valued and singled out for praise, as well as the regular events and opportunities to network with other businesses. This is only made possible by the fact that the scheme has three dedicated staff.

An attractive feature of the CHWP is its flexibility. Participating organisations are not overburdened by bureaucracy (as may be the case with other schemes we identified) enabling organisations to shape it to their particular needs. Onsite training was another popular feature. Whether a less well-funded scheme could provide such a service is unlikely.

In general, participants considered PHE a trustworthy provider of reliable information and authority on workplace health. However, the wellbeing toolkits they provide were perceived by participants as too information heavy for small and medium sized organisations. Furthermore, they lacked focus on the causes of workplace ill health. The majority of participants valued a workplace health needs assessment, but one thought it can act as a deterrent if it is a prerequisite.

This stage of the research offers useful insights into what makes for an effective workplace health offer, including: regular updates, bulletins, events, award ceremonies, information and idea sharing, relevant training, onsite training, flexible/adaptable standards, senior management buy-in, a workplace health needs assessment (in some cases). However, much of this is dependent on whether the scheme is well funded and the resources it can draw on. The CWHP is particularly well funded and well established, having been in operation for more than 10 years, with three dedicated part time staff. Whether this could be replicated nationwide across other regions is not clear.

5.5.1. Limitations of the employer roundtable

Due to the qualitative nature of this stage of the research and the small sample size, it should not be inferred that the findings from the roundtable are representative of organisations across Cornwall or indeed the UK. It is possible this stage of the research suffers from 'selection bias' whereby employers with already relatively high levels of engagement with the local scheme are more likely to take part in a research exercise dedicated to it.

6. Conclusions and recommendations

In this final chapter we offer our overall conclusions and recommendations. To recap, the findings from the first stage of the research – the evidence review of employer-led action to improve employee health and wellbeing – revealed a large body of evidence (of 100 reviews and meta-analyses). The majority of interventions focus on addressing specific health conditions, e.g. obesity, MSK conditions and mental health problems. Some look at health behaviours, e.g. alcohol consumption, smoking and physical activity. Others simply focus on ways to reduce absenteeism. While a small number take a holistic, non-biomedical approach, to improving employee health and wellbeing (focusing on the psychosocial work environment for example).

There are a number of components that tend to make for a successful intervention with sustained effects. These are:

- Co-production (involving the employee, employer and, if applicable, a relevant health practitioner)
- Buy-in from senior management to drive it
- Interventions that aim to modify the work environment as well as the employee's behaviour, so that they complement each other (i.e. holistic)

No intervention type can be described as the 'gold standard'. Similarly, there is no one-size-fits-all approach applicable to different sized organisations in different sectors. There is in fact a lack of intervention studies, and therefore evidence, involving small and medium sized organisations and 'blue collar' sectors in particular. Furthermore, there is a general lack of robust evidence underpinning the effectiveness of interventions and more research is needed in this regard.

The second stage – the mapping exercise – revealed 17 diverse public health workplace health schemes. Most schemes are provided by government (i.e. national, devolved or local). UK central government schemes are typically owned and provided by non-department public bodies, have national coverage and are well-established. A significant number of schemes provided at the regional level (often by local authorities) have been established more recently. Many have a general health and wellbeing focus but mental health and health and safety feature prominently too. The majority of the schemes can be described as 'conventional' (see Box B). There were many shared common elements between the schemes. Best practice sharing and tailored reports were both popular. Most schemes have a comprehensive accreditation process, involving several stages (see Box C). Participating organisations must often fulfil extensive criteria to be accredited.

Most schemes use 'general' health and wellbeing evidence as their evidential basis – rather than drawing on evidence generated by specific intervention studies (i.e. those reviewed in the first stage). Although it often is the case that investment in workplace health and wellbeing can improve health and reduce absenteeism, etc., such vague, potentially distant, benefits are unlikely to really appeal to businesses. Also, there is, overall, a lack of evidence and evaluations regarding the effectiveness of these schemes. Thus, just as there is a need for more robust evidence on the effectiveness of workplace health interventions, there is also a need for more evaluations on the effectiveness of workplace health accreditation schemes. Furthermore, levels of take-up are generally quite low.

The third and final stage of our research – the employer roundtable – provided some insight into what makes for an effective scheme. It was evident that organisations valued the flexible nature of the CHWP and the fact they could apply it to areas they considered a priority – rather than being obliged to comply with an entire standard. This ‘menu of options’ is likely to appeal to businesses. Furthermore, it was felt that a health needs assessment, although valuable, should not be a prerequisite. This could give an indication as to why some schemes, which insist on them, may have low take-up. Indeed, for very small workplaces they are just not feasible. The caveat to this is that the CHWP is particularly well funded and resourced. How feasible it is, therefore, to replicate it in regions across the UK is unclear.

All stages of the research are subject to a number of limitations (provided in each chapter) and the conclusions outlined above should be considered with them in mind.

6.1. Recommendations

Notwithstanding the limitations of the research, our findings indicate that the potential development of any new national public health workplace health standards would be faced with a number of challenges. Perhaps most importantly, participation rates are low (even for well-resourced schemes like the CHWP) given the size of the target populations. There are also question marks around the effectiveness of schemes (due to a lack of evaluations) and – more broadly – workplace health interventions in general (due to a need for more robust evaluations with organisations of different sizes and sectors, etc.). Furthermore, while a workplace health needs assessment has value – helping businesses prioritise areas for investment – insistence on it can deter organisations. An additional problem is that, having completed one, the next steps are not necessarily obvious given the lack of high quality robust studies on what interventions are effective.

Schemes that have a comprehensive set of general health and wellbeing standards that must be rigidly adhered to – IIP for example has 39 that all organisations must meet – can be perceived as overly bureaucratic and may have limited appeal – particularly amongst small organisations. Businesses may also question the value of trying to meet extensive criteria if it is based on primarily ‘general’ evidence of the health and wellbeing benefits of investing in workplace health (which most schemes are). A relatively vague payoff on an uncertain timescale may not be appealing.

It is also difficult to develop an inclusive set of standards that are relevant and appeal to a range of businesses varying in size, sector, workforce type, industry, etc. (which will probably have different needs as a result of these differences). A ‘catch-all’ scheme runs the risk of being too ‘high-level’, general, abstract, and therefore potentially not particularly relevant to any organisation. On the other hand, a scheme that is very specific and targeted at a certain organisation/population type obviously has more limited appeal. It is difficult to strike a balance between universality and specificity. Healthy Working Wales has attempted to deal with this issue by having a different set of standards depending on the size of the organisation. It is clear that, given these difficulties, a ‘menu’ of interventions that participating organisations can choose from would be preferable to long list of requirements – standards – that all organisations must comply with.

The overall aim of this research was to help inform a decision on whether to develop new national public health workplace health standards, i.e. whether they are valued and make a

difference. Our qualitative work suggests that, if executed properly, with adequate funding and resource, they are valued. However, the low level of take-up for schemes in general raises question marks over how much businesses value them. Furthermore, the lack of evidence and evaluations regarding their effectiveness makes it difficult to determine how much of a positive difference they actually make. An additional problem is the lack of robust evaluations on workplace health interventions in general. While the limitations of this research must be kept in mind, our findings suggest it might be difficult for PHE to make recommendations via a standard based on the evidence available.

PHE could therefore concentrate on developing 'commissioning guidance'. This could enable/help local authorities design their own accreditation schemes that cater to their local businesses' needs. Our (albeit limited, qualitative) evidence suggests employers consider PHE a reliable and trustworthy authority on this topic. PHE might therefore choose to focus on being a repository for best practice and knowledge that local authorities can draw on in order to develop their own offers.

Furthermore, there is a role for further research to play. A more ambitious systematic review, perhaps focused on a specific health topic, could address the limitations of the rapid evidence review presented here. In addition, there appears to be a need for more robust research – e.g. an impact assessment – of employer standards on their effects on participating organisations and their employees.

Appendix 1

Search terms used for **Stage One** (i.e. review evidence of employer-led action to improve employee health and wellbeing) included: 'work/workplace/worksites', 'work', 'occupation/job/employment', 'corporate health', 'sickness absence', 'occupational health support', 'work and well-being', 'working age health', 'health promotion', 'healthy choices', 'healthy eating', 'smoking', 'alcohol', 'drug use', 'health care', 'workplace health promotion', 'ill-health', 'early intervention', 'health insurance', 'wellness', 'disability', 'musculoskeletal', 'back pain', 'behaviour', 'attendance management', 'health management', 'vocational rehabilitation', 'early rehabilitation', 'return-to-work support', 'staying in work', 'attendance', 'sickness absence', 'workplace adjustments', 'ageing', 'workplace health', 'stress management', 'mental health', 'mental wellbeing', 'mental health interventions', 'workplace intervention'.

In addition, grey literature was searched with the main term 'workplace health and wellbeing' used in conjunction with the following:

- Workplace health promotion
- Physical activity in the workplace
- Workplace health improvement
- Mental wellbeing
- Stress
- Nutrition
- Smoking
- Alcohol
- Workplace environment
- Health and wellbeing policy

The additional search terms used for **Stage Two** (i.e. map global workplace charter/accreditation schemes) included: 'work/workplace/worksites', 'employer/corporate', 'scheme/initiative/offer/accreditation/programme', 'health/wellbeing/mental'.

The questions put to the employer roundtable in **Stage Three** (i.e. explore employers' views on public health workplace health offers, specifically local accreditation schemes) were as follows:

1. What is your level of awareness of local workplace public health offers and accreditation schemes?
2. How engaged are you in the development and take-up of these schemes?
3. What factors play a decisive role in whether you choose to participate?
4. What type of incentives/tools can be used to encourage participation?
5. What sources do you consider trustworthy; do you perceive PHE as an authority on this topic?
6. Do you see value in the 'workplace health needs assessment' (particularly as a precursor to the implementation of any scheme)?

Appendix 2

The rapid evidence review findings are listed below.

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