Workplace Wellbeing Charter

Analysis of take-up and impact

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RAND EUROPE
Preface

There is strong and growing evidence that work and health and wellbeing are closely and strongly linked and need to be addressed together. In June 2014, Public Health England (PHE) published a set of national standards for workplace health for the first time – the Workplace Wellbeing Charter (WWC or Charter), which was developed with the charity Health@Work and Liverpool County Council and was based on their scheme and others from around the country. The national standards aimed to introduce a level of coherence and consistency across the country to support local authorities that had different programmes, with their own standards and reporting requirements, or were planning to introduce them.1

The standards provide a universal baseline for local areas to commission or provide their schemes against, harmonising the core of existing schemes and allowing other elements to be tailored to local needs and interests. The WWC is designed to provide employers with a systematic, evidence-based approach to workplace health improvement.

While the need for employers to act on workplace health and wellbeing is unequivocal and the practice of bringing together resources within a coherent approach is valid, there has been limited research into the impact of the WWC as a method. This study investigates the take-up and impact of the WWC, maps available data on the number of organisations accredited with the Charter across England and provides insights into a diverse range of organisations that have invested in the wellbeing of staff in their workplaces.

This RAND Europe study was commissioned and funded by PHE. RAND Europe is a not-for-profit policy research organisation that aims to improve policy- and decisionmaking in the public interest, through independent research and analysis. This report has been peer-reviewed in accordance with RAND’s quality assurance standards.

For more information about RAND Europe or this document, please contact Joanna Hofman (jhofman@rand.org).

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Summary

Background

There is an increasing recognition among companies, local authorities and the government that health and wellbeing in the workplace is important. Against this background, in June 2014, Public Health England (PHE) published a set of national standards for workplace health for the first time. The Workplace Wellbeing Charter (WWC or Charter), designed by Liverpool Primary Care Trust in partnership with Liverpool City Council and supported by PHE through the national standards as a model for other local authorities to use, provides local authorities and employers across England with a comprehensive, systematic and universal framework for workplace health improvement.

Commissioned and funded by PHE, RAND Europe undertook an analysis of the take-up and impact of the Workplace Wellbeing Charter. The analysis was conducted at two levels. Firstly, we analysed data provided by local authorities, via PHE, on organisations participating in the Charter scheme (or an equivalent). However, the analysis was limited by data availability and, although the data present in the data set appears to be broadly reliable, using data missing from one area as evidence that there has been no take-up of the scheme there is inadvisable, and therefore we have not done this. Secondly, we carried out a set of case studies and carried out 37 interviews in 13 organisations to provide additional insights into the evidence that underpins the Charter.

Key findings

It is important to note that this study is not an impact evaluation, and did not attempt to draw robust conclusions about the overall impact of the WWC, or the likelihood or type of positive impact in any organisation. Rather, it uncovers areas in which the WWC has been particularly well-received and explores the potential impact of the WWC in a variety of contexts as a basis to allow organisations to make more informed decisions about the relevance of the WWC to their own needs and potential ways to implement it in their workplaces.

The accreditation process required a lot of effort and it was considered as long and time-consuming, particularly by micro and small organisations, unless organisations used collaborative software, dedicated tools and electronic data submission, which help to simplify the process.

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The most common motivation to undergo the accreditation process was a desire to reduce sickness absence and demonstrate commitment to workplace wellbeing to staff. Organisations also wished to improve motivation, satisfaction and staff engagement, and sought external validation and feedback on their pre-existing initiatives.

When exploring how organisations implemented staff health and wellbeing interventions, we found that information on resources invested was partial. We did, however, find that there were various forms of collaboration and partnership between the accredited organisations and local institutions, charities, healthcare and specialist providers, which brought expertise, advice, services and products directly to the case study organisations.

The study found a wide range of health and wellbeing activities implemented by the accredited organisations – from facilitating healthy choices, introducing new policies, and providing health screenings, through to workshops, training and team building activities.

However, the information on outputs (the overall number of wellbeing events and initiatives) and outcomes (staff participation data) was scarce. This lack of data made the link between the activities and impacts more difficult to capture – both for the organisations themselves and for the researchers.

While the study identified a number of improvements in policies, infrastructure and the provision of wellbeing programmes – sickness absence, job satisfaction and staff morale, to name but a few – these changes could not be unambiguously attributed to the WWC accreditation and the wellbeing activities. However, we found a number of areas where the WWC contributed to making a positive difference to the accredited organisations and their staff:

- The WWC provides organisations with an all-inclusive framework for identifying gaps and areas for improvements, while allowing them the flexibility to prioritise certain areas and pace changes according to their determination, resources and abilities. Of the 13 organisations featured in case studies, eight reported that they had been motivated to improve their workplace health and that the WWC had given them specific ideas or added structure to what they were doing.
- The WWC inspires novel approaches to achieve sustainable results in times of austerity and limited resources. Seven organisations explicitly mentioned partnerships with local organisations that provided services free of charge, and all said that the main investment was time rather than money.
- The WWC helps organisations capture results and realise how much they already do. It also demonstrates the benefits that organisations gain from wellbeing initiatives and encourages organisations to maximise the results. Ten organisations reported an improvement to a quantitative outcome measure that they believed the WWC had contributed to.

Although the case studies were self-selected and likely to be biased towards creating a favourable impression of the Charter, the reported results broadly point in a direction which suggests that the Charter can, in the right circumstances, make a positive contribution to workplace wellbeing. For similar organisations, the issues, activities and consequences reported here might be indicative of what they can expect to experience by undergoing WWC accreditation and investing in staff health and wellbeing.
Main recommendations

Based on these findings we arrived at the following suggestions for PHE:

1) Introduce a system to monitor the nationwide use of the WWC national standards as soon as possible.
2) Further develop and implement reporting guidance and tools for consistent reporting on WWC accreditation.
3) Create a toolbox with tried and tested solutions to simplify and aid the process for organisations applying for WWC accreditation for the first time.
4) Simplify the accreditation process for micro and small organisations by increasing flexibility, thereby making it less difficult for them to undergo the accreditation without compromising the national standards.
5) Specifically include examples of effective collaboration between accredited organisations and local providers in the aforementioned toolbox.
6) Embed the logic model approach in the WWC accreditation process to help organisations prioritise or introduce wellbeing interventions more likely to lead to intended or desired outcomes.

And for local providers:

7) Augment existing successful partnerships and continue working with organisations to build partnerships with local services, and to facilitate the links with relevant institutions and organisations.
Acknowledgements

We want to thank the project team at Public Health England for their support throughout this study. In particular, we are grateful to Dr Justin Varney, Dr Mike Brannan, Manuel Ramos, Louise Lees and Robin Burgess who provided helpful guidance and support throughout the duration of the study. We also wish to acknowledge the kind assistance of Martin Smith and Joan Brookman from Liverpool City Council, Rachel Faulkner from Cornwall Council, Gillian Maxwell-Barrett from Kirklees Council, Grace Davies from Bristol City Council, Jane Abraham from Flourish Workplace and Kevin Yip from Health@Work.

We are greatly indebted to all organisations participating in the case studies, namely: BAE Systems, Carillion Construction Training plc, Coventry City Council, Dearne ALC, Edgetech, Mersey Care NHS Trust, Munroe K Asset Management, Rowlinson Knitwear, Tameside Metropolitan Borough Council, The Regulatory Affairs Consultancy, University of the West of England, XPO Logistics and YMCA Cornwall. We wish to thank our interviewees – members of staff of these organisations – for sharing their experiences on wellbeing initiatives in their workplaces.

We are also grateful for feedback from our quality assurance reviewers at RAND Europe, Dr Joachim Krapels and Professor (Emeritus) Tom Ling, on previous versions of this report.

This report represents the views of the authors. Any remaining inaccuracies are our own.
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAs</td>
<td>Local authorities</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>WWC</td>
<td>Workplace Wellbeing Charter</td>
</tr>
</tbody>
</table>
1. Introduction

1.1. The workplace and wellbeing

There is an increasing recognition among companies, local authorities and the government that health and wellbeing in the workplace is important and can have profound impacts on individuals, organisations and societies. This is in part due to significant changes in the labour markets across industrialised countries, including: increased female participation; the move from blue collar to white collar jobs; the higher educational levels of workers; and the transition from an economy based on manufacturing to one more reliant on the services sector. A more knowledge-based economy also implies that policymakers will focus on the creation of ‘better jobs’. If the economy is to become more productive, and if it can be demonstrated that workplace wellbeing supports improved productivity, it makes sense for companies to improve the quality of jobs and invest in their workers’ wellbeing.

This increasing interest in the health and wellbeing of workers can also be explained by negative factors, such as increased job insecurity, worse working conditions, and the reduced possibilities of combining work with other private and social responsibilities.

Dame Carol Black’s Review – Working for a Healthier Tomorrow – recognised that there is strong and growing evidence that work and health and wellbeing are closely and powerfully linked and need to be addressed together. In the United Kingdom, in 2014–15, an estimated 1.2 million people were suffering from an illness they believed was caused or made worse by work and 142 workers suffered fatal injuries at work. Finally, an estimated 4.1 million working days were lost due to workplace injuries, on average 6.7 days per case. The 2011 Black–Frost report on sickness absence in the workplace in the UK highlighted that 140 million working days are lost to sickness absence and 300,000 individuals leave the workplace a

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3 See, for instance, European Commission, 2007.
7 Health and Safety Executive (homepage), as of 15 December 2016: http://www.hse.gov.uk/index.htm
year due to ill-health. The Centre for Mental Health has also calculated that the cost to the economy of ‘presenteeism’ from mental ill-health alone is £15.1 billion annually, while absenteeism from the same cause costs £8.4 billion.

As a consequence, more scholarly work has been undertaken to define the issue of health and wellbeing in the workplace and to also understand what is effective in addressing health and wellbeing in the workplace. In summary, there is good evidence that:

- **Work tends to be good for individuals and for society as a whole:** Compared with those out of work, the working population makes far less use of healthcare services, is generally happier and healthier, and contributes more to the public purse in taxes than it takes out in benefits. As a consequence, society can gain from supporting people in employment and providing rapid assistance for those under threat of unemployment or out of work.

- **Investing in health and wellbeing makes sense from a business point of view:** For instance, we know that a healthy and well-supported workforce is more productive and delivers better service. In the health service, for example, this is associated with better quality of patient care. RAND’s work for the Boorman Review on the health and wellbeing of NHS staff gave a sense of possible savings to organisations from adopting more effective ways of managing the health and wellbeing of staff: savings to the NHS alone were estimated at half a billion pounds a year.

- **Work can also be a cause of ill-health:** Exposure to physical hazards at work, a stressful working environment and physically or emotionally demanding work can increase the risk of sickness absence and pose a risk to health. Musculoskeletal disorders and common mental health disorders, such as stress, depression or anxiety, are now the major causes of self-reported illness among employees.

- **Workplace wellbeing interventions can be effective:** A recent systematic meta-review has shown that workplace interventions can help prevent common mental illnesses and facilitate the

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10 For overviews see for instance:


13 Health and Safety Executive (homepage), as of 15 December 2016: http://www.hse.gov.uk/index.htm
recovery of employees with depression or anxiety. A RAND study in the US found statistically significant and clinically meaningful improvements among programme participants in exercise frequency, smoking behaviour, and weight control. In the same study, participation in a wellness programme over five years was associated with lower health care costs and decreasing health care use.

In response to the above developments, in 2005 the government launched the cross-departmental programme ‘health, work and wellbeing initiative’ focused on improving health and wellbeing for the working age population. As part of the initiative, the government’s publication ‘Health, work and wellbeing – caring for our future’ set out a comprehensive strategy bringing together different strands of activity under one programme. The two overarching objectives of the strategy are centred on improving the general health and wellbeing of the working age population, and on supporting people with health conditions to stay in work or to enter the labour market. Importantly, the strategy builds on a collaborative approach, encouraging the participation of a wide range of stakeholders, such as employers, trade unions, professional organisations, voluntary bodies and other relevant organisations that can help to create a healthy environment and support individuals in making healthier lifestyle choices. The programme also aims at reducing health inequalities and social exclusion by reinforcing the link between employment and overall personal health and wellbeing. The government subsequently launched a number of initiatives to support and drive the strategy.

Despite growing evidence on the effectiveness of workplace wellbeing interventions, a number of factors affect employers’ engagement with workplace health promotion. A literature review has shown that these include: a lack of occupational safety and health infrastructure, a negative perception of occupational health requirements and benefits, a lack of relevant skills and qualifications, inadequate cooperation.
between key stakeholders in the process, bureaucratic requirements, the perceived need for major financial investment in a programme, and the misperception by employers and organisations that such interventions have limited or no benefits for the company, are too time-consuming, or are not their responsibility. In 2012, in a study of US employers, 46 per cent of all businesses surveyed said lack of interest was the key barrier to implementing a wellbeing programme, while 21 per cent of small business owners who pointed to difficulty of administering such programmes. The challenges for businesses in this regard may also relate to the size of organisations, the nature and patterns of work within particular organisations and logistical issues.

1.2. Workplace Wellbeing Charter

Against this background, in June 2014, Public Health England published a set of national standards for workplace health, the Workplace Wellbeing Charter (WWC), which was designed to provide employers with a systematic, evidence-based approach to workplace health improvement. The standards were developed with the charity Health@Work and Liverpool County Council and were based on their scheme and others from around the country. Local authorities who choose to run workplace health award schemes for organisations in their areas can adopt the WWC in its entirety or implement a local scheme based on the national standards; there is no single national scheme.

The Charter is based on three elements – leadership, culture and communication (Figure 1-1) – that are needed to make initiatives successful and sustainable. There are 95 Charter standards grouped into eight areas: 1) leadership, 2) sickness and absence management, 3) health and safety, 4) mental health, 5) smoking and tobacco, 6) physical activity, 7) healthy eating, and 8) alcohol and substance misuse. Standards can be met, partially met or not met. The standards are not specifically linked to the three elements, but inspired by them. They do not prescribe specific outcomes that must be met or any numerical objectives, but policies, systems or specific interventions that should be in place. Within each area, the standards are divided into three different levels of award towards which organisations can work:

- **Commitment**: This level should be met by all. It requires an organisation to have a set of health, safety and wellbeing policies in place that cover all areas and which provide employees with the tools to help themselves to improve their health and wellbeing.

- **Achievement**: This level requires an organisation to actively encourage employees to make positive lifestyle choices. An organisation also ought to be taking steps to introduce basic interventions to identify serious health issues.

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19 The survey was conducted by telephone among a nationally-representative sample of 1,005 US owners and decisionmakers of businesses with between 2 and 100 employees. The margin of error is ± 3.1 per cent, assuming a 95 per cent confidence. See NSBA, ‘Wellness Programs Impact Bottom Line’. NSBA, 27 September 2012, as of 15 December 2016: [http://www.nsba.biz/?p=4224](http://www.nsba.biz/?p=4224)

Excellence: This level signifies fully-engaged leadership, with a range of interventions and support mechanisms to help staff prevent ill-health, stay in work or return to work as soon as possible. Information about health and wellbeing should also be easily accessible and well publicised.

For example, standard 1.1, which is in the ‘leadership’ area and at the ‘commitment’ level is:

The organisation has assessed its needs and priorities around health and work.

*(The Workplace Wellbeing Charter: National Award for England: Self Assessment Standards)*

Organisations may complete a self-assessment process for their own benefit, but formal assessment is carried out by external assessors known as ‘providers’. The accreditation process involves a review of internal policies, processes and activities aimed at improving staff wellbeing, centred on the Charter standards. The review comprises short interviews with staff representatives and site visits to inspect the facilities in place and the work environment. If this is successful, then organisations are accredited with the WWC, or a local equivalent.

The aims of the standards are twofold. Firstly, they aim to harmonise practices across the country and support local authorities that had considered a scheme or had different schemes in place. As such, the standards provide a national baseline for local authorities to commission or provide their schemes against, while allowing for supplementary elements to tailor schemes to local needs and interests.

Secondly, the WWC is designed to provide employers with a systematic approach to workplace health improvement. For businesses, the Charter’s website describes the Charter as ‘a statement of intent, showing your commitment to the health of the people who work for you.’ It states that organisations can use it in different ways including:

- ‘Auditing and benchmarking against an established and independent set of standards’ – identifying what the organisation already has in place and what gaps there may be in the health, safety and wellbeing of your employees.
- ‘Developing strategies and plans’ – providing a clear structure that organisations can use to develop health, safety and wellbeing strategies and plans.
- ‘Gaining national recognition’ – The Charter award process is robust and evidence based. With over 1,000 organisations across England holding the award, The Workplace Wellbeing Charter is now widely recognised as the business standard for health, safety and wellbeing across England. The award helps to strengthen the organisation’s brand and reputation and supports in sales and marketing activities.

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21 Tony Vickers-Byrne, 2014.
While the need for employers to act on workplace health and wellbeing is unequivocal and the practice of bringing together resources within a coherent approach is valid, there has been limited research into the impact of the WWC as a method.

This study investigates the take-up and impact of the WWC, maps available data on the number of organisations accredited with the Charter across England and provides insights into a diverse range of organisations that have invested in the wellbeing of staff in their workplaces.
2. Methodology

2.1. Overall approach and methods

We adopted a two-pronged approach in order to investigate the take-up and impact of the WWC:

1. We conducted a secondary analysis of available quantitative data on accredited organisations and those working towards accreditation with the Charter (or an equivalent scheme).
2. We carried out a series of qualitative case studies in 13 accredited organisations to better understand the accreditation process, the implementation of the WWC (or an equivalent scheme), the results that have been achieved so far, the likely impact of the Charter on these organisations, and the health and wellbeing of their staff.

The analysis of the take-up of the Charter – based on the analysis of data on accredited organisations – aimed to provide PHE with characteristics of the said establishments and the WWC coverage across England. The mapping of the accredited organisations was to be complemented by an exploration of impacts the WWC had had on the participating organisations.

The aim of this exploration was to investigate the potential impact of the WWC, to help organisations decide whether or not, and if so how, to implement the WWC in their own contexts. We did not aim to evaluate the WWC or to reach any overall assessment of its impact. Instead, we used a qualitative approach to understand what types of impact exist, how they are likely to occur and where the WWC adds most value to the participating organisations. We actively sought out positive examples to better understand the full range of possible impacts.

We describe each of these methods and their limitations in more detail below.

2.2. Scope of this report

Although the intended audience for this report includes PHE and local authorities, the case studies in particular are intended to demonstrate the possible benefits of the WWC to other organisations, to help them consider whether or not the WWC is likely to be appropriate for them. Therefore, in this report we describe what happened in the organisations we consider, rather than to make claims of generalisability. This reflects the stage of development that the WWC is at, and further research would need to be done, with a different study design, to reach a rigorous assessment of the impact of the WWC.

This study is not an evaluation and should not be seen as attributing any impacts to the WWC conclusively. In order to establish impacts of the WWC, we should provide a counter-factual, for example by comparing the performance of the accredited organisations with identical or similar organisations.
without the accreditation\textsuperscript{24}: the only difference between the two groups being the lack of (or presence) of the WWC accreditation. If any changes between the groups were observed over time, this would support causality and we could discard any other factors or explanations coming into play when attributing the achieved impacts to the intervention (here: the WWC accreditation). However, in this study, there was no control group (which could have been achieved, for example, by randomly assigning organisations to be accredited or not). It was also not possible to use comparison groups, since the characteristics of the accredited organisations were unknown and only explored in this study. Other techniques to establish counterfactual evidence (such as regression discontinuity designs or interrupted time-series models) were not feasible for this study, because of the lack of available data. To establish causality, more rigorous research is needed, such as a randomised controlled trial. One prerequisite for a rigorous evaluation would be a central record of all accredited organisations, or more robust processes to collect that data in a reliable form and timely manner. At the moment neither exists.

In the area of health and wellbeing at work, attribution of outcomes to an intervention such as the WWC is very difficult because organisations tend to have a lot of health wellbeing initiatives in operation. Any such attribution is at best anecdotal, and interviewees were often unable to separate the effect of the WWC from other initiatives.

Causal relationships are further complicated by apparently paradoxical timelines. The WWC is intended to unify other workplace wellbeing accreditation schemes, which existed before the WWC. Even within the boundaries already described, this report is not assessing the WWC in opposition to similar workplace wellbeing accreditation schemes, but rather as a part of this group. Thus outcomes might be related to a scheme other than the WWC, but this might still be an indicator of a potential impact of the WWC. In many instances an organisation was already offering a service or resource advocated by the WWC before they had heard of the WWC. For that organisation the WWC did not lead to that service being provided; however, it is still useful to know what it achieved if it is something advocated by the Charter, as in another organisation the WWC could lead to similar outcomes. Finally, WWC accreditation is awarded in recognition of measures that have been put into place in organisations, often but not always specifically in preparation for the WWC, and which could thus already be leading to positive outcomes at the time of accreditation. Therefore, it would not be unreasonable for impacts of the WWC to be seen before accreditation occurs.

Varying implementation across local authorities also means it is hard to define the intervention itself in a consistent, accurate manner (which we had not appreciated at the start of this study), and this intervention would also need to be defined clearly in future research. Is the intervention the provision of standards by PHE to local authorities, or is it a specific model of implementation by one local authority? If the latter, different areas would have to be evaluated separately, and ideally compared to identify what works in what context. This would lead to related questions about how tightly PHE controlled the

\textsuperscript{24} This similarity would have to include being motivated to be accredited under the Charter. For example, one way of testing the Charter would be to use a step-wedge design: take a group of organisations who wish to be accredited and then randomly divide them into one group of organisations that go through the process and another group that delay it, so that outcomes can be compared while one group is still unaccredited.
implementation of the WWC and what its model of spread is. This is a research topic of increasing interest.

Since the case studies are in no way representative of accredited organisations, exact numbers of organisations should not have too much meaning read into them. We provide numbers only as a rough indication of the evidence that exists. The case studies do provide a reasonable cross-section of the sector, size and location of accredited organisations, and in this sense larger numbers do indicate potential applicability in a greater range of settings.

2.3. Data on take-up of the WWC

The analysis of the take-up of the WWC across the country is limited by data availability and, although the data present in the data set appears to be broadly reliable, using data missing from one area as evidence that there has been no take-up of the scheme there is inadvisable. As the WWC accreditation is carried out at the local level, the data of individual organisations accredited or working towards accreditation are owned by local authorities. These data are not immediately available to PHE who needed to obtain it from local authorities for the purpose of this study.

The request for data was sent from the PHE National Team to local authorities via the nine PHE Centres before RAND Europe had been commissioned to carry out this study (see Appendix A). The local authorities who were sent the request comprised 27 non-metropolitan county councils, 36 metropolitan district councils, 55 unitary authorities and 32 London boroughs. In addition, where PHE Centres were aware that a scheme was being administered by a non-metropolitan district council, this council was sent the request as well. Data was requested in aggregate and categorised form rather than at the level of individual accredited businesses, which limited options for analysis. The categorisations requested were year of accreditation, size of business and sector.

Local authorities provided data to the PHE Centres, who collated it and sent it to the PHE National Team, who collated it and sent it to RAND Europe on 9 February 2016. The available data was patchy (not all authorities presented data disaggregated by both size and sector) and was reported by a very small proportion of the 150 local authorities across England (see Table 2-1). It was not generally possible to distinguish local authorities without schemes from those who did not respond to the request for data. It was also not possible to resolve some inconsistencies in the data from individual authorities, for example, where the reported number of organisations by size did not match the reported number of organisations across all sectors. There were some areas where the scheme was better established and data was more readily available (see Figure 3-1); these areas were also the source of our case studies.
### Table 2-1: Number of local authorities reporting WWC data

<table>
<thead>
<tr>
<th>Scope of reporting:</th>
<th>Number of LAs who reported on accredited organisations (% of all 150 LAs)</th>
<th>Number of LAs who reported on organisations working towards accreditation (% of all 150 LAs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported (some) data</td>
<td>39 (26%)</td>
<td>4 (3%)</td>
</tr>
<tr>
<td>Reported no data available</td>
<td>12 (8%)</td>
<td>N/A</td>
</tr>
<tr>
<td>Reported no scheme</td>
<td>16 (11%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Did not report</td>
<td>83 (55%)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

2.4. Case studies

2.4.1. Sample selection

The case studies aim to illustrate a wide range of different initiatives under the Charter and of impacts of undertaking action under the Charter. The candidates for case studies were identified by WWC providers (who accredit organisations; see section 1.2) at the request of PHE (see Appendix A), who indicated no specific criteria apart from the willingness of the accredited organisations to share their experience in taking action on the WWC (or equivalent) scheme.

We received 39 suggestions in total and the contact between the accredited organisations and the study team was facilitated by WWC providers. However, the actual recruitment process proved to be difficult. Despite numerous attempts to establish contact or arrange interviews with all 39 organisations, only 13 finally agreed and participated in the study.

As such, the process was largely driven by self-selection and most likely resulted in a sample biased towards more successful organisations – since they were not only identified by WWC providers but also willing to share their stories. While the selected organisations cannot, therefore, be considered as representative of all accredited organisations, they provide a combination of public, private and third sector employers, different size bodies, and industry sectors. They also represent various lengths of experience with the WWC (or equivalent) – from the organisations who have been accredited for a long time to those who only recently joined the scheme (Table 2-2). However, the experiences of the case study organisations described in this report effectively illustrate the kind requirements, activities and consequences that similar organisations applying for WWC accreditation can expect.
Table 2-2: Case study organisations

<table>
<thead>
<tr>
<th>No</th>
<th>Organisation</th>
<th>Type of organisation</th>
<th>Size</th>
<th>Industry sector</th>
<th>First accreditation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>BAE Systems</td>
<td>Private</td>
<td>Large</td>
<td>Defence</td>
<td>2011</td>
</tr>
<tr>
<td>2.</td>
<td>Carillion Construction Training plc</td>
<td>Public</td>
<td>Small</td>
<td>Construction</td>
<td>2015</td>
</tr>
<tr>
<td>3.</td>
<td>Coventry City Council</td>
<td>Public</td>
<td>Large</td>
<td>Public administration</td>
<td>2014</td>
</tr>
<tr>
<td>4.</td>
<td>Dearne ALC</td>
<td>Public</td>
<td>Medium</td>
<td>Education</td>
<td>Pending</td>
</tr>
<tr>
<td>5.</td>
<td>Edgetech</td>
<td>Private</td>
<td>Medium</td>
<td>Manufacturing</td>
<td>2013</td>
</tr>
<tr>
<td>6.</td>
<td>Mersey Care NHS Trust</td>
<td>Public</td>
<td>Large</td>
<td>Health and social care</td>
<td>2015</td>
</tr>
<tr>
<td>8.</td>
<td>Rowlinson Knitwear</td>
<td>Private</td>
<td>Small</td>
<td>Manufacturing</td>
<td>2015</td>
</tr>
<tr>
<td>9.</td>
<td>Tameside Metropolitan Borough Council</td>
<td>Public</td>
<td>Large</td>
<td>Public administration</td>
<td>2013</td>
</tr>
<tr>
<td>10.</td>
<td>TRAC</td>
<td>Private</td>
<td>Small</td>
<td>Business services</td>
<td>2012</td>
</tr>
<tr>
<td>11.</td>
<td>University of the West of England</td>
<td>Public</td>
<td>Large</td>
<td>Education</td>
<td>2013</td>
</tr>
<tr>
<td>12.</td>
<td>XPO Logistics</td>
<td>Private</td>
<td>Large</td>
<td>Transport</td>
<td>2015</td>
</tr>
<tr>
<td>13.</td>
<td>YMCA Cornwall</td>
<td>Third sector</td>
<td>Small</td>
<td>Health and social care</td>
<td>2011</td>
</tr>
</tbody>
</table>

* Note: As the WWC brought together existing local schemes, the first accreditation under the local scheme may have been before the WWC was launched.

2.4.2. Approach and methods

For each of the case studies, we took a logic model approach\(^{25}\) to understand the motivation behind the WWC accreditation and to see how the actions and strategy put in place logically led to outputs, outcomes and potentially impact. A logic model presents a plausible and sensible model of how an intervention or programme works,\(^{26}\) in this case the WWC. Basing a research approach around a logic model can therefore help test the validity of the assumed causal mechanisms underlying it. We used this framework to develop interview protocols (see below) and establish how this impact can (or cannot) be logically attributed to the actions undertaken.

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We distinguished different kinds of results: outputs refer to what the organisations produced through their activities, such as the number of health and wellbeing events, new policies or initiatives; outcomes refer to the attendance at events, uptake and use of wellbeing programmes (which are outputs) by employees; and impacts refer to improvements in staff health and wellbeing, organisational benefits such as reduced sickness absence and staff turnover, and wider social, economic or legal changes that arise as the result of the outputs and outcomes. As shown in the diagrammatic representation of the logic model in Figure 2-1, there is hypothesised to be some causal link from outputs to outcomes and thence to impacts (usually with other factors also coming into play), which means that the successful generation of outputs or observation of outcomes could be a step towards creating impacts. The terms ‘achievements’ and ‘results’ are therefore used to refer collectively to all of these.

In each case study, we used the following methods:

- Documentary examination: we reviewed available documentation and data on the WWC accreditation and its impact within the organisation on sickness absence rates, staff turnover, staff engagement, and other areas – where this information was available.
- Semi-structured interviews: we carried out semi-structured interviews with staff. In each organisation we aimed to carry out three interviews with representatives of the following groups:
  - organisational leaders – to understand their rationale for taking up the Charter
  - HR staff – to gain their professional view on the impact
  - staff representatives – to hear their views on the benefits of the initiatives.

However, the available interviewees did not always directly relate to these categories of staff. Each interview followed a draft protocol (Appendix B) and took approximately 30 minutes. Between December 2015 and June 2016 we carried out 37 interviews in total. The interviews were often carried out with only a small sample of the staff, many of whom had vested interests in presenting their organisations in a positive light and whose views could not be generalised to the entire organisation. Because the interviews were carried out in only a few organisations, we did not generalise the interview findings to all accredited organisations.

2.4.3. Analysis and reporting

The case study analysis was carried out at two levels: at the level of each establishment and across all selected organisations. The evidence gathered at the level of each case study organisation shows the likely effects of WWC accreditation on the establishment and its performance. This evidence was scrutinised against Nesta Standards of Evidence and the analysis against the RAND Quality Standards, to make sure the impact of the WWC is not overestimated in this study. In addition, we examined the data available to identify any potential limitations and biases. The Nesta Standards of Evidence describe five

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levels of evidence that might exist. These levels are cumulative, with each level including all attributes of the previous levels:

Level 1: Organisations can describe what they do and why it matters, logically, coherently and convincingly.
Level 2: Organisations capture data that show positive change, although they cannot confirm the causal link.
Level 3: Organisations can prove causality through using a control group or comparison groups.
Level 4: Organisations have at least one independent replication evaluation that confirms the conclusions.
Level 5: Organisations have manuals, systems and procedures to ensure consistent replication and positive impact.

All investigated organisations achieved Level 2, but none proved causality (Level 3). Level 1 includes a clear description of who did what. At Level 2, in the absence of experimental or quasi-experimental data, the Bradford Hill criteria can be useful indicators of causality.\(^29\) For example, the positive change must occur after the intervention and the change is likely to be at a scale commensurate with the activity.

Drawing on the elements of the logic model likely to resonate with other employers (such as motivations, activities, results, resources), we developed a case study template, which was agreed with PHE (Appendix C). Each case study report provides a clear and accessible summary of our findings, highlighting the evidence on the impact and explaining how the impact appears to have been achieved (see Appendix D).

The second level analysis was carried out across all selected organisations and individual case study reports. In analysing the 13 case studies we tried to identify any recurring themes and patterns emerging from the data. The results of this analysis are presented in section 3.2.

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\(^{29}\) The Bradford Hill criteria are a group of guidelines for providing evidence of a causal relationship between a cause and an effect. See Austin Bradford Hill, "The Environment and Disease: Association or Causation?", *Proceedings of the Royal Society of Medicine* 58 (1965): 295–300.
3. Findings

In this chapter we present the findings from the two main data sources: section 3.1 provides an overview of the reported data on the take-up of the WWC and section 3.2 describes and details experiences of selected accredited organisations.

3.1. Data analysis

The following sections include information about the number of accredited organisations and organisations working towards accreditation. We start with a description of the overall numbers for England as a whole and subsequently provide a breakdown by local authorities, where possible and relevant. We include information on the distribution of the organisations by size and by industry sector.

3.1.1. Number of organisations

Figure 3-1 shows the geographic distribution of the accredited organisations across England at the level of local authorities. Among local authorities for which we received the data, Darlington and Liverpool have by far the highest numbers of accredited organisations (278 and 148 respectively) followed by Cornwall (77).  

30 Calculated as the sum of organisations by size (or by industry sector).
Figure 3-1: Reported geographic distribution of Charter schemes and accredited organisations within this study

Figure 3-2 shows the number of organisations that were either accredited or working towards accreditation from 1 April 2012 to 31 March 2015. Local authorities reported a large increase in the number of accredited organisations over time, from only 42 in 2012–2013 to 410 in 2014–2015. Overall, in the first three years the number of accredited organisations among the reporting local authorities increased by more than nine times. The picture is quite different for the number of organisations working towards accreditation. Local authorities reported fewer organisations working towards accreditation in 2013–2014 compared with 2012–2013. However, more organisations were reported to have started to work towards accreditation during 2014–2015.
3.1.2. Size of organisations

Figure 3-3 illustrates the type of organisations to either gain accreditation or be working towards it based on size. For the accredited organisations, large organisations (with 250 or more employees) represented the largest group, followed closely by medium-sized organisations (50 to 249 employees). Third was the group of small organisations (10 to 49 employees), with those employing fewer than 10 employees (micro) making up the smallest proportion of the accredited organisations. A similar picture, with even higher participation of large and medium-sized organisations, can be drawn for organisations working towards accreditation.
NOTE: Liverpool used a different categorisation of business sizes from the rest of the country (small: 1-30, medium: 31-150, large: 150+) and therefore was excluded from the analysis.

SOURCE: WWC data reported to PHE by local authorities (2015).

Figure 3-4 provides a more detailed picture of the size of accredited organisations in the two local authorities that reported the largest numbers of accreditations disaggregated by size.

SOURCE: WWC data reported to PHE by local authorities (2015).
The analysis presented here is based on data submitted to PHE by local authorities and is clearly incomplete. The data is largely driven by a few local authorities with the largest numbers of accreditations, and thus is not necessarily representative of the total number of accredited organisations and organisations working towards accreditation. It is, however, symptomatic that organisations with fewer than ten employees are likely to be under-represented among those that undergo the accreditation, given that small businesses accounted for 99% of businesses in the UK.\(^3\) By the same token, large organisations are likely to be overrepresented among those already accredited. This is well illustrated by Figure 3-5 which provides comparison between the proportions of businesses and accredited organisations by size in Darlington.

![Figure 3-5: Proportions of enterprises and accredited organisations by size](source)

The size of an organisation may have certain implications on the breadth and depth of health and wellbeing activities. Our case studies do not allow us to reach any firm conclusions; however, the larger organisations all had fairly wide offerings not necessarily offered to everyone, while the smaller organisations had universal offerings that could be relatively simple or quite varied. Section 3.2 and Appendix D illustrate different approaches adopted by accredited organisations, depending on their size:

- For examples of the activities and achievements of **micro and small organisations**, see Appendices D.2 (Carillion Training PLC), D.7 (Munroe K Asset Management), D.8 (Rowlinson Knitwear), D.10 (TRAC) and D.13 (YMCA Cornwall).
- For examples of **medium-sized organisations**, see Appendices D.4 (Dearne ALC) and D.5 (Edgetech).

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For examples of large organisations, see Appendices D.1 (BAE Systems), D.3 (Coventry City Council), D.6 (Mersey Care), D.9 (Tameside Metropolitan Borough Council), D.11 (University of West of England) and D.12 (XPO Logistics).

3.1.3. Organisations by industry sector

Figure 3-6 further divides the organisations by industry sector\(^\text{32}\). The largest group among the accredited organisations and those working towards accreditation was formed by the service industry\(^\text{33}\) (38 and 53 per cent respectively). Companies in manufacturing\(^\text{34}\) represented the second largest group (accounting for 17 per cent of accredited organisations and 20 per cent of organisations working towards accreditation).

The third largest group – health and social care – accounted for 17 per cent of accredited organisations and 13 per cent of those working towards accreditation. The last group, knowledge industry,\(^\text{35}\) was represented by 16 per cent of accredited organisations and 13 per cent of those working towards accreditation. Only small proportions of organisations belonged to other production sectors (9 per cent of accredited organisations and 4 per cent of those working towards accreditation).

The reported data shows a high level of variation at the local level – from areas visibly dominated by one group such as the service industry in Bristol and Darlington or manufacturing in Coventry, to a more equal distribution across different groups in Cornwall (Figure 3-7).

\(^{32}\) Please note the sectors were defined by PHE in their data request to WWC accreditation providers (see Appendix A).

\(^{33}\) These include: Retail, Transport, Storage and Distribution, Real Estate, Public Administration and Defence, Hotels and Restaurants, Community, Social and Personal Services, Admin and Support Services.

\(^{34}\) These include: Pharmaceuticals, Machinery, Electrical and Transport Equipment, ICT and Precision Instruments, Chemicals, Automotive, Aerospace, Shipbuilding, Other Manufacturing, Metal, Plastic and Non-Metal Mineral Products, Food, Beverages and Tobacco.

\(^{35}\) These include: Research and Development, Business Services, Financial Services, Education, Digital, Creative and Information Services, Communications.
The case study organisations represent a wide range of industry sectors:

⇒ Examples of organisations in **public administration and defence** can be found in Appendices D.1 (BAE Systems), D.3 (Coventry City Council) and D.9 (Tameside Metropolitan Borough Council).

⇒ For institutions working in **education**, see Appendices D.4 (Dearne ALC) and D.11 (University of West of England).

⇒ Institutions in the **health and social care** sector are presented in Appendices D.6 (Mersey Care NHS Trust) and D.13 (YMCA Cornwall).

⇒ Accredited **construction, logistics and manufacturing** organisations included in the case studies are presented in Appendices D.2 (Carillion Southampton), D.5 (Edgetech), D.8 (Rowlinson Knitwear) and D.12 (XPO Logistics).

⇒ A **centre management** organisation is the subject of a case study in Appendix D.7 (Munroe K Asset Management).

⇒ A case study on a **consultancy** organisation is in Appendix D.10 (TRAC).
3.2. Case study analysis

In this section we synthesise the results of the 13 case studies and identify any recurring trends and patterns emerging from individual case study reports. We pay particular attention to specific approaches or tendencies shared by organisations of similar characteristics, such as size or industry sector, in order to draw conclusions relevant for other similar organisations.

In this section we follow the main element of the generic logic model: we start by outlining the reasons different organisations undergo the WWC accreditation process and invest in the health and wellbeing of their staff (3.2.1). We then summarise their testimonies on how much they invested (3.2.2) and what types of activities they implemented (3.2.3) in order to highlight the reported results and types of likely impact (3.2.4).

3.2.1. Motivations and the WWC accreditation process

The case study organisations described a wide range of motivations behind their decision to apply for WWC accreditation. Five organisations – which represented different sizes and types of establishment, from a small private company to a large public organisation – pointed to their desire to reduce sickness absence, and thus improve productivity and business outcomes or services.36 The second most frequently quoted reason for undergoing accreditation – indicated by four organisations – was a desire to demonstrate the organisation’s commitment to its staff.37

Improving motivation, increasing satisfaction and better levels of engagement of staff drove three small establishments,38 while another three organisations – different in size – needed a framework to better look after their employees and inspire new initiatives.39 In a similar vein, two large organisations explained that they wanted to receive comprehensive and objective feedback on their initiatives so far, have them externally validated and draw lessons for further improvements.40 Two organisations considered improving health and safety to be their responsibility, leading them to adopt the standards.41

Another two organisations explained that in time of staff reductions, they needed to focus on the remaining staff and move their focus from retention to building resilience.42 Only one organisation explicitly mentioned attracting and retaining top talent as their motivation behind the WWC accreditation.43

The accreditation process involves a review of internal policies, processes and activities aimed at improving staff wellbeing, centred on the areas of the Charter (Figure 3-8). The review comprises short

36 Carillion Construction Training plc, Dearne ALC, Mersey Care NHS Trust, Tameside MBC, XPO, YMCA
37 EdgeTech, Coventry City Council, Dearne ALC, UWE
38 Munroe K, Rowlinson Knitwear, XPO
39 Munroe K, TRAC, UWE
40 BAE Systems, Coventry City Council
41 Carillion Construction Training plc, EdgeTech
42 Tameside MBC, YMCA
43 BAE Systems
interviews with staff representatives and site visits to inspect the facilities in place and the work environment.

Figure 3-8: The eight national standards

Organisations apply for accreditation, which is granted (at an appropriate level; see section 1.2) with an assessment of their practices and suggestions for further improvements. Based on this feedback, organisations that are already accredited can plan future activities and apply for re-accreditation, once they have made further progress.

Most of the case study organisations (ten) agreed that the accreditation process required a lot of effort and was time-consuming because of the need to collect the evidence and schedule interviews – the more policies and initiatives that were in place, the more data there was to collate. While the interviewees found it difficult to quantify the costs of the accreditation process, some offered an estimation of the amount of time they spent on it: from 16 to 120 hours, spread over several months (from making the decision to apply and receiving the accreditation).

As the collection of data was usually carried out for the first time for the accreditation, it was most painfully felt by smaller organisations without dedicated HR staff to facilitate the process. However, four organisations pointed out that re-accreditation was (or should be) easier, thanks to collaborative software used to collate evidence, the electronic submission of documentation and the fact that data was being collected on a regular basis.

44 BAE Systems, Coventry City Council, Dearne ALC, Mersey Care NHS Trust, Rowlinson Knitwear, Tameside MBC, TRAC, UWE, XPO Logistic, YMCA
45 Dearne ALC, Mersey Care NHS Trust, Munroe K, Rowlinson Knitwear
46 Munroe K, Rowlinson Knitwear, XPO Logistic, YMCA
47 Tameside MBC, TRAC, UWE, YMCA
Some organisations (three), including small ones, emphasised positive aspects of the accreditation process, including good collaboration with, support from and regular communication with their WWC provider.48

3.2.2. Resources for wellbeing initiatives

In addition to the costs of the accreditation process, the case study organisations invested their resources in various health and wellbeing initiatives. However, only five interviewed organisations (small, medium and large) reported specific figures dedicated to improving staff wellbeing (annual budgets between £900 and £1,500 or individual grants between £1,000 and £3,000).49 A few establishments emphasised that implementing health and wellbeing initiatives did not necessarily require considerable financial resources.50 Among these, one large employer, who used to invest in expensive wellbeing programmes in the past, explained that in the absence of financial resources dedicated to the health and wellbeing of staff, they collaborated with trade unions and partners to identify and implement minor but original initiatives that would have a lasting effect on their organisational culture.51 For example, a ‘Time to Talk’ initiative encouraged staff to take short but regular breaks from a computer screen. Rather than provide estimations of monetary costs, four mainly small organisations pointed to the time staff dedicated to developing wellbeing policies and organising related activities.52

The majority of interviewed organisations – from small to large – emphasised collaboration with local partners, charities and other organisations that specialise in offering health and wellbeing services. The links and partnerships with local providers reported by the case study organisations are well illustrated by the following examples:

- **Specialist organisations that offered their support and advice:**
  - British Heart Foundation helped run a workshop on risk areas around alcohol consumption, eating habits, etc. (BAE Systems).
  - Mind provided specialist advice and support (Coventry City Council, XPO Logistics).
  - Addaction provided specialist advice and support (XPO Logistics).
  - Cornwall Sports Partnership helped to promote physical activity (TRAC).

- **Local authorities and healthcare service providers offered:**
  - presentations on health and wellbeing topics to staff on site (Carillion Construction Training plc, Edgetech).
  - health screenings for staff on site (Dearne ALC).

- **Local providers donated their unsold fruit to provide breakfast** for staff and apprentices (Carillion Construction Training plc).

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48 BAE Systems, Carillion Construction Training plc, Rowlinson Knitwear
49 Dearne ALC, Edgetech, TRAC, UWE, YMCA. However, Edgetech reported that the initial setup costs were about £32,000.
50 Dearne ALC, Tameside MBC, Rowlinson Knitwear
51 Tameside MBC
52 Munroe K, Tameside MBC, TRAC, Rowlinson Knitwear, YMCA
3.2.3. Activities, outputs and outcomes

Activities that have been undertaken by the case study organisations can broadly be grouped into the following categories:

- **Facilitating healthy choices around:**
  - **physical activity:** nearly all organisations (12) reportedly engaged in promoting outdoor activities and cycling to work schemes, and providing free cycling maps, discounts for gym memberships, exercise classes during worktime, running or walking clubs, sporting competitions, walking business meetings and more.\(^{53}\)
  - **eating:** nine organisations provide healthy eating displays, water machines, fresh fruit, sugar awareness days, free or discounted healthy meals, healthy menus in staff canteens, healthy options in vending machines and healthy eating competitions.\(^{54}\)
  - **(non-)smoking and alcohol consumption:** five (both large and small) organisations reportedly encouraged participation in Stoptober, promoted national No Smoking Day, and ran no smoking competitions.\(^{55}\)

- **Introducing or tweaking policies and procedures** around the standards, developing action plans around work–life balance, flexible working, bullying and harassment, encouraging staff to take breaks, including health and wellbeing issues in staff induction programmes and providing employee assistance programmes – at least one of these was reported by nine organisations.\(^{56}\)

- **Health screenings** aimed at helping individuals to understand their own health situation better (e.g. BMI assessment, blood glucose test, blood pressure, cholesterol tests) – at least one of these was reported by eight organisations ranging in size, from large to small.\(^{57}\)

- **Workshops and training** focused on a wide range of topics, such as leadership and absence management programmes, smoking or alcohol awareness, cancer, stress and mental health, the effects of technology on sleep – at least one of these was reported by three organisations of varying sizes.\(^{58}\)

- **Staff engagement activities** were introduced by three organisations (medium to small) and comprising voluntary work and team-building activities.\(^{59}\)

- **Additional services**, such as inviting a car mechanic on site, providing ironing and dry cleaning services – these were reportedly provided by one medium-sized organisation.\(^{60}\)

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\(^{53}\) BAE Systems, Carillion Construction Training plc, Coventry City Council, Dearne ALC, Edgetech, Mersey Care NHS Trust, Rowlinson Knitwear, Tameside MBC, TRAC, UWE, XPO Logistic, YMCA

\(^{54}\) BAE Systems, Carillion Construction Training plc, Coventry City Council, Edgetech, Mersey Care NHS Trust, Rowlinson Knitwear, Tameside MBC, TRAC, UWE

\(^{55}\) BAE Systems, Rowlinson Knitwear, Tameside MBC, UWE, XPO Logistic

\(^{56}\) BAE Systems, Carillion Construction Training plc, Dearne ALC, Edgetech, Mersey Care NHS Trust, Munroe K, Tameside MBC, TRAC, YMCA

\(^{57}\) BAE Systems, Dearne ALC, Edgetech, Munroe K, Tameside MBC, TRAC, UWE, XPO Logistic

\(^{58}\) Coventry City Council, Edgetech, XPO Logistic

\(^{59}\) Dearne ALC, XPO Logistic, YMCA

\(^{60}\) Dearne ALC
Only a few organisations were able to share information about the precise number of outputs (events, initiatives and programmes implemented as part of their drive for staff health and wellbeing). This number also varied by the size of the organisation in question. For example, UWE reported organising 330 health and wellbeing events in February 2016 alone (including 106 events relating to physical activity and 87 events on healthy eating), while small organisations pointed to much lower numbers of events, spread over a longer period of time.

The case studies provide limited information on the take-up of these activities among their staff. However, those organisations which shared some figures show a participation rate of between 20 and 60 per cent.61

3.2.4. Impacts

Observable changes

The interviewed organisations reported a number of observable (tangible and intangible) changes – these are presented below. However, interviewees did not claim that all of these changes were results of the accreditation with the WWC and ensuing activities, as some organisations described workplace wellbeing activities that had not been motivated by the WWC. The extent to which these changes can be attributed to the WWC accreditation is a complex issue and we discuss it in the section entitled ‘Attribution of impact’.

Direct improvements in policies, infrastructure and the provision of wellbeing programmes

The case studies showed a number of improvements implemented by organisations in their work environments and wellbeing programmes as a result of suggestions received through the WWC accreditation process. For example, three establishments reported introducing new, or tweaking existing, policies to bring their practices in line with the standards in relation to physical activity, health and safety, healthy eating, smoking and other areas.62

The recommendations from the WWC accreditation led one large employer to construct an on-site gymnasium.63 Reportedly, they also directly affected the design of a new manufacturing facility at the same organisation, with more space around machinery and a humidity control system. The same employer (BAE) confirmed that they introduced improvements in the canteen, new outdoor picnic tables and healthier snacks in vending machines (the latter was also reported by Mersey Care).

Following the WWC accreditation and suggested improvements, another organisation reported moving their smoking area – originally located inside the main factory building – to a separate block.64 This decision was welcomed by non-smoking staff and reportedly led to some reduction in smoking (see the section entitled ‘Healthier behaviours’).

61 BAE Systems, Edgetech
62 Munroe K, TRAC, YMCA
63 BAE Systems
64 Rowlinson Knitwear
Reduce in sickness absence

As mentioned above, a reduction in sickness absence and associated costs was reported as one of the main drivers behind investing in staff health and wellbeing. The organisations that provided data about the reductions in sickness absence that they achieved varied in the way they reported improvements. For instance, reductions were reported as occurring over different periods of time. For this reason, direct comparisons were not possible. Below, we present the data as reported by the organisations and grouped around the type of indicators used.

Overall, these data show a trend of a reduction of sickness absence, from incremental improvements to a 50 per cent reduction, bringing substantial savings for the organisations, regardless of their size:

- BAE Systems (first accredited in 2010):
  - from 277 people took some sick leave in 2011
  - to 98 people took some sick leave in 2015 (with the same number of staff).

- Edgetech (first accredited in 2009):
  - reduction of 3 per cent in total sick leave in 2013
  - reduction of 1 per cent in total sick leave in 2014
  - reduction of 2 per cent in total sick leave in 2015 (with the staff increasing by 40 per cent).

- Carillion Construction Training plc (first accredited in 2015):
  - from 18 person-days lost in 2014
  - to 5 person-days lost in 2015.

- Dearne ALC (to be accredited in 2016):
  - from 752 person-days lost among the teaching staff in 2012–2013
  - to 484 person-days lost among the associated staff 2012–2013
  - from 342 person-days lost among the teaching staff in 2014–2015
  - to 226 person-days lost among the associated staff 2014–201565.

- TRAC (first accredited in 2012):
  - on average 1.77 days lost per employee in 2011
  - on average 1.55 days lost per employee in 2015.

- YMCA Cornwall (first accredited in 2011):
  - on average 8.35 days lost per employee in 2010–2011
  - on average 4.75 days lost per employee in 2012–2013.

- Coventry City Council (first accredited in 2014):
  - reduction of 2.25 days lost per employee per year (between 2009 and 2016)
  - equivalent of £4.5m cost reductions.

- Tameside Metropolitan Borough Council (first accredited in 2013):
  - reduction of 5.9 days lost per employee per year (since 2001)
  - equivalent of £0.5m non-cashable savings.

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65 Dearne ALC expects the accreditation in 2016.
Reduced number of accidents at work

Only one organisation reported the number of accidents at work, which reduced from 3–4 per year before 2015 to 1 since 2015.66

Lower staff turnover

Only a few (small) organisations declared changes in staff turnover. As was the case with reductions in sickness absence, improvements were seen. However, given the small size of the reporting organisations and a limited number of observations, the data provided below needs to be interpreted with care:

- Edgetech (first accredited in 2009) stated their average turnover improved from 8 per cent to 5 per cent between 2009 and 2013. The organisation considered this as a particular success, given that their staff increased by 40 per cent over the same time period.
- Rowlinson Knitwear (first accredited in 2015) specified that over the last 5 years (so including the period before the accreditation) their turnover fell below one person per year (out of 24 employees).
- TRAC also reported high staff retention but did not share corresponding evidence.

Healthier behaviours

The case studies indicate some changes in employee behaviour. We make a distinction below between whether the information is based on a staff survey or captures perceptions of our interviewees only. Both types of source are prone to a number of limitations: for interviews there is a risk of bias, while survey data often lacks the information that would allow us to judge the results as robust (e.g. unknown sample size, response rates and questions asked). We have outlined these limitations in detail in Appendix D.

- At BAE Systems 19 per cent of surveyed staff reported doing physical activity on a regular basis.
- At UWE 57 per cent of responding staff reported eating more fruit and vegetables as a result of having access to the new fruit and vegetables stall.
- Two interviewees from small organisations (Edgetech and Rowlinson Knitwear) reported eating more healthily (e.g. fewer snacks or more fruit).
- One interviewee (also from a small organisation) stated that several people reportedly stopped smoking, or reduced the amount they smoked, as a result of a dedicated smoking area being moved to a location further away from the work environment (Rowlinson Knitwear), while another said that smoking among apprentices was reduced, from 85 per cent before the accreditation to 40 per cent in 2016 (Carillion Construction Training plc).

Improved job satisfaction and staff morale67

Three large organisations provided data on employee satisfaction levels before and after the accreditation. In one organisation (BAE Systems) employee satisfaction increased from 84 per cent to 91 per cent between 2010 and 2015. At UWE the share of responding staff who felt their line manager was interested

66 Carillion Construction Training plc
67 The survey data in this section are prone to the same limitations as mentioned above (‘Healthier behaviours’) and detailed in Appendix D.
in their wellbeing increased from 68 per cent to 73 per cent between 2012 and 2014. In Mersey Care NHS Trust staff engagement measured on a 5-point scale (with 1 being the lowest and 5 being the highest score) showed incremental improvements: from 3.65 to 3.74 between 2013 and 2015.

Although three other organisations (two small and one large) showed only one data point (after their accreditation), the results were also positive and high:

- At Rowlinson Knitwear employee satisfaction was at 89 per cent, 86 per cent of respondents felt valued, 95 per cent reported the company cared about their health and wellbeing, all respondents considered their workload to be manageable and 98 per cent of respondents felt proud to work for the organisation.
- At TRAC all respondents valued their employer’s commitment to promoting a healthy workplace and 88 per cent of respondents felt the introduction of flexible working had had a positive impact on their work–life balance.
- At Tameside Metropolitan Borough Council the staff satisfaction level was also (relatively) high, at 65 per cent, while 73 per cent of respondents felt that their job allowed them to maintain a good work–life balance. These results – although low when compared with BAE Systems, TRAC or Rowlinson Knitwear – should be considered in the context of recent austerity measures that led to staff reductions and increased pressure on the remaining staff.

According to interviewees from six organisations, the wellness activities and programmes provided a way for staff to keep in touch and connect with each other, which helped improve the atmosphere and motivation – changes which are more difficult to capture, but can be easily felt at the workplace.68

*Improved company reputation*

Although the case study organisation did not provide evidence to support it, the interviewed employers at one company reported increased visibility (through appearance and presentations at Chambers of Commerce, and in the local press) that gained them recognition among suppliers, partners and a wider audience.69 In the opinion of four interviewees, these benefits also facilitated recruitment and helped attract new talent.70

*Attribution of impact*

Many of the changes observed and outlined above followed a basic chronology of events, allowing us to suggest plausible links between the WWC accreditation, the wellbeing activities and the results.71 However, such evidence is not sufficient to claim that there is a direct causal relationship.

In fact, there are many factors that could help to explain the changes listed above and the WWC is just one of the possible explanations. Some organisations emphasised that changes they observed stemmed

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68 Edgetech, Rowlinson Knitwear, TRAC, Dearne ALC, XPO Logistics, YMCA
69 BAE Systems, Coventry City Council, Edgetech, UWE
70 BAE, Coventry City Council, TRAC, UWE
71 For Dearne ALC the results occurred before the WWC accreditation, which was expected in 2016. However, it is still plausible that activities that were put in place in order to achieve accreditation contributed to observed changes.
from wellbeing programmes and activities that had been implemented over a long period of time, and which often preceded the accreditation with the WWC.\textsuperscript{72} Moreover, three organisations emphasised that many (if not all) activities would have taken place regardless of the WWC accreditation.\textsuperscript{73} Hence, attributing any of these impacts to the WWC alone is not possible.

Instead, below we highlight areas where the WWC seemed to make a positive difference and add value over and above that which might have happened otherwise.

\textbf{Added value of the WWC}

The case studies highlighted a number of areas where the WWC made a positive difference to accredited organisations and their staff. The case studies were chosen to cover a range of organisations where the WWC was considered a success, and not intended to be representative in any way. Therefore, we strongly urge caution around any quantification of impact or over-generalisation of results. We do not have sufficient evidence to make a judgement on the likelihood of other organisations achieving similar results, but do have strong evidence of the potential impact of the WWC across a cross-section of organisations. The case studies highlight evidence pointing in similar directions across a wide variety of organisations. We list these below:

\begin{itemize}
  \item \textbf{Providing a comprehensive framework to identify gaps and areas for improvements} – nine organisations spanning all sectors emphasised the role of the WWC accreditation process in determining their position in an ongoing journey towards staff health and wellbeing, or in adding structure or new ideas to their offerings. The standards form an all-inclusive structure against which organisations are independently and systematically assessed. The assessment helps the organisations to identify targets to work towards in future while leaving them the flexibility to prioritise certain areas and pace organisational changes according to their determination, resources and abilities.\textsuperscript{74}
  
  \item \textbf{Inspiring novel approaches to achieve sustainable results} – in times of austerity and limited resources, the WWC encouraged organisations to do things more creatively with less money. Seven organisations, particularly the smaller ones and public-sector employers, explicitly mentioned partnerships with local organisations who provided services free of charge, with one emphasising that instead of investing significant resources in wellness programmes, they were looking for solutions which – embedded in organisational culture and staff behaviours – would result in lasting changes. Such solutions and approaches do not need to be expensive (in terms of money or time) and it is often possible to draw on expertise from specialist organisations to help introduce these in the workplace.\textsuperscript{75}
  
  \item \textbf{Capturing and maximising the results} – perhaps the most striking difference the WWC made was in helping organisations to monitor and evidence the effects of health and wellbeing
\end{itemize}

\textsuperscript{72} BAE Systems, Coventry City Council, Tameside Metropolitan Borough Council

\textsuperscript{73} Carillion Construction Training plc, TRAC and XPO Logistics

\textsuperscript{74} BAE Systems, Carillion Construction Training plc, Coventry City Council, Mersey Care NHS Trust, Rowlinson Knitwear, TRAC, UWE

\textsuperscript{75} Coventry City Council, Tameside MBC, Munroe K
interventions for their staff. This process often helped them to understand how much they were already doing and what benefits these activities contributed to. For ten organisations, the WWC also provided a vehicle to maintain good, or achieve better, performance results by investing in staff health and wellbeing, and quantitative outcome measures supported this.\textsuperscript{76}

- **Accelerating changes** – finally, one organisation acknowledged that the WWC helped them implement changes faster than they would have done otherwise.\textsuperscript{77}

\textsuperscript{76} Dearne ALC, Tameside MBC, YMCA
\textsuperscript{77} XPO Logistics
This chapter presents our overarching conclusions and recommendations, bearing in mind the limitations of the study.

4.1. Limitations

This study was prone to a number of limitations highlighted in the text of the report and summarised below. That said, this study has effectively made new evidence available that contributes to an understanding of the potential effectiveness of the WWC. The limitations were:

- **Approach for measuring impact**: the study aimed to map the take-up of the WWC across England and explore its impact through a series of case studies. In the absence of control or comparison groups, this approach was chosen as a viable alternative to help PHE (and the scheme providers) better understand the characteristics of the accredited organisations (and those undergoing the accreditation) across England and in each region, and to provide other employers with insights into the potential benefits associated with investing in the health and wellbeing of their staff. At the same time, the chosen approach did not allow for clear attribution of observable changes to the WWC accreditation.

- **Data availability**: as only a small proportion of local authorities (26 per cent) shared data on WWC accreditation, the picture of the take-up of the Charter is very patchy. The lack of data limited our ability to analyse the accredited organisations by region, size, industry sectors and other characteristics, or compare these with a general population of enterprises in England and in each region. It is possible that most of the missing data came from local authorities without workplace health schemes, but without the data we cannot be sure.

- **Case studies**: the case studies included 13 organisations that agreed to share their experience of the WWC accreditation and any achievements resulting from investment in staff health and wellbeing in general. The sample comprised a varied group of largely self-selected organisations that were not representative of all accredited organisations. Although we carried out a total of 37 interviews, this number was limited to three per organisation, so the views and opinions of our interviewees cannot be generalised to all staff of these organisations and should be interpreted with caution as there was a risk of bias. Finally, we drew on available administrative and survey data, but the robustness of this was also often limited by the lack of information on sample sizes and response rates.

These restrictions significantly affected the level of evidence used in this study and did not allow firm inferences to be drawn. However, the purpose of this study was to investigate and highlight the potential
impact of the WWC, not to evaluate the impact systematically. Although the case studies are almost certain to be from organisations where the WWC has had a greater impact, they still allow us to explore the range of possible impacts and the broad directions of change, although any quantification of these should be treated with scepticism.

While the data are clearly incomplete, they can still be informative. The case studies are self-selected and likely to be biased towards creating a favourable impression of the Charter. These organisations are also likely to be employers more committed to improving staff health and wellbeing than an average business. However, for similar organisations, or those that aspire to become like these, the issues, activities and consequences reported here might be indicative of what they can expect to experience. Furthermore, the reported results all broadly point in a direction that suggests the Charter can, in the right circumstances, make a positive contribution to workplace wellbeing.

Within the boundaries of the available evidence, we highlight the key conclusions and suggest possible improvements to the implementation and impacts of the WWC.

4.2. Conclusions and recommendations

In this section we present our conclusions from the study, with accompanying recommendations where appropriate.

Accreditation data

Section 2.2 presented the limitations of the data on accredited organisations and organisations working towards accreditation and Section 3.1 showed that the analysis carried out on the available data pointed to the major problem: the lack of a fully functioning system to regularly monitor the implementation of the Charter at the national level. While local providers might have necessary information about WWC accreditation, this is not immediately (or easily) available to the PHE National Team (and the researchers). Until the issues of ownership of the data and access to these are addressed by PHE National Team, the nine PHE Centres and local providers, it is impossible to draw any overarching conclusions on the response to the Charter in different regions and organisations, or on how well it was received and whether its implementation was successful in harmonising local practices (and local schemes) across the country.

**Recommendation 1:** The study team recommends that the PHE National Team, PHE Centres and local providers agree on and implement a system to monitor the nationwide use of the WWC as soon as possible.

We identified some inconsistencies in the data (i.e. regarding the size of businesses, differences between the number of organisations by size and by industry sector). The categorisation of accredited organisations into different industry clusters provided by PHE from the data request to local providers included the following five groups: service industry, manufacturing, knowledge industry, health and social care sector and other production. This categorisation may lend itself to different interpretations; however, we were unable to verify this, as data was provided in aggregated form only. These discrepancies and possible risks
point towards a need for better guidance around data collection, definitions used and quality assurance of the data.

**Recommendation 2:** The study team recommends that PHE develop and implement guidance and tools for consistent reporting on WWC accreditation, and develop a data check protocol to help those responsible for scheme-monitoring at the local, regional or national level to review if data are complete, accurate and consistent.

**Accreditation process**

According to most of the case study organisations, the accreditation process required a lot of effort and it was long and time-consuming. This was particularly emphasised by small organisations, which felt the process requirements did not sufficiently accommodate size (and capacity) differences among the applicants. At the same time, we found that those few organisations which applied for re-accreditation perceived the process as less burdensome, as they used collaborative software, dedicated tools (such as evidence grids) and electronic data submission. These methods – developed by the accredited organisations themselves – facilitated the process of re-accreditation. Such practices and solutions could be suggested to new applicants to reduce the weight of the accreditation process.

**Recommendation 3:** The study team recommends that PHE, together with the nine PHE Centres and local providers, create a toolbox with examples of solutions used to meet each standard by accredited organisations in each size category and sector, to aid the process for organisations applying for the WWC accreditation for the first time.

**Recommendation 4:** The study team recommends that PHE simplify the accreditation process for micro and small organisations by being more flexible about what evidence is acceptable, to make it less difficult for them to undergo the accreditation without compromising the national standards.

**Motivations**

The most common motivation to undergo the accreditation process – regardless of the different characteristics of the organisations – seemed to be the desire to reduce sickness absence and to demonstrate a commitment to workplace wellbeing. The wish to improve motivation, satisfaction and staff engagement seemed more common among small establishments, while large organisations appeared to seek external validation and feedback on their initiatives so far. However, the small sample of case study organisations paired with a wide range of reasons provided for pursuing accreditation did not allow any robust associations to be drawn.
Resources
The study found partial information about the resources invested in staff health and wellbeing, with annual budgets between £900 and £1,500 and individual grants of between £1,000 and £3,000 being reported. The case study organisations emphasised that the determination and time of those responsible for wellness activities and interventions were often more important than money. Various forms of collaboration and partnership with local organisations, healthcare and specialist providers emerged as a very prominent theme across the case study organisations. Drawing on existing expertise, advice and services available and offered at a local level seemed like a promising practice for all but especially for those with constrained budgets.

Recommendation 5: The study team recommends that local providers augment existing successful partnerships by identifying areas of the WWC that they do not currently actively support and working with organisations to build partnerships with local services to facilitate links with relevant institutions and organisations.

Recommendation 6: The study team recommends that PHE, the nine PHE Centres and local providers specifically include examples of effective collaboration between the accredited organisations and local providers in the WWC toolbox recommended in Recommendation 3.

Activities, outputs and outcomes
The study found a wide range of health and wellbeing activities implemented by accredited organisations. These included: facilitating healthy choices around physical activity, healthy eating, smoking and alcohol consumption; introducing or tweaking health and wellbeing policies and procedures; arranging health screenings for staff; organising workshops and training on specific subjects; and offering team building activities and other services for staff. The study did not establish any patterns suggesting that organisations of certain characteristics were more (or less) likely to focus on a particular type of activity.

However, the information on outputs and outcomes was scarce (with only a few organisations sharing information about the overall number of their wellbeing events and initiatives and the take-up of these among their staff). This gap made the link between activities and impacts more difficult to capture – both for the organisations themselves and for the researchers.

Recommendation 7: The study team suggests that PHE embed the logic model approach in the WWC accreditation process by linking each standard to the relevant component of the logic model and ensuring that all components are covered, thereby helping organisations to prioritise or introduce wellbeing interventions more likely to lead to intended or desired outcomes.

Impacts and added value
While the study identified a number of improvements in relation to policies, infrastructure and the provision of wellbeing programmes, sickness absence, job satisfaction and staff morale to name but a few, these changes could not be unambiguously attributed to the WWC accreditation and the wellbeing
activities. However, we found a number of areas where the WWC clearly contributed to making a positive difference to the accredited organisations and their staff:

- The WWC provides organisations with an all-inclusive framework to identify gaps and areas for improvements while leaving them the flexibility to prioritise certain areas and pace changes according to their determination, resources and abilities.
- The WWC inspires novel approaches to achieve sustainable results in times of austerity and limited resources.
- The WWC helps organisations capture results and realise how much they already do and what benefits they gain. Thus, it encourages organisations to maximise the results.
Appendix A. Data request from PHE to providers

The PHE National Team provided the following template for the nine PHE Centres to use in their requests for data from local authorities.
FOR ACTION – Workplace Wellbeing Interventions mapping exercise

1. Following the initial mapping exercise carried out earlier in the year the national team is conducting a follow-up exercise. The aims are to establish the number of Workplace Wellbeing Charter or equivalent schemes running, numbers of businesses accredited, and to find individual organisations willing to share their story as part of a case study collation exercise. This will help us to spread good practise across the country and encourage further take up of the scheme.

2. As a local authority and/or provider of the Workplace Wellbeing Charter (or equivalent) scheme, you are asked to help gather this information using the Excel spreadsheet provided. This has three tabs as follows:

   - Details of your Charter providers across each of the upper tier local authorities (this has been populated with information from last time, so may need updating);
   - Details of organisations accredited under each scheme (this is blank and needs to be populated); and
   - Names and contact details of organisations willing to share their story as part of a case study collation exercise, which will be completed later in the year.

3. The second tab – organisations accredited – is the most substantial section. Here, we are interested in the total number of organisations accredited, as well as the types of organisation, i.e. (i) the size (are they small, medium or large?), the sector that they work in, and (iii) whether they are based on your geographical patch or outside it.

4. To make this process as easy as possible, we have put together a short FAQs document. If you have any other questions – or are not sure what is required – please email Louise Lees at louise.lees@phe.gov.uk

5. **It would be helpful if you could return your completed spreadsheet by 23rd October,** which will allow us to proceed with the next stage of the mapping exercise – the case study collation. Thanks for your support – we really appreciate it!
Appendix B. Interview protocol

RAND Europe (an independent policy research institute) has been commissioned by Public Health England to undertake an analysis of the take-up and impact of the Workplace Wellbeing Charter (WWC). This includes some case studies of organisations who have been accredited under the scheme. The case studies will be a part of the final report that is to be published in summer 2016.

We would like to thank you in advance for taking the time to speak with us; the interview will be treated in confidence and your name will not be stated in the report, unless you give us your explicit permission. Please note that some of the questions may not be relevant, depending on your involvement in the WWC application/implementation.

Approximate length: 20–40 minutes.

Logic model of the interview:

Motivation -> Resources -> Activities -> Outputs -> Outcomes

1. Background

• Would you mind if I record the interview? It will help me to check whether I captured all the important information. The recording will never be played to anyone else and will be deleted once the write-up is complete.
• Please describe your role in your organisation.
• What was your involvement in the WWC application and/or implementation?

2. Motivation

• What do you understand to be the aims and objectives of the WWC?
• What was the main motivating factor(s) behind your decision to participate?
  o How did your business become aware of the scheme and its potential benefits?
  o Did you consider any potential downsides of participation?
• Did you have specific mid-term and long-term aims?
• Who was involved in the WWC application/accreditation process? Who in the organisation decided to go ahead and apply?
  o Who was involved in the implementation of interventions included in WWC accreditation?
• Did you complete the self-assessment to establish the WWC level of your organisation before applying? Have you monitored changes in the assessment score over time?

3. Resources

If directly involved in the application/implementation process:

• When did you apply for the accreditation?
• In which stage of the accreditation process are you?
• If completed, which provider gave you the accreditation? If not yet completed, which provider are you working with?
• How did the accreditation process seem to you? (e.g. in terms of scale of effort involved, whether onerous, bureaucratic, views on support given, etc.)
• Did you have all relevant information required readily available? If not, what did you have to do to gather it? Please include information about data sources, how it was collected, and its use.

If relevant in terms of responsibilities:

• How much time and money did you spend on implementation of the WWC (from the starting point to accreditation)? Please provide separate figures for the accreditation process and for the set-up costs of any newly established interventions.
• What are the annual costs for your organisation related to newly established interventions?
• Have you hired any new employees as a result of the application/accreditation?

4. Activities

• Have you introduced any changes/differences in the operation of your business as a direct result of participation in the Workplace Wellbeing Charter? Please include, for instance, changes to the workplace environment, involvement with local services/providers, new training opportunities, policies, procedures, etc. Which have affected you? – employee
• What, if any, activities have taken place as part of your implementation of the Workplace Wellbeing Charter standards (e.g. sports days, health events)? Which have you participated in? – employee
• How do your managers encourage participation in the programmes?
• What initiatives/rewards do you use/are you offered? Why?

If relevant in terms of responsibilities:

• What partnerships (if any) did you enter into as part of the accreditation process?
• Did you engage with your local NHS services or local health promotion team?
• Did you commission any services from training providers or consultants? Please include details about type of service, reason for its commissioning and costs.
• Was the service beneficial to your organisation? – Ask employee service-specific questions once we have them from management/HR.
• Is the relationship ongoing?
• If accredited, do you promote your accreditation within/outside of the company? How do you promote it?
• If not accredited, do you communicate the ongoing changes with the stakeholders? How do you communicate it?

5. Outputs

Direct

• Please provide details of any quantifiable impacts on your organisation from implementing the Charter standards. Please include any figures you feel are relevant – e.g. improvements in self-reported wellbeing/morale in staff surveys, improvements in health (for example weight loss or reduction in smoking), reduction in staff sickness absences, improvement in number of return-to-work interviews, productivity, staff retention, or reduction of accidents or injuries.

Indirect – on the organisation

• Has completion of the Workplace Wellbeing Charter provided any positive external business benefits? For example, please consider whether there has been an improvement in customer satisfaction/reputation, in attracting more business/talent, or corporate social responsibility factors.
• Have these benefits been at local or national level?

Indirect – on the staff or work environment

• Are there any other positive impacts on your organisation that are not covered by the above? This may include some of the measures listed under ‘direct’ benefits if they were not direct benefits of the interventions.
• Do you have any recommendations for the WWC? Regarding accreditation/information/support/standards, etc.

6. Outcomes

• Do you consider WWC implementation in your organisation has been beneficial for (in what ways?):
  o The employees?
  o The organisation (including business resilience)?
  o For the work environment?
  o For you personally?
• Do you consider the changes have been accepted well by the employees? What responses have you had?
• Have you noticed any changes in the employees’ behavioural patterns (e.g. diet adjustments, taking more responsibility for health), attitudes to work and the organisation?
• Have you received any feedback from other stakeholders (e.g. directors, family of staff, customers, suppliers, regulatory bodies)?

7. Employees

• Do you consider WWC implementation in your organisation beneficial for:
You personally?
○ For the company?
○ For the work environment?
- Have the practices affected your behaviour/performance/attendance and, if so, how (e.g. walking to appointments instead of driving, providing showers means I can cycle to work, providing information about local and national health advice means I’m more likely to use it/trust it)?
- What would you like to change or introduce?

8. HR

- Do you consider WWC implementation in your organisation beneficial for the workers? The work environment? In what ways? Please provide examples.
- Do you measure employee satisfaction/attendance/productivity/engagement or other similar measures? Have they changed since the accreditation? Please provide the measures you use.
- What would you like to change or introduce?
Appendix C. Case study template

Title

Abstract

About X

Why did X decide to participate?

Key quotation

Key statistic/descriptive outcome – with icon

Actions and their impacts.

How much did X invest?

List of interviewees and documents
Appendix D. Case studies

The 13 case studies outlined below represent a diverse selection in terms of their size and industry sectors. The case study reports were prepared in line with NESTA Standards of Evidence\(^{78}\) and RAND Quality Standards.\(^{79}\) We were looking for clear evidence to support conclusions on the impact of the health and wellbeing activities undertaken by the selected organisations and to avoid over-claiming the impact of the WWC.

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<th>Evidence level and justification*</th>
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| 1. | BAE Systems                         | Level 2: Organisation captures data that shows positive change, although they cannot confirm the causal link. There are some limitations to the data presented in this report:  
   - Employee surveys: 2015 survey was completed by 94 people (27 per cent of the workforce) but 2010 counts unknown; there is no additional information on possible bias.  
   - Data on sickness absence: it is possible to provide explanations alternative to the implementation of the WWC for the achieved reductions. |
| 2. | Carillion Training PLC               | Level 2: Organisation captures data that shows positive change, although they cannot confirm the causal link.                                    |
| 3. | Coventry City Council               | Level 2: Organisation captures data that shows positive change, although they cannot confirm the causal link. There are some limitations to the data presented in this report:  
   - Data on sickness absence: it is possible to provide explanations alternative to the implementation of the WWC for the achieved reductions. |
| 4. | Dearne ALC                          | Level 2: Organisation captures data that shows positive change, although they cannot confirm the causal link.                                    |
| 5. | Edgetech                            | Level 2: Organisation captures data that shows positive change, although they cannot confirm the causal link.                                    |
| 6. | Mersey Care NHS Trust               | Level 2: Organisation captures data that shows positive change, although they cannot confirm the causal link. There are some limitations to the data presented in this report:  
   - NHS Staff survey: there is no information on the sample size, response rates, exact questions and possible bias. |
| 7. | Munroe K Asset Management            | Level 2: Organisation captures data that shows positive change, although they cannot confirm the causal link.                                    |
| 8. | Rowlinson Knitwear                  | Level 2: Organisation captures data that shows positive change, although they cannot confirm the causal link. There are some limitations to the data presented in this report:  
   - Staff turnover: although it is reportedly reduced, no exact figure is available. Also, it is possible to provide explanations alternative to the implementation of the WWC for the achieved reductions. |

\(^{79}\) As of 8 August:  
[http://www.rand.org/standards/standards_high.html](http://www.rand.org/standards/standards_high.html)
Workplace Wellbeing Charter: Analysis of Take-Up and Impact

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|    |              | - Customer satisfaction: although it has reportedly improved, no exact figure is available. Also, alternative explanations are possible.  
|    |              | - Profit margins: although these have reportedly risen, no exact figures are available. Also, alternative explanations are possible.  
|    |              | - Employee survey: there is no additional information on the sample size, response rates, exact questions and possible bias. |
| 9. | Tameside Metropolitan Borough Council | **Level 2:** Organisation captures data that shows positive change, although they cannot confirm the causal link. There are some limitations to the data presented in this report:  
|    |              | - Data on sickness absence: it is possible to provide explanations for the achieved reductions in cost of sickness absence and lost FTE days other than the implementation of the WWC.  
|    |              | - Staff survey: although scores for job satisfaction and work–life balance are reportedly high and outperform other LAs, there is no additional information on the sample size, response rate, average results, exact questions and possible bias. |
| 10. | TRAC | **Level 2:** Organisation captures data that shows positive change, although they cannot confirm the causal link. There are some limitations to the data presented in this report:  
|    |              | - Staff survey: although the results are reportedly positive, there is no additional information on the sample size, response rates, exact questions and possible bias. |
| 11. | University of the West of England | **Level 2:** Organisation captures data that shows positive change, although they cannot confirm the causal link. There are some limitations to the data presented in this report:  
|    |              | - Employee surveys: although the results have reportedly improved, there is no additional information on the sample sizes, response rates and possible bias.  
|    |              | - Fruit and vegetables consumption: although data are provided on a basis of a short on-site survey carried out with 156 staff during one week in December 2014, there is no additional information on the response rate, exact questions and possible bias. |
| 12. | XPO Logistics | **Level 2:** Organisation captures data that shows positive change, although they cannot confirm the causal link. |
| 13. | YMCA Cornwall | **Level 2:** Organisation captures data that shows positive change, although they cannot confirm the causal link. |

NOTE: * The NESTA standards of evidence categorise the collection of evidence for interventions in according to five levels, from the least to the most mature models of collecting evidence:  
Level 1: Organisations can describe what they do and why it matters, logically, coherently and convincingly.  
Level 2: Organisations capture data that shows positive change, although they cannot confirm the causal link.  
Level 3: Organisations can prove causality through the use of a control group or comparison groups.  
Level 4: The results shown in one intervention have been successfully replicated elsewhere.  
Level 5: Organisations have systemic approaches with manuals, systems and procedures to ensure consistent replication and positive impact.