Research report

Health, Work and Well-being: A study of the Co-ordinator and Challenge Fund initiatives

by Roy Sainsbury, Katharine Weston, Anne Corden, Annie Irvine and Linda Cusworth

DWP Department for Work and Pensions

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Research Report No 811

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A report of research carried out by the Social Policy Research Unit at the University of York on behalf of the Department for Work and Pensions

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First published 2012.

ISBN 978 1 908523 91 4

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Acknowledgements

We are very grateful to the people who agreed to take part in the surveys, individual interviews and focus groups for this study: Health, Work and Well-being Co-ordinators, senior public health personnel, Department for Work and Pensions (DWP) policy makers, those who managed or took part in Challenge Fund initiatives, and other firms or organisations that were in contact with Co-ordinators.

The evaluation was managed by Steve Daly, Clare Glass, Amy Lee, Amu Premadas, Simone Capolupo, Bola Akinwale and Hannah Jones at the DWP and we are grateful for their support and constructive contributions at various stages throughout the study.

We would also like to thank colleagues at the Social Policy Research Unit (SPRU) – Michael Hirst for his valuable contributions to data collection and analysis and to Sally Pulleyn who provided excellent administrative and secretarial support as usual.

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Glossary of terms

The Health, Work and Well-being Challenge Fund (Challenge Fund)	A fund for initiatives to improve workplace health and well-being. Introduced in 2009, the fund was open to applications from small and medium sized enterprises (SMEs) and local partnerships for funding for up to two years. The minimum grant was £1,000 and the maximum £50,000 for each year.
CBI	Confederation of British Industry.
CIPD	Chartered Institute of Personnel and Development.
Cycle to Work scheme	Government-backed scheme allowing the loan of cycles and cyclists' safety equipment to employees as a tax-free benefit.
Employer Coalitions	Groups of leading employers who work with those involved in the planning and delivery of publicly-funded employment and skills programmes to open up job and career opportunities to local people, particularly those facing significant barriers to work.
Employment and Skills Boards	Local employer-led partnerships bringing together a range of private, public and third sector organisations for an integrated approach to improving the skills and employment opportunities of local people.
Fit for Work Service pilots	Seven pilots in Great Britain providing personalised, case-managed support for workers in the early stages of sickness absence in order to expedite return to work and support job retention.
Health and Well-being Boards	Local statutory body collaborating across NHS and local authorities to address communities' needs.
Health Inequalities Programme	Government cross-departmental programme for action to address the root causes of poor health and health inequalities.
Health, Work and Well-being Co-ordinators	Eleven Co-ordinators accountable to Regional Directors of Public Health in England, the Director General for Public Health in Scotland and the Chief Medical Officer for Wales with the objective to champion integrated approaches to health, employment and skills support, encourage local public sector employers and exemplars and build engagement with small business.
Healthy Working Lives	Scottish NHS initiative with the principle focus to work with employers to enable them to understand, protect and improve the health of their employees.
Local Enterprise Partnerships	Joint local authority-business bodies aiming to promote local economic development. Local Enterprise Partnerships replaced Regional Development Agencies.

NHS Champions	Locally organised schemes involving local residents and NHS services, generally promoting and recognising high standards of health care.
Primary Care Trust (PCT)	In England, 151 Primary Care Trusts are responsible for managing local primary health care services, such as GPs, dentists and opticians.
Public Health Responsibility Deal	Government initiative introduced in March 2011 encouraging organisations to commit to taking action voluntarily to improve public health through their responsibilities as employers, as well as through their commercial actions and community activities.
Regional Development Agency (RDA)	Regional bodies established in England's nine regions to further economic development and regeneration, promote business efficiency, investment and competitiveness, promote employment, enhance the development and application of skills, and contribute to sustainable development. All RDAs closed on 31 March 2012.
Regional Employment Teams	Regional partnerships of public and voluntary sector organisations working to improve employment opportunities for people with mental health conditions.
Independent Review of Sickness Absence	A Government commissioned independent review of the management of sickness absence at work, to seek ways of helping more people stay in work, informed by an analysis of the costs of sickness absence between employers, employees and the state. See Black, C. and Frost, D. (2011).
Strategic Health Authority (SHA)	Ten Strategic Health Authorities manage the NHS locally and provide a link between the Department of Health and the NHS. In particular they are responsible for planning health service improvement, ensuring quality service provision, increasing service capacity, and ensuring the integration of national priorities into local service plans.
Workplace Well-being Charter, England	A voluntary scheme, setting standards for employers in running a business which supports the workforce, to which employers can commit.

Summary

Following the publication of *Working for a Healthier Tomorrow* by Dame Carol Black in 2008, two initiatives were set up by the Department for Work and Pensions (DWP):

- start-up funding for the employment of 11 **Health, Work and Well-being Co-ordinators** in Scotland, Wales and the nine English Regions; and
- a **Health, Work and Well-being Challenge Fund** to provide funding for initiatives to improve workplace health and welfare.

The Co-ordinators' role was aimed at developing partnerships between employment and health networks, co-ordinating health, work and well-being strategies and activities within and across regions and countries, and promoting best practice and innovation within firms (including via the Challenge Fund). The Challenge Fund was aimed at small and medium enterprises (SMEs) and local partnerships to encourage initiatives to improve workplace health and well-being through innovative approaches which ensured worker engagement.

A research study was conducted between 2009 and 2012 to explore the impacts of these initiatives with a particular emphasis on engagement with SMEs and addressing the issue of mental health. Interviews were held with Health, Work and Well-being Co-ordinators, senior NHS public health officials, and policy makers within the DWP. A survey of 59 Challenge Fund winners and a survey of 279 organisations that had been in contact with the Co-ordinators were carried out. In-depth case studies of 12 Challenge Fund winners were also undertaken. Data collection commenced in February 2010 and was completed in October 2011.

A significant contextual factor that affected the work of the Co-ordinators in England was the announcement in 2010 of the restructuring of public health responsibilities in England.

The work of the Health, Work and Well-being Co-ordinators

Co-ordinators came from a range of backgrounds and experience. Geography and socio-economic features, and existing interest in, and activity around, health, work and well-being influenced Co-ordinators' goals. The role was considered challenging, with wide potential. There was general agreement about the importance of working both at strategic and operational levels, and of working with and building on what was already happening.

Co-ordinators undertook a wide range of activities. Their achievements included creating a profile for the health and well-being agenda, co-ordination of health, work and well-being activities, creation of new partnerships and networks, work at a strategic level, and contributions to a Workplace Well-being Charter, employer awards and 'tools' for business.

In relation to working with small businesses, Co-ordinators made early decisions about the balance between working directly, working with umbrella organisations in touch with businesses, and taking a more strategic approach. Most took the view that they would have more impact working through umbrella and other organisations rather than working directly with SMEs. Firms and organisations in contact with Co-ordinators said their experiences were generally positive, with over 80 per cent reporting that they found their contact useful or very useful. Mental health issues were included generally in all aspects of their work, but for a variety of reasons not everybody made mental health a specific focus of activity. Some Co-ordinators lacked experience of working on mental health issues, there were pressures on Co-ordinators' time and resources that led them to prioritise other

work, and engaging employers on mental health issues was often difficult. Some Co-ordinators suggested a need to develop better ways of engaging employers, such as using language that they were familiar with and did not find threatening. By the end of 2011, Co-ordinators were prioritising work that would sustain achievements and take forward the agenda.

The Co-ordinators and Senior Public Health officials suggested a number of lessons for the development of policy. There were advantages in location of the role alongside other parts of public health teams, but there are potential new opportunities for sustaining and developing the focus in England following the relocation of public health from the NHS to local authorities. In engaging with business, there is a need for a better evidence base about returns on investment in health and well-being in the workplace in relation to mental health.

Overall, much was achieved by the Co-ordinators, in the challenging context of structural change and economic downturn.

The Health, Work and Well-being Challenge Fund

The offer of the Challenge Fund generated health and well-being activity in a number of ways, as an **enabler** (to implement plans by removing financial barriers), **accelerator** (implementing plans more quickly), **enhancer** (adding to existing activity), and **initiator** (kick-starting new thinking and initiatives). The Challenge Fund Winners Survey indicates that thinking and activity was initiated in roughly six in 10 organisations.

Single organisations tended to introduce activities aimed at individual employees, whilst partnerships concentrated more on corporate activities (such as health promotion and education). Physical exercise and mental health initiatives were the most common. Helpful aspects of project implementation included good project design, flexibility, and the availability and reliability of local providers. Employees' participation in activities was influenced by their timing, location, content, format and cost, and by people's personal motivation. Partnerships met mixed responses when engaging employers, finding that a perceived lack of time or failure to understand the benefits to business were barriers.

The most immediate impacts of the Fund reported by those managing projects were on workplace culture and increased knowledge about work and health. The greatest impact reported on employee health was on mental well-being. Overall, there was less perceived impact on reducing sickness absence, though few organisations were able to measure changes because they had not been monitoring absence previously. Some organisations who did perceive improvements felt able to attribute these to funded projects.

Eighty-six per cent of Fund winners surveyed thought the Challenge Fund had been necessary for implementing activities, either by supplying money or by providing the idea about putting measures in place. Fourteen per cent believed they did not need the Fund and felt that health and well-being measures had been inevitable. However, there were perceptions that using the Fund had created projects of greater value than those instigated by organisations themselves. There was evidence that merely knowing about the Fund (but not receiving an award) could have a positive effect on health and well-being activity.

Over 60 per cent of Challenge Fund initiatives were expected to continue beyond the funding period. Factors with a positive effect on sustainability included activities perceived to be successful, management commitment, initiatives that had become established within workplace practices, positive employee motivation, and external factors such as government promotion and local accreditation schemes. Whether and how activities would be funded was also important. A lack of

funding was cited in over 50 per cent of the instances where an initiative would not continue. In general, organisations were willing to continue activities of no or low financial cost.

There were a number of lessons that might inform policy thinking about Challenge Fund type initiatives in the future. Relatively small amounts of money for a specific agenda can kick-start new activity, though not necessarily guarantee sustainable change. Sustainability was more likely when there was a permanent change in the physical environment, where the benefits were clear and considered worthy of investment of time and money, and where local supportive schemes were in place. Flexibility in project design and operation is needed to suit organisational circumstances and changes over time. Popular interventions were those which were relevant to individuals, which were free to access and which could be conveniently accommodated. Measuring the impact of the use of funds was challenging for organisations, suggesting the need for expert assistance to set and measure appropriate variables.

Culture and behaviour towards workplace health and well-being

Before engaging with a Co-ordinator or winning a Challenge Fund award many organisations were aware of the health and well-being agenda and alert to opportunities for advancing the agenda more. The Challenge Fund appeared to attract organisations which were generally less engaged with thinking about health and well-being compared with organisations which had contact with a Co-ordinator.

Levels of awareness of health and well-being generally increased over the course of the Co-ordinator and Challenge Fund initiatives, though some organisations (ten per cent) reported a deterioration. Just over half of organisations said they had good awareness of health and well-being in mid-2010 and this increased to two-thirds a year later. A higher proportion of third sector organisations reported increases in awareness than organisations in the public or private sectors. Among the sub-group of Challenge Fund winners in the survey of organisations in contact with a Co-ordinator, 40 per cent reported an improvement compared with 24 per cent for the whole sample.

In June/July 2010, three-quarters of those in the survey of organisations in contact with a Co-ordinator were engaged with some form of health and well-being activity. A year later around a third of SMEs and third sector organisations said that their activity had increased. Decreases in activity were almost all within the public sector. Challenge Fund winners were more likely to report an increase in activity compared with other organisations.

There was evidence of continuing commitment to health and well-being activity in the future across a majority (two-thirds) of organisations in contact with a Co-ordinator and an increased commitment in one in ten organisations. Third sector organisations appeared to be the most committed to more activity. In contrast, one in ten public sector organisations seemed to be scaling back their activities.

In the survey of organisations in contact with a Co-ordinator, a majority said that improvements in awareness of health and well-being, increases in activities, and improved health and well-being policies would be long lasting. Some Challenge Fund winners thought a change in culture was more likely to be maintained if activities were embedded in the organisation's operations and training. Employees doing activities together contributed to sustained culture change, more so than where participation was more individually focused.

Conclusions and lessons for the future

There was considerable evidence that Co-ordinators had made progress in meeting the strategic aims of the post. Co-ordinators worked to develop and encourage partnerships between employment and health networks. Public sector engagement was wide-ranging including working with Primary Care Trusts (PCTs) to help them assess needs in the workforce, set goals and measure outcomes, and advising Strategic Health Authorities (SHAs), Local Enterprise Partnerships and emerging Health and Well-being Boards in England.

Co-ordinators perceived that the extent of direct contact with SMEs did not match the aspirations of government. There was some specific activity that addressed health and well-being across firms and organisations (such as developing charters and accreditation schemes) but there was relatively little direct contact with SMEs. There were about four times as many contacts with large public sector organisations (particularly in the NHS) as with private sector SMEs.

Addressing mental health was challenging for the Co-ordinators. It was hard to engage employers on the subject and, as explained earlier, mental health did not become a focus of some Co-ordinators' work, particularly those with little experience of mental health issues. Work-related stress was the most commonly cited problem among firms and organisations, and many wanted to achieve improvements in mental well-being and put in place initiatives to do this. A majority of organisations awarded the Challenge Fund said that they perceived improvements in worker mental well-being as a result of what they had put in place.

Data from the survey of organisations in contact with a Co-ordinator and the Challenge Fund survey show varying levels of reported positive impacts. Impact from both initiatives was perceived as greater in helping organisations to develop networking activity and initiating new health and well-being activity, but less so in actually improving health and well-being in the workplace or reducing sickness absence rates. Positive impacts on culture towards workplace health and well-being were being made following engagement with a Co-ordinator or use of Challenge Fund money. Most changes were expected to be long lasting. There was considerable evidence that many activities and networks would continue beyond March 2012 when funding for the Co-ordinator initiative was due to end. However, at the level of individual organisations, some health and well-being initiatives looked vulnerable because of the lack of future funding.

A number of lessons emerged from the study that can inform the development of health and well-being policy. The Co-ordinators were given broad objectives, with wide discretion to tailor their approach to their local area. Some felt that if they had been given more specific objectives from the outset, however, this would have helped them to focus their work. Some drew the conclusion from this that there was a need for more effective coordination of policy at departmental level, which suggests that the links between the Co-ordinators' objectives and the strategic cross-government policy aims could have been more clearly communicated. The number of SMEs with direct contact from Co-ordinators was small but the quality of contact with SMEs was largely positive. Although the Co-ordinator role ended in March 2012, the challenge for DWP and public health bodies for the future is how to balance direct contact with SMEs with more indirect means.

The evidence from this study indicates that the non-commercial benefits to organisations from health and well-being activity, such as improved management-staff relations, can reinforce the case for employer investment. The benefits from health and well-being activity in organisations are more likely to be sustained when the activity is embedded within mainstream, day-to-day practices, has clear support from senior management and is based on the views and aspirations of staff.

1 Introduction

This report presents findings from a research project to assess the effectiveness of two related initiatives commenced in 2009 to promote the health and well-being of the working age population – the appointment of 11 Health, Work and Well-being Co-ordinators in Great Britain and the introduction of a Challenge Fund to promote local innovations to improve health and well-being in the workplace. The project was funded by the Department for Work and Pensions (DWP) and ran from October 2009 until April 2012.

1.1 Policy background – the Black Review and Government response

In March 2008 Dame Carol Black's review of the health of Britain's working age population, *Working for a healthier tomorrow*, was published (DWP, 2008). The report included a wide range of recommendations and highlighted the importance of integration between health and employment bodies at a local and regional level in promoting the health and work agenda, and recommended using local networks to implement health, work and well-being policy initiatives. In addition, Dame Carol argued for '*a shift in attitudes ... to ensure that employers and employees recognise not only the importance of preventing ill-health, but also the key role the workplace can play in promoting health and well-being*' (p.10). Without making specific recommendations the report also proposed that '*Government should explore practical ways to make it easier for smaller employers and organisations to establish health and well-being initiatives*' (p.60). Recent research suggests that employers are broadly supportive of activities that promote health and well-being (Young and Bhaumik, 2011).

As a result a number of pilots were set up including:

- funding for the employment of 11 **Health, Work and Well-being Co-ordinators** (in Scotland, Wales and the nine English Regions) for two years; and
- a **Health, Work and Well-being Challenge Fund** to provide funding for initiatives to improve workplace health and well-being.

The intention was for Co-ordinators to be accountable to Regional Directors of Public Health and their equivalent in Scotland and Wales and to work across departmental boundaries in order to fill what was identified as a 'gap in the health, work and well-being infrastructure'. Their overall objective was to '*champion integrated approaches to health, employment and skills support (in and out of work), encourage local public sector employers and exemplars and build engagement with small business ...*' (p.34). These broad objectives were refined in further policy and administrative documents to form benchmarks against which the performance and impact of the Co-ordinators can be assessed. These are set out in Section 1.2.

The appointment of the Co-ordinators commenced in the autumn of 2009 and all were in place in early 2010. Start-up funding was initially to last for two years from appointment but additional funding was provided in 2011 to allow all the Co-ordinators to continue working until March 2012. The Co-ordinators' role included the administration of the Challenge Fund locally.

The purpose of the Challenge Fund which was '*focused on supporting SMEs*' (small and medium enterprises) was set out as follows: '*the Challenge Fund will encourage local initiatives that improve workplace health and well-being, through innovative approaches which ensure worker engagement*' (p.86). The Fund was set up in 2009 and was open to applications from SMEs and local partnerships

for funding of projects that lasted for up to two years. The amount of funding available for a project was between £1,000 and £50,000 for each year. Local partnerships were defined broadly as '*different stakeholders seeking to work together in partnership to provide a health, work and well-being solution to the businesses in their locality*' – this could include public sector as well as large employers. The funding was intended for new projects (not to support existing projects) that brought an innovative solution to an identified problem, such as high levels of sickness absence. Some spending was not permitted, such as on capital works. Small businesses were encouraged to consult their staff about their plans. Decisions were made by 11 local assessment panels – one in each region or country in early 2010. Seventy-three projects were awarded funding for up to two years.

1.1.1 Subsequent changes in the external environment

Some of the factors that affected the ability of Co-ordinators to meet the expectations of their role were external and therefore, outside of their ability to influence. Two of the more important of these are the reorganisation of public health provision in England and the mainly adverse economic conditions prevailing during 2009–12.

In November 2010, the Coalition Government published its plans in *Healthy Lives, Healthy People* for the future provision of public health in England (Department of Health (DH), 2010). Following a public consultation process an updated version of the Government's plans was published in July 2011 (DH, 2011). Proposals relevant to the work of the Health, Work and Well-being Co-ordinators in England included the relocation of the principal responsibility for public health to local authorities in collaboration with existing Directors of Public Health; the establishment of new local statutory Health and Well-being Boards to support collaboration across NHS and local authorities to address communities' needs; and the establishment of a new dedicated, professional public health service, Public Health England, which was to act as a source of information, advice and support for local authorities and clinical commissioning groups as they developed local approaches to improve health and well-being (DH, 2011).

Although full implementation of public health reform will not take place until 2013, local authorities were expected to have appointed shadow Health and Well-being Boards by April 2012. At the time of writing most local authorities had set up these shadow boards (DH, 2012). The effect of these developments in the organisation and structure of public health in England will be discussed in Chapter 2.

The second external factor affecting the work of the Co-ordinators was the mainly adverse economic conditions prevailing during the last two or three years. Throughout the time of this study, therefore, it was recognised that attempting to change the attitudes and practices of firms and organisations was more of a challenge when their focus was more on survival, consolidation and contraction than expansion and investment. The Co-ordinators' job description made this point explicitly: '*In light of the current economic situation this (health, work and well-being) agenda will be faced with adversity, but is undoubtedly more pertinent than ever before.*'

It should be noted that the Co-ordinator and Challenge Fund initiatives were part of a wider set of policies aimed at improving the health and well-being of the workforce, promoting job retention and increasing labour market participation. Examples include the Fit for Work Service (HM Government, 2009; Hillage *et al.*, 2012), the Occupational Health Advice Lines (Sinclair et al., 2012), health and well-being award and accreditation schemes, the Workplace Well-being Tool for employers to assess workforce health and well-being (see www.dwp.gov.uk/health-work-and-well-being/our-work/workplace-well-being-tool/), and public health initiatives such as the Responsibility Deal (DH, 2011). Also of relevance for the work of the Co-ordinators was the independent review of sickness absence (Black and Frost, 2011) set up by the DWP to seek ways of helping more people stay in work, informed by an analysis of the costs of sickness absence between employers, employees and the State.

1.2 Assessing effectiveness – the policy aims of the Co-ordinators and Challenge Fund

One of the key challenges for this study has been to collect and interpret data on the effectiveness or impact of the work of the Co-ordinators and the use of Challenge Fund awards.

The Co-ordinators' job description allowed them wide discretion to tailor their approach and activities to their own region or country (in their own work and through the Challenge Fund).[1] They were not given any **quantified** objectives or measures of success to achieve. What we present below is a summary of the broad aims and expectations placed on the Co-ordinators collated from public documents, job descriptions, information provided to Challenge Fund applicants and the research specification prepared by DWP. We used the indicators in this summary as benchmarks against which to assess the impact of the Co-ordinators and the Challenge Fund.

The Co-ordinators were given both a strategic and a local focus. Their generic job description set out three overall objectives as follows:

- develop and encourage partnerships between employment and health networks;
- co-ordinate health, work and well-being strategies and activities within and across regions and countries;
- recognise and promote best practice and encourage innovation within firms on health, employment and skills – working with smaller businesses in particular and using the Challenge Fund as a key tool to achieve this.

The range of means by which the Co-ordinators were to meet these objectives is further elaborated in the job description. How to address their strategic role is set out in some detail:

- influence the strategic work of local/regional partners – by developing collaborative relationships with Regional Development Agencies (RDAs), Employer Coalitions, Business Link, CBI, TUC and other relevant local and regional partners;
- make links with Regional Employment Teams and Jobcentre Plus to develop engagement with employers – with a particular focus on mental health;
- work with local authorities and Jobcentre Plus through the Local Area Agreement process;
- work with Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) to engage the public sector in promoting their role as health, work and well-being exemplars.

How to effect change at the level of the workplace is less detailed:

- administer the Challenge Fund to generate small business investment in health and well-being growth and innovation;
- identify, report upon and promote best practice at a local level and share best practice through networks across the English regions and across countries.

[1] This approach can be seen as consistent with, and a contribution to, a more general focus on promoting locally-centred responses to a range of policy issues, brought together recently in the Localism Act 2011.

The aims of the Challenge Fund, which as mentioned already had a clear focus on SMEs and local partnerships, can be summarised as follows:

- to improve workplace health and well-being, through innovative approaches which ensure worker engagement;
- to focus in particular on practical initiatives for mental health and well-being in smaller businesses.

It was always clear from the start of this study that there was no readily available dataset on the health and well-being of the workforce in general or workforces in individual organisations that could be used to measure the impact of the Co-ordinator and Challenge Fund projects. The approach to assessing impact has, therefore, been to use, as far as possible, the perceptions and views of the key stakeholders, i.e. the Co-ordinators themselves, the organisations with whom they had contact, and the Challenge Fund winners.

1.3 Research objectives and design

The research was designed as two complementary components to reflect that health, work and well-being Co-ordinators and the Challenge Fund can be treated as distinct policy instruments.

1.3.1 Aims of the study

The Co-ordinator component was designed to meet the following research objectives:

- to describe the role/operation of the Co-ordinators, and identify the similarities and differences of the delivery models chosen;
- to investigate the (perceived) impact of the Co-ordinators on the levels of health and well-being amongst the organisations engaged;
- to identify whether Co-ordinators succeeded in promoting the health, work and well-being agenda amongst key stakeholders and firms, and whether sustained **cultural change** was achieved;
- to understand to what extent and how the Co-ordinators have developed relevant health and work partnerships/networks amongst key stakeholders and agencies;
- to understand the sustainability of the actions/systems the Co-ordinators put in place after the start-up funding for the posts had come to an end.

The Challenge Fund component of the research was designed to meet the following aims:

- to explore the application and selection process of the Challenge Fund;
- to understand motivations of firms and partnerships behind applications to the Challenge Fund, their attitudes to health and work, and the role of the Co-ordinator in supporting applicants;
- to describe the types of employers that received an award and the initiatives funded, and identify successes and the barriers to implementation of the initiatives within firms;
- to investigate the additionality of the Challenge Fund and (perceived) impact on employers and partnerships including well-being indicators (e.g. sickness absence, presenteeism, employee morale and engagement, and productivity), and dentify the business case for implementing the health and well-being initiatives;
- to understand the impact of the Challenge Fund on employees;
- to understand changes in awareness of and attitudes to health and work, and the culture within beneficiary organisations.

1.3.2 Research design

The research design was aimed at meeting the research objectives outlined above and collecting data from a number of main stakeholders including:

- Health, Work and Well-being Co-ordinators;
- senior public health officials (from NHS Regional Directorates of Public Health in England and their equivalents in the devolved administrations of Scotland and Wales);
- policy makers within the DWP;
- organisations that had had contact with Co-ordinators;
- Challenge Fund award winners;
- employees of Challenge Fund winners.

A summary of the methods used for the study are presented in Table 1.1. Some further explanation is also provided but full methodological details are collated in the appendices. All interviews were conducted by members of the research team using semi-structured topic guides. Digital recordings were made and transcribed for analysis using the Framework method, a thematic charting tool developed by the National Centre for Social Research which is a systematic and transparent approach to organising qualitative research data (Ritchie and Spencer, 1994). The first stage of analysis involves familiarisation with the data and identification of emerging issues to inform the development of a thematic framework (which also included some topics that were agreed between the research team and DWP as key issues). This comprises a series of thematic matrices or charts. Organising the data in this way enables themes to be explored within a common analytical framework which is grounded in respondents' own accounts. The final stage involves analysis of the charted data in order to identify patterns, explanations and hypotheses.

Table 1.1 Summary of research design

	Element of research design	Scale and timing of fieldwork
Exploring the work and impact of the Co-ordinators		
1	Depth interviews with 11 Co-ordinators	Three waves of interviews were held in: – spring 2010 (face-to-face – autumn 2010 (face-to-face) – autumn 2011 (telephone)
2	Depth interviews with 11 senior public health officials	One set of face-to-face interviews in autumn 2010 (but see notes below)
3	Depth interviews with three key DWP policy makers	One set of face-to-face interviews in autumn 2010
4	Survey of organisations in contact with Co-ordinators	279 organisations surveyed. Telephone interviews took place in summer 2011
5	Follow-up depth interviews from the survey of organisations in contact with a Co-ordinator	19 telephone interviews carried out in early autumn 2011.
Exploring the use and impact of the Challenge Fund		
6	Survey of Challenge Fund winners	59 Challenge Fund winners surveyed in spring 2011 by telephone.
7	Case studies of Challenge Fund winners	Two waves of depth fieldwork in: – summer 2010 – summer 2011

Interviews with Co-ordinators

It was recognised and expected that the work of the Co-ordinators and their impact would change over the two-year period they were in post. It was decided, therefore, to interview them on three occasions. The first interview took place in the early months after their appointment and focused on early experiences and plans and aspirations for the future. The second interview, after about a year in post, concentrated on achievements so far and changes made to their activities. The final interview towards the end of their tenure focused on a retrospective view of their work and impact, and on the sustainability of health, work and well-being activity.

Interviews with senior public health officials

Interviews were held with Directors of Public Health (or an appropriate colleague) in England and officials from the Health Improvement Strategy Division of the Scottish Executive in Scotland and the Health Improvement Division of the Welsh Assembly in Wales. Interviews took place at the same time as the first Co-ordinator interviews and similarly focused on looking forward to plans and aspirations. An intended second wave of interviews (to coincide with the third and final Co-ordinator interviews) was abandoned because of the changes to the responsibility for public health in England discussed in Section 1.1.

Interviews with key DWP policy makers

As useful background to the work with other stakeholders, depth interviews were held with three key policy and implementation officials in DWP. The focus of the interviews was to collect data on the rationale behind the Co-ordinator and Challenge Fund initiatives, the objectives DWP wanted to meet and how effectiveness could be assessed.

The survey of organisations in contact with a Co-ordinator

The aim of this survey was to analyse the relationship between the Co-ordinators and organisations and firms with whom they had made contact. Data were collected on the nature and frequency of contacts between them, the health and well-being issues and problems facing organisations, and the changes in these over the course of their contact with a Co-ordinator. The survey was an attempt to measure, as far as possible, the perceived impact of the Co-ordinators from the perspectives of the organisations they were trying to help and influence.

The sample for the survey was generated by asking Co-ordinators to record all their contacts (by telephone, email or face-to-face) over three two-week periods between July 2010 and March 2011. A sample of 493 was generated in this way and 279 organisations eventually took part. The principal organisational characteristics of the responding organisations are presented in Table 1.2.

Table 1.2 Organisation types in the Contacts Survey

	Number	%
Public sector – large organisations[1]	110	39
Public sector – small/medium organisations[1]	39	14
Private sector – large firms	25	9
Private sector – SMEs[1]	31	11
Third sector – small/medium organisations	59	21
Other	15	5
Total	279	100

[1] Large organisations are defined as having 250 or more employees, small and medium organisations have between one and 249.

Of the 110 large public sector organisations in the sample, 82 were NHS organisations, 32 were local authorities and 15 were part of the Civil Service. NHS organisations, therefore, represented 29 per cent of all the respondent organisations. Fifteen per cent of the sample were holders of Challenge Fund awards and a further 47 per cent had heard of the Fund.

Follow-up depth interviews from the survey of organisations in contact with a Co-ordinator

The aim of the follow-up interviews was to explore in depth issues arising from the survey and other components of the research design. In consultation with DWP a number of issues were identified as worthy of further exploration. Organisations were therefore selected if they reported high levels of absenteeism, presenteeism, work-related stress, poor diet or weight issues; or positive changes in workplace culture or network building; or a high percentage of positive impacts that would be long-lasting. Nineteen follow-up interviews were carried out in autumn 2011.

Survey of Challenge Fund winners

As mentioned previously there were 73 Challenge Fund winners. All the winning organisations were invited to participate in the survey and 59 responses were received. The survey questions focused on perceptions of health and well-being issues and culture in their organisations, use of Challenge Fund money and perceived impact. The principal organisational characteristics of the survey respondents are presented in Table 1.3.

Table 1.3 Characteristics of organisations in the Challenge Fund survey

	Number	%
Type of organisation		
Single business/organisation	38	64
Partnership	21	36
Industrial sector of single organisations		
Private sector	17	45
Third sector	20	53
Size of (single) organisations		
Small, 1-49	16	42
Medium, 50-249	20	53
Large, 250+	2	5

Case studies of Challenge Fund winners

In order to generate a deeper understanding of the use and impact of the Challenge Fund 12 case studies were carried out of diverse award holders, including partnerships and single businesses. The 12 projects were selected following analysis of their bid documents to produce a sample that included a range of organisation sizes and sectors and variation in project design (such as types of health condition targeted, scale of funding and type of activities). (A fuller explanation of the sampling approach is included in the appendices.)

Visits to each winner took place in the summer of 2010, some months after receiving their award. Key people in management and human resources were interviewed, plus a group of employees. Where appropriate, external providers of services were also interviewed. The focus of the visits was on understanding health and well-being issues and culture, how the Challenge Fund was being used and on aspirations for the future. There was particular interest in how the organisations themselves were assessing the impact of having a Challenge Fund award. Follow-up visits were made a year later to collect data on the impact of Challenge Fund activities and their sustainability.

1.4 Structure of the report

The structure of the report is based on the key areas of policy interest identified in consultation with DWP. Chapter 2 deals with the activity and impact of the Co-ordinators, Chapter 3 presents findings on the use and impact of the Challenge Fund and Chapter 4 explores the effect of the initiatives on culture and attitudes towards health, work and well-being among the firms, partnerships and organisations that took part at various stages during the research study.

Chapter 5 summarises findings on the main outcomes from the two initiatives and their sustainability beyond the two-year start-up period, and draws lessons for DWP and DH policy, public health and the business community.

2 The work of the Health, Work and Well-being Co-ordinators

This chapter presents findings on the evolving role of the Health, Work and Well-being Co-ordinators, their activities and their achievements compared with their aims and objectives. In particular we focus on their work in relation to mental health and their engagement with small and medium sized enterprises (SMEs).

2.1 The evolving role of the Co-ordinators

2.1.1 Background and experience

People appointed to the Co-ordinator role came from a range of backgrounds, including NHS public health; strategic or workforce development within local authorities; public, private and voluntary sector employment services, and the private sector. Several had experience in more than one of these areas. The two people who took over the role from initial Co-ordinators both had a background in public health. In Wales, the Co-ordinator's role was shared between two people, one of whom already had a core post addressing several of the objectives set for the Co-ordinators. In order to avoid duplication of what was already happening, an additional person was recruited to widen the scope of work already being undertaken, and the role was jointly delivered.

Whatever their background, people generally felt that the scope and remit of the Co-ordinator role fitted well with their previous experience. They could bring relevant expertise, and at the same time the focus of the role matched their interests and enthusiasms and offered career progression. Past experience of working with the business community was considered valuable, affording insight into employers' perspectives, and some understanding of the drivers and motivations within the business community.

2.1.2 Operational issues

In each region and country, geography and socio-economic features were important influences on how the Co-ordinators approached their role. Such features included population distribution; administrative infrastructure; communications, and representation of occupational and business sectors. All Co-ordinators said they knew of pockets of particularly high levels of unemployment, low incomes and economic disadvantage, and some described areas with pockets of low levels of skills and learning, especially among young people. SMEs were to be found both in more prosperous parts and in the most deprived. They were described as highly variable, with quite different needs for support and advice, and different motivations to seek out or use the already existing range of products and services to support business.

Most Co-ordinators were initially located organisationally within NHS directorates of public health in the English regions, and the equivalent administrations in Scotland and Wales. Being situated alongside other parts of the public health team was generally felt to be beneficial. Co-location with colleagues working on, for example, tobacco, alcohol, obesity and health inequalities programmes meant there was easy access to each other's knowledge and expertise. The one Co-ordinator in England not initially located in a public health directorate was working within the regional economic development team and perceived advantages in being alongside colleagues with expertise relating to businesses and the regional economy. As mentioned in Chapter 1, structural changes

in public health organisation had an impact on most of the Co-ordinators in the English regions during 2010 and 2011. Although office moves were disruptive, people who had been moved to new NHS locations by late 2011 were seeing some advantages in being closer to new contacts, for example, NHS Champions schemes, and personnel in touch with European Union regional funding opportunities.

Reflecting their organisational placement, most Co-ordinators were line managed by a senior public health official. General satisfaction with their supervisory and line management arrangements and relationships continued for most Co-ordinators throughout the project, although one had always been very disappointed at the level of interest and 'buy-in' among senior public health staff.

The administrative support and facilities available to Co-ordinators were highly variable. Most people had some kind of administrative support for at least some periods of time. Having consistent support throughout the project was unusual, but those who did have this recognised what an advantage it had been.

2.1.3 Initial perceptions of role

Initially, Co-ordinators generally perceived the role as challenging, with wide-ranging potential. Some spoke of their initial uncertainty and lack of clarity about their role, and there was some surprise that the role spanned such a wide range of ways of working, at strategic, operational and administrative levels. More direction from central DWP at this stage, and greater opportunity for general discussion about the role with the other Co-ordinators would have been helpful to some people. Generally, at the time of the first research interviews, action plans and firm goals were still being constructed or refined.

Co-ordinators variously identified the following components of role and purpose:

- integrating the health, work and well-being agenda within regional long-term policies and strategies;
- building on and developing what was already going on;
- influencing change;
- shifting the focus on health and work beyond the 'worklessness agenda';
- identifying ways of engaging with business;
- putting the Challenge Fund into operation and learning from it;
- informing and contributing to national government strategies and policies;
- working within personal professional development plans.

There was general agreement about the importance of working at a strategic level, towards structures and mechanisms that could sustain any impact of improvement of health and well-being at work. The operational role was also perceived to be important, in seeking opportunities to influence change directly. All emphasised the importance of working with what was already going on in their region in the field of health and well-being at work. At this early stage, apart from engaging directly with businesses as part of their role with the Challenge Fund, much of what Co-ordinators were expecting to do with small and medium sized enterprises was at a strategic level. This included finding and influencing the messages that motivate employers, and identifying ways of reaching small businesses and their employees.

2.1.4 Development of the role

After a year or so in post people felt there had not been major changes in their basic concepts of role and purpose, but some shifts in understanding of what was possible and where priorities lay. Some now felt the job was bigger than anticipated after they discovered how far was the health and well-being at work agenda from current interests of key players in their region, for example GPs. Some had not expected it to be so hard to increase understanding of what they were trying to do, for example, among current groupings in the business community, and the highest levels of public health administration.

There was now wide spread feeling among Co-ordinators in the English regions that the strategic part of their role had been less easy to maintain as structural changes took hold, with uncertainties about future groupings and responsibilities. Developing a business plan, described as an important influence on some Co-ordinators' initial perceptions of role, was generally considered to have been a useful process. These plans were described as working tools, and by updating and revising the plans, most people felt they had a live document as a dynamic tool that helped them manage development of work and was a useful instrument for reflection.

2.1.5 Views of senior public health personnel

Views from the senior public health personnel who line managed or supervised Co-ordinators were sought shortly after initial discussions with the Co-ordinators, and provide a useful perspective on the Co-ordinators' role and early achievements. In describing what they hoped the Co-ordinators would achieve in their region or country, views clustered around the following themes (in no particular order):

- increasing employer awareness of the benefits of workplace health, and the economic argument that having healthier staff can have a positive impact on productivity and profits;
- increasing availability, accessibility and uptake of health promotion activities, support services and workplace health initiatives (for example employers' award schemes);
- extracting and disseminating learning from workplace health initiatives, including Challenge Fund projects;
- improving understanding of how to communicate successfully and engage with businesses;
- joining up activity and brokering relationships across sectors to enable more dialogue and co-ordinated activity;
- gaining strategic commitment to workplace health, particularly in the public sector;
- laying foundations for sustainability beyond the lifetime of the Co-ordinator post.

For the most part, senior public health personnel were positive and optimistic about what the Co-ordinator role would add to workplace health activity in the region. At the same time, it was important that the Co-ordinator project fitted or took account of work already under way in the region and did not contradict, duplicate or otherwise 'muddy the waters' of programmes already in operation. They saw challenges for the Co-ordinator in having to work in an environment of major structural reorganisation and change, and in trying to engage organisations across all sectors in a difficult economic climate.

That said, all felt there was already evidence, from the first six months following appointments, of Co-ordinators' activities and the progress made. Mentioned here were relationships, networks and links built across sectors; events organised; information provided for regional public health policy; a raised public profile for the health, work and well-being agenda; development of business award schemes; and work undertaken with Jobcentre Plus.

2.1.6 Working as part of a Co-ordinator 'network'

From the start of the project Co-ordinators attended monthly meetings, mostly in London, to enable them to meet as part of a 'network' with the central policy team. Members of the research team sometimes joined the meetings, and the agenda often included presentations from other invited participants. Initially, some people identified the Co-ordinator network as a positive element, enabling people to learn from each other, and as a means of maintaining consistency and direction.

In the final research interviews, the general view was that the monthly Co-ordinator meetings had been especially useful in providing some mechanism for feeling part of a team, for those who had found the role isolating or found little support from senior personnel. Some felt meetings had become more enjoyable as people learned how to interact with each other, and the balance of the content moved more towards discussion, and away from information provision and external presentations. However, some people felt the meetings never met their full potential, and Co-ordinators for Wales and Scotland sometimes found little to contribute when discussion was mainly relevant to England.

Outside the meetings, most people made some helpful contacts with other Co-ordinators, especially when working together on particular agendas such as GP engagement, the Work and Well-being Charter, and local business accreditation programmes. Some said their work would have been more difficult and less successful without these contacts.

2.1.7 Working with central government

The Co-ordinators project was a joint DWP/Department of Health (DH) initiative, governed by the cross-government Health, Work and Well-being Executive[2]. Co-ordinators' contact with central government was mainly through the DWP policy branch, although Dame Carol Black, as National Director for Health, Work and Well-being, was closely involved with the programme.

Apart from criticisms of the central management of the administration of the Challenge Fund, reported in the following chapter, the general view at the end of 2011 was that people in the central DWP policy branch had provided efficient management and had been supportive. There was appreciation of easy access to individual policy makers, and quick and appropriate response to requests for information. But some feelings expressed in the first year, of need for a more robust central steer about purpose and the outcomes required, did remain.

A series of monthly network meetings provided a forum for the Co-ordinators to share experiences and best practice. (Policy and strategy were a matter for discussion at the national Health, Work and Well-being Executive meetings.) Responsibility for organising and chairing the meeting was rotated each month amongst the Co-ordinators, which involved setting the meeting's agenda, and inviting speakers and other participants. Some Co-ordinators commented spontaneously that they were disappointed and surprised that in a joint DWP/Department of Health programme there was almost no senior DH representation at network meetings, although the reasons for this were not clear from the research data.

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[2] The Health, Work and Well-being Executive includes senior officials from DWP, DH, Health and Safety Executive and the devolved Administrations of Scotland and Wales.

2.2 The Co-ordinators' activities

Co-ordinators undertook a wide range of activities during the course of the project. This part of the chapter outlines the main direction and balance of activities. We also report on Co-ordinators' perceptions of how useful different approaches had been.

2.2.1 Scoping and mapping

Initial months in post generally involved scoping and mapping current activity around the health, work and well-being agenda. Some people commissioned employer surveys to gauge the extent and type of activity underway and to identify existing good practice and perceived areas of need. Desk work included literature reviews of the evidence base on workplace health, to inform their future approaches. By the time of the second interview, people had generally moved on from this kind of work but a small number of new, more specific mapping initiatives were ongoing, such as a focus on small business forums across the region. In overall reflection at the end of 2011, the general feeling was that time spent on such activities had been useful in providing essential context.

2.2.2 Networking and familiarisation

Initial months had always involved substantial amounts of time 'getting out there', meeting or giving presentations to a range of key stakeholders with whom it would be important to form working links. Among the wide range of organisations mentioned here were TUC; chambers of commerce; local authorities; universities; Jobcentre Plus personnel, and Fit for Work Service pilots; CIPD; Regional Development Agencies; regional business networks, and local services supporting health and work.

In interviews around one year after the Co-ordinator appointments, these initial activities were bearing fruit. Indeed, some Co-ordinators said they were now so well known and had generated interest to such an extent that there were continuous demands to attend events and give presentations and they had to think carefully about the best use of their time. By this stage Co-ordinators were also focusing on building links between existing networks and, where gaps were perceived, on creating and supporting new networks. Examples were a network for local authorities; one for large organisations; one for service providers and commissioners; and one for practitioners directly involved in commissioning or providing workplace health activity.

During 2011, Co-ordinators worked to consolidate and extend networks and partnerships, focusing work towards links that would be sustainable beyond the funded project and in the changing structural environment.

2.2.3 Marketing materials and information provision

Early priorities included development of marketing and information materials, so as to have coherent and accessible information to offer businesses. Materials described ranged from simple business cards to folders of good practice case studies on workplace health, and information packs detailing the range of tools and resources available to businesses. What could be achieved here depended on the amount of administrative support available.

By the end of their first year in post several Co-ordinators had developed initial marketing and information materials into electronic newsletters for employers, and developed websites. Some people regularly prepared information and news items for insertion in newsletters produced by other organisations. Short pieces in, for example, local trade newsletters and trades union bulletins proved useful ways of engaging with businesses and did not require financial outlay. Keeping information flow going in such ways went on throughout 2011, and Co-ordinators continued to take any new opportunities.

2.2.4 Business and employer engagement

By the end of their first year in post the general picture was one of considerable progress in engagement with businesses and employers. Several local conferences, meetings and events had been held in most regions and countries. While useful, these did tend to attract the larger businesses and those already interested in, and committed to, good practice. It was proving much harder to engage with small businesses, and employers for whom the agenda was new. The general view was that the most useful approach was through working with organisations and associations already in touch with such businesses and a range of activities had been tried. An example from Wales was an information pack prepared by the joint-Co-ordinator describing government-backed services offered free of charge, which was currently being offered as part of the members' subscription to a builders' federation representing around 9,000 builders.

Examples of more direct engagement came from the work some Co-ordinators were doing towards preparing 'case studies' of good practice around health and well-being among selected small businesses. Such studies were being used as showcase material for information giving, for example, at events or in strategic approaches. Portfolios of case studies were well developed in two regions by the end of 2010.

Throughout 2011 all Co-ordinators had spent time working with organisations which already had health, work and well-being as part of their agenda to strengthen approaches and increase effectiveness, for example, working with Fit for Work Service pilots and, in Scotland, Healthy Working Lives. Work continued on looking for routes for communication with, and provision of information to, businesses; contributing to management and training programmes; putting on events, and giving presentations. One innovative approach was making arrangements for banks to promote a Co-ordinator's website with their business customers. In another region, the Co-ordinator was working with an alliance of over a thousand businesses which was looking at workplace health as a new market.

2.2.5 Strategic approaches

Contributing to strategic developments grew in importance for the Co-ordinators during 2010, and the overall picture was one of considerable involvement with the public sector. People described working directly with Primary Care Trusts (PCTs) and other health trusts for example, helping them assess needs in the workforce, set goals and measure outcomes. Similar work had been continued in one region with the armed forces and emergency services. Several people had been asked to write briefing papers or reports for groupings in their Strategic Health Authority (SHA); the Local Enterprise Partnership; the emerging Health and Well-being Boards, or similar contributions such as a chapter for a chief medical officer's report, or a briefing paper for a minister. In Wales, the Co-ordinator was contributing much time to help develop a five-year Action Plan for Wales on health, work and well-being.

Commitment to strategic work continued throughout 2011, and some Co-ordinators intensified their activities here, to ensure legacy from the project in the challenging environment of structural change. Examples included finding ways to align established partnerships with the new Public Health Responsibility Deal; supporting and promoting findings from the Independent Review of Sickness Absence (Black and Frost, 2011); working with Directors of Public Health who were moving to the local authorities; making new links for the new environment, with Health and Safety, and Environmental Health forums; and looking at NHS contracts with business in the community, to put in standards for health, work and well-being and evaluation for outcomes. In Wales, the health and work agenda had been embedded in the main economic development programme.

2.2.6 Challenge Fund

Local administration and implementation of the Challenge Fund was a key activity for many Co-ordinators during the first few months. By the time of the first research interview only a few people had had direct contact with the winning organisations. Overall, expectations of future role and activities combined elements of nurturing and encouragement alongside monitoring and accounting. There were also intentions to engage with organisations that had submitted full bids but been unsuccessful. At this stage, Co-ordinators were expecting a second round of Challenge Fund awards (see Chapter 1).

During 2010 working with winners took up variable amounts of time, related both to the number of winners in the region and to the amount of support perceived appropriate. Co-ordinators provided information, and sign-posts to resources and services. They discussed concerns and helped find solutions to problems. In some cases they helped refocus a project that was not going the way bidders hoped, or supported projects to strengthen elements that would be sustainable. In most places there was little further work with non-winners.

During 2011 Co-ordinators generally continued a fairly 'light touch' approach, but some projects needed more intensive support and monitoring. Co-ordinators' views on the usefulness of the Challenge Fund are described in the following chapter.

2.2.7 Working responsively

A range of new projects and activities came onto Co-ordinators' agendas in the latter part of 2010 and 2011 as they took initiatives to fill perceived gaps, and responded to structural changes. There was a picture of flexibility in response to new situations, while maintaining the focus of their role. As an example, awareness of GPs' need for information about the new policy environment led to collaborative work between two Co-ordinators to bring together and promote information that would be helpful. In the London region there were opportunities to take part in small-scale local health-focused events for the general public, which provided useful learning about ways of engaging with business. In another region, organisational change had created need for services to support organisations facing redundancies and funding cuts and the Co-ordinator was working here with a council for voluntary services. Several Co-ordinators were asked individually to lead on initiatives coming from central government, including the Workplace Well-being Charter, England; a business accreditation award; and development of an information leaflet about the fit note. Response to the Independent Review of Sickness Absence (Black and Frost, 2011) led to specific focus on sickness absence in one region, developing ways of asking businesses about sickness absence and helping public sector organisations to quantify and use sickness absence data.

Working on local workplace well-being or health at work accreditation and award schemes became an important part of work for several Co-ordinators. Where this was a new initiative for a region, considerable work was required in negotiating with local partners, explaining self-assessment tools to businesses, building interest and commitment, and launching the scheme. In regions with longer established schemes, the challenge was often to bring different awards together, and move the targets away from public sector employers and good corporate flagship companies and towards SMEs.

Finally, in a small number of regions, Co-ordinators had put effort into working with the university sector to build academic links around the health, work and well-being agenda, and encourage co-ordination in research focus. This had sometimes led to disappointing outcomes but in other regions local universities with various streams of work which could provide the evidence base for effectiveness of different initiatives had started working together to build a more co-ordinated approach.

Over half of organisations surveyed who worked with a Co-ordinator initiated the contact themselves. This might be an indication that Co-ordinators were succeeding in establishing some sort of presence in their areas. Rather than being proactive they were responding to interested outside parties.

In summary, the overall picture was of a broad range of activities undertaken. Outcomes were often likely to come beyond the lifetime of the project, as discussed in Section 2.7. Different influences on balance and direction of Co-ordinators' activities were linked both with variation in opportunities and challenges across regions, and with the developmental stages expected in a time limited project of this kind (start-up, exploration, momentum, consolidation, and moving towards end). The specific examples described here were chosen to give some flavour of the breadth of activity, but represent only a very small part of the volume of work undertaken.

2.3 Meeting aims and objectives

In the last research interviews, at the end of 2011, Co-ordinators reflected on their activities, their main achievements thus far and where they had met particular challenges or disappointments.

2.3.1 Monitoring progress and measuring impact

All Co-ordinators said it would be important to monitor their progress and try to measure outcomes against objectives. From the beginning they regularly looked at the balance of activities, contacts made and what had been taken forward. Revisiting their action plan on a regular basis with their supervisor helped them assess progress and learn from what was happening. Where appropriate they modified or refined objectives. Much of their process evaluation depended on their own 'continuous personal stock-taking' and seeking feedback from individual people (partners and stakeholders) about which activities were helpful.

Measuring outcomes was expected to be hard. It would be easy to demonstrate contacts and events attended and arranged but much harder to capture evidence of outcomes such as increased partnership working or business engagement. Great care was needed in choosing indicators and interpreting results. Initially, the Co-ordinators were generally interested in looking for the following kinds of evidence:

- changes in numbers from accessible data, such as staff sickness absence figures from selected public sector and business settings;
- evidence of embedding the agenda in organisational strategies and plans, such as implementation of health, work and well-being strategies by local authorities and PCTs;
- evidence of 'joining up' and connections made, such as new regional networks or steering groups;
- emergence of 'exemplars' in public and business settings, for example, champion organisations implementing and promoting the agenda;
- increased interest in the Challenge Fund for the second round that was expected at that stage.

By the end of the Co-ordinators' first year, there was a wide spectrum of monitoring activity. At one end was implementation of a 'key partner review', in which the Co-ordinator presented work achieved and received feedback from 12/13 key local partners. Several people submitted regular written progress reports to Regional Directors of Public Health. At the other end of the spectrum, much less formal monitoring activity was related to a perceived lack of interest from senior public health personnel. Along the spectrum were other ways in which people judged their progress: recording contacts made and networks built; using feedback forms at events and meetings;

and recording requests for information. Some of the quantitative measures of impact initially anticipated were proving impossible, however, as structural changes and resource constraints led to interruptions in, or lack of access to, some longitudinal data such as sickness absence figures from public sector settings. It was also apparent that it was likely to be harder than initially expected to show evidence of embedding the agenda in organisational structures and plans, particularly in the English regions.

2.3.2 Main achievements perceived

Looking back at the end of 2011, Co-ordinators were generally pleased with their achievements. They had always been busy and most had felt stretched in their capacity to meet levels of interest and demands. In drawing together what they said about their main achievements and how these reflected initial objectives it is important to remember they started work from very different local environments of interest and activity which affected their scope for potential achievements. There were also different policy and organisational environments in Wales and Scotland. Their initial hopes about what they would achieve were described in Section 2.1.3. At the end of 2011 they reflected on how they had met these aims thus far. Their main achievements centred around:

Creating a local profile

Creating and maintaining a profile for the health, work and well-being agenda and their own role, across sectors, was seen as important where Co-ordinators felt they had started from a low base of understanding or, by contrast, in an area like London where there was such diversity among communities. Throughout the project, Co-ordinators saw evidence of achievement – increasing numbers of enquiries, invitations for presentations at public sector and business events, requests for short pieces in public health reports and trade journals and requests to take part in local events.

Co-ordination of health, work and well-being activities

Most felt they had increased co-ordination and consistency in activities to do with health, work and well-being. Being able to bring co-ordination across a whole region or country depended very much on geography, structural organisation and what was already happening. Some Co-ordinators saw this part of their achievement at a more local level, for example, increased co-ordination within one county, conurbation or one SHA, with the potential for extending such work into wider areas.

Specific selected examples of increased co-ordination included having established leads for workplace health in more (sometimes all) PCTs, and closer contacts and joint understanding across local authorities, health boards and the third sector – although inclusion of the private sector was more of a challenge here.

Creation of new links, partnerships and networks

All Co-ordinators described having created new networks and partnerships through which there was increased capacity for shared learning and action. Structural changes in English regions had led to some such partnerships being now more fragmented, but Co-ordinators were generally encouraged that nuclei were being maintained and new members attracted. As an example, a London forum for health and well-being at work, with quarterly meetings, was established for local authorities and NHS organisations. In another region a network of 45 stakeholders across sectors was going well, with newsletters and an electronic 'community of practice' for sharing experiences and learning.

Working at strategic level

Working strategically had always been perceived as important. There was disappointment that structural changes meant that some of the value of strategic work begun in the English regions might have been lost. Closure of the Regional Development Agencies and Government Offices, the end of SHAs and loss of key personnel undermined some initial objectives in 'embedding the agenda'. However, by the end of 2011 Co-ordinators were working strategically within the new structural alignments appearing. Some already saw progress in getting the agenda embedded within the Health and Well-being Boards. Some had briefed Directors of Public Health to take the agenda into local authorities. As described above, several Co-ordinators reported having increased the number of PCTs offering support in the workplace. One factor influencing Trusts' interest here was understanding how some of their health targets could be reached by going into the workplace. For example, offering age-related health checks in a factory setting brought in many men in their targeted age groups.

With less disruption due to organisational change, strategic work in Wales had gone much as hoped. The Health, Work and Well-being Action Plan for Wales was launched in May 2011, and work on implementation started by the end of the year. Guidelines for health, work and well-being were built into local authority and health boards' strategies for social care and well-being. In Scotland, the Co-ordinator had continued to work within and alongside the Scottish Executive's strategy, Healthy Working Lives, to embed health, work and well-being in the public services agenda. Here, as in other places, there was a feeling that achievements might be quicker if there were stronger messages about the importance of health at work, with a basis in evidence.

One useful way of working strategically was to take part in other locally targeted programmes. An example from an English region was contributing to a programme to improve eating behaviour among commercial and public sector vehicle drivers – a joint initiative between public health teams, universities and trades unions.

Contributions to a charter, employer awards and 'tools' for business

Development of a Workplace Well-being Charter in England was an important achievement for several Co-ordinators in English regions. By the of 2011, collaboration among a group of Co-ordinators who made this a particular focus of activity was leading towards achievement of a national resource for all public, private and voluntary sector organisations. Some Co-ordinators were working towards achieving increased participation among particular targeted groups, such as bus companies and delivery firms, and construction companies.

In some regions, getting an employers' health at work award scheme up and running by the end of 2011, with increasing numbers of registrations of committed organisations, was perceived as a major achievement.

As explained in Section 2.2.7, Co-ordinators started from very different baselines in work already going on here, so what was achieved varied. Some were pleased with achievements in strengthening and promoting 'tools' for employers to self-assess where their organisation stood under sets of standards, and what their needs might be. Some had set up electronic systems for delivery of products and services to match needs, and seen increased levels of interest and commitment among organisations, monitored through website contacts and direct enquiries.

Responding to change

At a more general level, Co-ordinators felt some satisfaction in the way they had maintained focus and momentum despite the difficult financial climate, interruptions due to the 2010 election and

structural uncertainties and change. They were looking forward to developing further, during the last months of the project, some of the new opportunities starting to arise in the changed general context. Examples here included making new links with health and safety, and environmental health forums, and taking forward agendas with the Directors of Public Health, as posts were filled at local authority levels.

2.3.3 Factors enabling achievements

One aim of this evaluation was to describe the role of the Co-ordinators, and identify the similarities and differences in the way they worked. In practice, as there were a relatively small number of Co-ordinators, who undertook a range of similar activities, it was not possible to reliably identify distinctions between their approaches.

Co-ordinators in regions where there was already a well developed infrastructure for development of the health, work and well-being agenda said this had been an advantage. People whose work had been less interrupted by the uncertainties of structural change (Scotland, Wales and the one other person located outside public health) also recognised this advantage. Some people valued supervisors who were themselves keenly interested, and gave practical assistance with initial opportunities. One person said the nature of the role itself was an enabling factor – the separation from a designated service delivery role provided time and an identity to build new relationships and look for ways of engaging employers.

Co-ordinators did not themselves mention their own personal skills and energy, but this was reported by senior public health personnel and Challenge Fund winners.

2.3.4 Challenges

Co-ordinators working in English regions said that uncertainties related to structural changes in NHS organisation following the general election, and the implementation of new arrangements which followed had affected what they had achieved. Some action plans became less relevant and some regional partnerships of professionals and employers just *'disappeared overnight'*. Key personnel moved to new posts, with different agendas. Some previous partners, uncertain of their own futures, became reluctant to continue to commit themselves.

At the same time, the worsening economic climate meant fewer resources, across all sectors, for expenditures not seen as essential. Some small businesses were focusing only on staying afloat, and some public and third sector organisations restricted staff time and resources. Some organisations withdrew from award schemes; some ended training modules in which health, work and well-being components had been embedded.

For some Co-ordinators, regional geography and administrative infrastructure meant that it was particularly hard to work effectively in some local areas. Some Co-ordinators spoke of the continuing challenge of the length of time it took to move some organisations from awareness and understanding, to commitment for action, and then behavioural change.

When people had been disappointed by lack of interest from senior public health personnel, organisations such as chambers of commerce, or GPs, they felt there had been missed opportunities. People who would have welcomed a stronger central steer at the outset, about the overall goals of the project, felt this would have enabled them to get off the ground more quickly.

2.4 Working with small and medium sized enterprises

Co-ordinators recognised a range of direct and indirect ways of engaging with SMEs, each offering opportunities but also some disadvantages. They made early decisions about the balance they would set between working directly with individual businesses, working with umbrella organisations in touch with small businesses, and taking a more strategic approach, such as strengthening self-assessment tools which might be used by all organisations, including small businesses. On reflection at the end of 2011, several people felt they were not anywhere near meeting initial DWP aspirations for the numbers of small businesses they would meet directly. However, they did not perceive this as failure, as they had learned other ways of engaging with business which were more effective.

Most were satisfied with what they had achieved in their reach to organisations in touch with SMEs, including employers' federations, trades unions, trade associations, banks and some chambers of commerce. When such organisations understood and were fully committed to the health, work and well-being agenda, they had often proved useful advocates and became actively involved in information provision, and support and encouragement for businesses. Such umbrella organisations were sometimes undergoing their own structural changes and effects of the economic downturn, however, and this did affect their responsiveness to Co-ordinators.

While some sole traders could be reached through umbrella organisations, some Co-ordinators felt that detailed knowledge about market segmentation, and local groupings at the level of individual towns and villages, would be required to make more impact.

Strategic achievements in making impact on SMEs had included working with Fit for Work Service pilots and Citizens Advice to promote tools such as the health needs assessment and charter, and working with local public health teams to encourage links with Employment and Skills Boards and economic development programmes. Reaching small businesses through supply chains of larger organisations, including the public sector, had been recognised as an opportunity by some Co-ordinators who had worked strategically to embed awareness of the agenda within NHS and local authority commissioning arms. It was too soon yet for them to know how far this latter approach might be effective.

2.5 Activity around mental health

In the first round of interviews, several Co-ordinators were still thinking how best to address mental health issues in their work. Several had found 'patchy' levels of interest, or awareness of links between mental health and employment restricted within the 'worklessness' agenda, for example, helping people return to work after a period of treatment for mental illness. Some said mental health was not yet a priority area for regional strategic policy and resource planning. One person who had a specific aim at this stage to prioritise mental health issues had previously worked professionally in this field.

By the end of 2010, the Co-ordinators' general approach was to include mental health issues within all aspects of their work, but without identifying them for special attention. There were some specific examples of proactive interventions and initiatives by Co-ordinators, especially by Co-ordinators who had previous experience in the mental health field or where networks of mental health service providers and users were well developed. Some Co-ordinators had responded when approached by other organisations, to contribute to their own initiatives. Examples included developmental work on 'resilience courses' with a local university, working with a voluntary organisation to get impact of organisational change into their presentations and campaigns, and involvement in brokering and developing research projects led by other groups. Views expressed in the final series of interviews

were that such initiatives had been successful. In one region funding from the Health Inequalities Programme had enabled strategic work (linking a Challenge Fund project to other initiatives) and direct project work (with a third sector partner to support organisations facing redundancies). In another region, the Co-ordinator had gained EU funding for a research project, with a new post, looking at ways of supporting people with mental health issues in work.

However, some had found it very challenging to get employers even to engage with mental health issues. In the final interviews several Co-ordinators said mental health issues permeated their agendas at a general level, there was advice and support available for employers in dealing with stress at work, they themselves had worked to get mental health addressed within tools, within Fit for Work Service pilots, and within training modules for managers. They had not, however, made this a main focus of their own work, especially when people had little professional expertise in mental health. Views were expressed that there was not a shared and comfortable 'language' for talking about mental health issues. Some felt a better evidence base was needed to present a strong business case for addressing mental health in the workplace.

Some Co-ordinators mentioned spontaneously a feeling that they had never received a strong lead from DWP about focusing particularly on mental health issues, beyond a commitment in very general terms.[3] Others did not mention this issue, and the extent to which they shared this feeling cannot be assessed from the data.

2.6 Stakeholder views about Co-ordinators

Using mainly the survey of organisations in contact with a Co-ordinator as a source of data, we explored stakeholder experiences of their contact. We wanted to explore the extent to which the Co-ordinators were meeting the needs of organisations and what more they would have liked from the Co-ordinators.

2.6.1 Overall views of the usefulness of contact with a Co-ordinator

Respondents were asked to assess the usefulness of their contact with Co-ordinators on matters not associated with the Challenge Fund. Table 2.1 presents their responses by type of organisation.

[3] The Co-ordinator job descriptions include one specific mention of mental health, in relation to making links with Regional Employment Teams and Jobcentre Plus offices. Mental health is not referred to specifically in the aims and objectives of the Co-ordinator role.

Table 2.1 Views about usefulness of contact with Co-ordinator, by type of organisation

	Public sector organisations		Private sector		Third sector small/ medium organisations	All organisations in survey
	Large	Small/ medium	Large firms	SMEs		
	%	%	%	%	%	%
Very useful	50	54	40	42	51	50
Useful	35	38	44	45	44	38
Not very useful	13	8	8	6	5	9
Not at all useful	3	0	8	6	0	3
Total number of respondents	110	39	25	31	59	279

Source: Survey of organisations in contact with a Co-ordinator.

Assessments of usefulness were generally positive. Among all types of organisation combined scores for 'very useful' and 'useful' exceeded 80 per cent and in the case of small/medium organisations in the public and third sectors, 90 per cent. The least positive responses came from the larger organisations, in both the public and private sector – 16 per cent in each group considered contact with the Co-ordinator either 'not very useful' or 'not at all useful'.

The frequency of contact (including face-to-face, telephone and email contact) between organisations and Co-ordinators was explored in order to explore whether this had any bearing on the organisations' experiences. Findings showed that there was a significant correlation between positive experiences and the level of contact.

2.6.2 Meeting the needs of firms and organisations

Table 2.2 presents another view of the input from Co-ordinators. Respondents to the survey of organisations in contact with a Co-ordinator were asked to assess the level of support against their needs.

Table 2.2 Views about the adequacy of Co-ordinator support, by type of organisation

	Public sector organisations		Private sector		Third sector small/ medium organisations	All organisations in survey
	Large	Small/ medium	Large firms	SMEs		
	%	%	%	%	%	%
Exactly right for our needs	55	56	52	48	81	60
Adequate	25	31	28	42	12	25
Not sufficient for our needs	5	5	12	3	3	6
Don't know/ not applicable	14	8	8	6	3	9
Total number of respondents	110	39	25	31	59	279

Source: Survey of organisations in contact with a Co-ordinator.

Noticeable in this table is the high percentage of third sector organisations who said that support from the Co-ordinator was exactly right for their needs (81 per cent). The other organisation types varied between 48 and 56 per cent. The percentage of organisations where support was thought to be not sufficient was relatively low (at six per cent across all organisations) but slightly higher for larger private sector firms, 12 per cent.

When asked whether they would have liked more or less support from their Co-ordinator a large majority of respondents (88 per cent) were content. Only nine per cent said they would have liked more support, and three per cent would have been happy with less. Eleven per cent of respondents said they would like more face-to-face contact.

In order to explore what more the Co-ordinators could have done to help, the 86 respondents who found the support they received was either adequate or not sufficient were asked what more they wanted. A third said they would like to work more closely with Co-ordinators and nearly a quarter would have liked more information about health and well-being. One in ten responded that they would have liked clarification about the role of the Co-ordinator.

The overall picture from the survey is that Co-ordinators were reaching high levels of satisfaction among the firms and organisations they had contact with. Interestingly, given the emphasis placed on developing their strategic role, the correlation between satisfaction and levels of contact and the desire among some organisations for more face-to-face contact suggest that there are competing demands between the strategic and the direct approaches to achieving cultural and behavioural change.

2.7 Sustainability

As soon as they started work Co-ordinators were thinking about ways of effecting long-term change which would be sustained beyond the end of the funded project. Their aspirations were broadly of two kinds: First, they hoped that workplace health and well-being would be embedded or 'mainstreamed' within both long-term strategies and shorter-term operating plans of all public

sector organisations within their region. Public sector employers, in particular the NHS, might then be exemplars of good practice. Among private sector employers, they hoped that a good proportion would have health, work and well-being policies as a standard part of their practice. They hoped employers would have begun to take a more proactive (rather than reactive) approach to workplace health, seeing this as contributing to their competitive advantage, and 'everyday business'. Secondly, Co-ordinators said that to support employers in sustaining commitment to workplace health there would need to be continuing good access to a range of support, services and products for employers across sectors. They were thinking of support such as training modules for line managers and human resources personnel, and employer accreditation programmes.

By the end of 2010, experience of structural change and being closer to the end of project funding had sharpened the Co-ordinators' thinking about the sustainability of what they were achieving. At this stage, in the English regions, there was some uncertainty about how the health, work and well-being agenda would continue to be embedded at strategic levels. It was important that what had been achieved strategically was maintained within the new Health and Well-being Boards. At the same time, some people saw new opportunities in the relocation of public health to the local authority level, for example, proximity to regulatory authorities such as trading standards, environmental health, and licensing officers. Although some partnerships and networks were now fragmenting, networks created with specific membership for the business community and local authorities appeared to have a good chance of being sustained through the ongoing structural changes.

There were also views that sustainability was most likely when employers and employees wanted changes and made these themselves. This kind of business ownership might develop slowly, however, in the current economic climate, and might depend on long-term changes in people's general expectations and aspirations for their lives.

By the end of 2011 all Co-ordinators were looking hard at the sustainability of what had been achieved thus far. They identified the following range of structures and mechanisms which would take forward health, work and well-being, and were expecting to prioritise these in the last few months in post:

- continued embedding and promotion of the health, work and well-being agenda in the new public health environment at local authority level in the English regions, involving Directors of Public Health, Health and Well-being Boards, health and safety, and environmental health departments;
- continued development of the agenda within the particular Welsh and Scottish structural contexts;
- continued support for and development of the Health, Work and Well-being Charter, and local Health at Work Awards for employers and organisations;
- continued improvement and availability of established training modules and tools for employers across all sectors;
- continuation and development of established regional networks and partnerships, perhaps with new features for sustainability such as revolving the location of the chair;
- emphasis on working with partners, colleagues and other organisations in ways that embedded their ownership of the agenda, rather than 'handing over';
- co-ordination of regional university activity, to increase coherence in relevant research and mobilise resources for knowledge transfer;
- continuation of a funded dedicated regional presence similar to the Co-ordinator role, to maintain momentum of achievements through structural reorganisation.

2.8 Conclusion

The Co-ordinators largely met the two strategic aims of developing and encouraging partnerships between employment and health networks and co-ordinating strategies and activities within and across regions and countries.[4] Public sector engagement was wide-ranging, including working with the Scottish Centre for Healthy Working Lives, Healthy Working Wales, PCTs, SHAs, Local Enterprise Partnerships and emerging Health and Well-being Boards. Co-ordinators' achievements also included promoting health and well-being activity across a range of organisations and partnerships. Workplace health accreditation schemes, self-assessment tools and well-being charters helped promote activity in SMEs.

The series of interviews with Co-ordinators also provides some lessons for future policy making. A cross-government approach is essential in linking health, employment and welfare reform. There were some advantages in the initial location of the new Co-ordinator role mainly within public health administration, but there would also appear to be potential new opportunities for sustaining and developing a focus on health, work and well-being within the changed structural context in the English regions.

Greater initial clarity from DWP about objectives would have saved some Co-ordinators time in getting going. In particular, a stronger central steer about objectives around mental health might have led to more activity in this area.

Co-ordinators maintained their strong commitment to working strategically throughout the project, and believed that sustainability of what they achieved was strongly related to achievements in 'embedding' understanding of and commitment to the agenda at senior levels of public administration and workplace management. In engaging with business, and in particular SMEs, they felt a need for a better evidence base about returns on investment in health and well-being in the workplace, in order for employers to understand that this was part of economic competitiveness.

Co-ordinators placed different emphases on the various aspects of their role depending on the socio-economic characteristics of their area, their own backgrounds and experiences, and the extent to which health and well-being activity was already going on. It was not possible, therefore, to identify any distinctive 'model' or approach adopted by any particular Co-ordinators that might serve as a blueprint for the role in the future.

The role of Co-ordinator, created for this pilot project, was very challenging and demanded a range of professional and personal skills. Availability of administrative support was variable, but was a key factor in what could be achieved. The high level of concerns about mental health in firms and the continuing policy focus on mental health in the workplace suggest that mental health must be a strong focus for any successor of the Co-ordinator role.

Feedback from organisations in contact with Co-ordinators was predominantly positive. The high percentage reporting that the level of contact was right for their needs indicates that Co-ordinators were acting flexibly and responsively. The correlation between number of contacts and satisfaction emphasises the importance of Co-ordinators maintaining personal contact with organisations.

Overall, much was achieved by the Co-ordinators, in the challenging context of structural change and economic downturn.

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[4] The final series of research interviews was conducted in the autumn of 2011 when most Co-ordinators expected to be in post for up to six more months. Any assessment of their achievements must, therefore, recognise that they still had this time in which to pursue their overall objectives.

3 The Health, Work and Well-being Challenge Fund

The Challenge Fund was a grant scheme designed to improve workplace health and well-being by funding initiatives in small and medium sized enterprises (SMEs) or delivered by local partnerships. One round of funding took place in 2009–10 and 73 organisations were awarded sums of money.

3.1 Administration of the Challenge Fund

The Department for Work and Pensions (DWP) received over 750 expressions of interest for the Challenge Fund and over 250 full applications, the monetary value of which exceeded the funds available. In each region or country a Local Assessment Panel had responsibility for determining successful bids. Co-ordinators and senior public health personnel agreed that the administration of the Fund was difficult in a number of respects, including: the tightness of timescales, the amount of time consumed, and a perceived lack of clarity regarding the criteria on which bids would be judged. Particular concerns were raised about the possibility that organisations may have been deterred from making an application because of the time demand and complexity of the paperwork. The tight timescales, it was suggested, meant that there had been limited opportunity to support organisations to improve their bids in advance of submission. From interviews with a number of Fund winning organisations it emerged that the short application period had closed down opportunities to consult with Co-ordinators, or potential participants and providers of initiatives. Other problems encountered by those managing funded projects were centred on perceived clashes between organisations' aspirations to improve well-being and DWP rules about the use of Fund monies, the timescale for expenditure, and the availability of just one year's funding rather than the two that had been bid for.

3.2 Generating health and well-being activity

3.2.1 How activity was generated by the Challenge Fund

The first wave of case study research found that the offer of the Challenge Fund acted to generate health and well-being activity in a number of ways, which we then explored in the Challenge Fund Winners Survey. Thus, the money had a role as an:

- **enabler**: enabling organisations to implement pre-existing plans by removing financial barriers;
- **accelerator**: helping organisations implement plans more quickly;
- **enhancer**: providing an opportunity to add to existing health and well-being activity;
- **initiator**: kick-starting new thinking about health and well-being and new initiatives in organisations which had not considered implementing interventions previously.

These roles were not necessarily mutually exclusive. The qualitative and survey findings demonstrate that the offer of the Fund could act in different ways, though one role could be more prominent than another.

The Challenge Fund Winners Survey indicates that the Fund initiated thinking and activity in roughly six in ten organisations. This finding suggests that the Fund had attracted organisations which had

not previously thought of or invested in workplace well-being, as well as those already committed to the agenda. The case study research revealed that the offer of the Fund had not just inspired new ideas to enhance staff well-being and possibly business, but appealed to organisations because it also provided the (financial) means to make ideas achievable or realistic. Organisations which perceived the Fund as initiating activity did not necessarily lack prior interest in health and well-being. Rather their interest was not fully developed or organised. This was evident in the finding that the projects of single organisations which identified with the initiator role were not designed to resolve particular workplace-related health problems and did not have well-defined desirable outcomes.

3.2.2 The funded initiatives

Table 3.1 shows the types of activity funded by the Challenge Fund, according to respondents of the Challenge Fund Winners Survey. It is apparent that single organisations tended to introduce activities aimed at the individual employee more so than partnerships, which concentrated their efforts more on corporate activities (such as health promotion and education, and staff support). This difference in focus was to be expected and reflects a more strategic or capacity-building role for partnerships, as opposed to that of single organisations that were more likely to concentrate on identified areas of need. Survey findings also show that, overall, activities promoting physical exercise were the most common, with mental health initiatives also popular.

Table 3.1 Type (and percentages) of initiatives funded by the Challenge Fund

Type of activity	Single businesses/ organisations		Partnerships		All	
	Number	%	Number	%	Number	%
Physical exercise programmes	38	24	10	13	48	21
Specific mental health initiatives	27	17	14	18	41	18
Provision of various therapies*	27	17	8	11	35	15
Health promotion/ awareness/education/ information activities	15	10	20	26	35	15
Eating/diet initiatives	15	10	4	5	19	8
Miscellaneous actions to support staff**	29	19	18	24	47	20
Other	5	3	2	2	7	3
Total	156		76		232	

* Examples were acupuncture, osteopathy, massage, reflexology, reiki.

** Examples were team-building exercises and training for ‘well-being champions’.

3.2.3 Comparing project design with policy objectives

In this sub-section we compare policy objectives and expectations concerning the Challenge Fund with the aims and design of funded projects. Such a comparison gives an indication of the extent to which those who were awarded sums of money understood policy aims. The overarching policy objectives for the Fund were outlined in the Government's response to the Black Review (DWP and DH, 2008) and are discussed below using case studies and Challenge Fund Winners Survey data. The aims were:

To encourage local initiatives to improve workplace health and well-being, through innovative approaches which ensure worker engagement

Findings from the case studies suggest that making a difference to health and well-being was not always the prime focus of projects. Thus there were projects centred on improving staff relationships or leadership and business development, which seemed to have only an indirect impact on the relief of stress or the happiness of staff.

To implement practical initiatives for mental health and well-being

Findings from the survey and case studies suggest that, largely, problems regarding mental health were equated with work-related stress, with over 90 per cent of organisations identifying stress as a problem. Although the survey shows that almost one-fifth of initiatives were focused on mental health (see Table 3.1), the case studies findings suggest that relieving stress or feeling happier were expected to be by-products of many other types of interventions, such as those focused on exercise and improved nutrition. Moreover, virtually all (58 of 59) survey respondents said that improving mental well-being was a project aspiration.

To focus on initiatives in smaller businesses

The Fund was awarded only to businesses classed as small or medium sized or to local partnerships expected to work with 'businesses in their locality' (which could be any size and sector). Although all partnerships involved in the case studies had aims to serve local small and medium sized enterprises (SMEs), some of those who took part in the case studies were less strict when observing this aim in practice. Thus, one project recruited workers from public sector organisations and another offered services in the community where it was hoped, rather than certain, that SME workers would benefit.

The Fund bidding process outlined a number of additional expectations to shape funded projects. These expectations were that projects would:

Be new rather than a continuation of existing projects

We have established above that the Fund initiated new thinking and action in roughly six in ten organisations. It was also clear from the case study analysis that even where organisations were adding to existing activity, most were undertaking new interventions to complement rather than extend existing activities. However, there was evidence that some partnerships were not starting new activities, but rather re-packaging them to form a discrete project. Thus, one partnership delivered to businesses interventions usually offered to the wider community, and another offered its usual service but limited to a specific target group and over a set period of time.

Offer solutions to identified problems

The case study research found that health and well-being were not necessarily key concerns within workplaces prior to learning about the Challenge Fund and nearly a third of respondents to the survey did not identify specific needs for health and well-being support. Whilst these findings could

suggest a role for the Fund in kick-starting awareness of health and well-being, they could also call into question whether all Fund winners had an 'identified problem', as was expected.

Involve staff consultation

The survey suggests that little consultation involving employees was completed, with 50 per cent of organisations undertaking low level or no consultation either before or after getting an award. According to the case studies data, low level or a lack of consultation resulted from having limited time available. There was some evidence to suggest the imposition of activities through a 'top down' approach from management. For example, the survey showed that eating initiatives, and to a lesser degree physical exercise programmes, did not arise from high levels of staff consultation.

Encourage sustainability of workplace health and well-being initiatives

Analysis of the case studies data highlighted variation in the extent to which organisations had considered and planned for sustainability. Mostly, plans for the continuation of initiatives and their impact were based on the expectation that activities would be of no or low cost in the future, or that the expense would be met by participants or employers (in the case of partnership projects). The extent to which organisations have since shown a sustained commitment to health and well-being is explored further in Section 3.5.

3.2.4 Experiences of project implementation and engagement

Overall about half of the Challenge Fund Winners Surveyed had experienced problems regarding implementation and engagement, with a higher proportion of partnerships than single organisations reporting difficulties. There was no dominant type of problem.

Regarding project **implementation**, a number of factors emerged from the case study research as helpful or unhelpful:

Project design

Projects with multiple elements or which required a lot of organisation and energy from those leading projects were said to create stress and take up more time than expected. Some interventions were found to have hidden costs and take longer to implement than envisaged, such as installing gym apparatus which needed to meet health and safety requirements. One view that advice should have been available from DWP at the outset about the feasibility of projects emerged from a firm which had attempted to deliver many and diverse activities within the 12-month implementation period.

Project flexibility

Some people responsible for managing projects welcomed what they perceived as flexibility to decide what was delivered, the implementation timescale and how they paid for it. However, in contrast, some perceived a lack of flexibility in the rules for spending the Fund, such as the restriction not to spend on large capital costs and their understanding that funds needed to be spent within a certain time period. Not being able to spend the money as they wished, for example, on renovating a canteen, had resulted in some organisations spending money more quickly than they would have chosen and in ways they did not feel were entirely beneficial.

Service providers

A willingness to work flexibly was perceived by some project managers as an advantage of involving small, local providers in funded projects. However, some organisations encountered problems engaging suitable providers (for example, a provider willing to supply healthy lunches to a workplace in a remote location), or found that their provider was unreliable about delivering services at the agreed time.

The case studies also provided insights into the enablers and barriers affecting **participation and engagement**:

Convenient timing and location of activities

There were many examples of how location and timing encouraged participation, with activities needing to be at the workplace during work hours, or near to home and fitted around family commitments outside of work. A lack of time for activities was an often repeated reason for non-participation, particularly amongst employees of micro or small firms, or staff in management positions. Reluctance to participate was particularly strong when employees might lose pay as a result of taking part (for example, in firms where staff were paid piece rates for work completed – see Box 3.4).

Personal motivation

Being personally motivated to take part was evident in people who perceived that activities would meet a recognised health problem or interest, or who liked to take up opportunities presented to them. Most project leaders identified a core of staff who seemed unmotivated and who preferred to do their job and resist extra-curricular activities.

Attitude of others

Initially reluctant people could be encouraged where they saw peers taking part, heard positive feedback, or where colleagues acted as 'motivators'. People could also be motivated by the attitudes of managers who visibly supported projects, or by trades unions and GPs when consulted in advance.

Format or content of activities

It was apparent from the case studies that perceptions of the format or content of activities could act as barriers to participation, such as where activities were unfamiliar (for example Tai Chi), where activities made people feel uncomfortable (such as exercise classes or massage), or where activities were time-intensive (such as a multi-session stress management course). Providing information in advance, particularly demonstrating the effectiveness of interventions, was thought to enhance employee buy-in. Compulsion to participate in activities was rarely used in the projects studied, though it could boost attendance.

Cost to participants

A financial cost to participants could put people off trying activities, though in general the fact that most activities were free or low cost was a reason for taking part.

Additional enablers and barriers were apparent from partnerships' accounts of attempting to engage local employers and employees. Engaging employers required active promotion and the use of arguments setting out the benefits to business. Employers' responses were mixed, with some showing initial interest (which was not always followed through) and some declining on the basis

that there was no time for such activities or that their staff would not be interested. A pervading view from partnerships was that getting the message through to SMEs about the importance of worker health and well-being was hard where firms were driven by tight deadlines and preoccupied by day-to-day matters, not monitoring sickness absence, or interested only in whether there would be a financial gain in the short term. However, employers were engaged where partnerships were able to capitalise on prior positive contact, where employers were happy to accommodate short taster sessions as part of staff training, or where they wanted to offer their employees something. In some cases employers were said to have deliberately acted as gatekeepers, choosing not to cascade information about initiatives to their employees, though failings in communication from well-intentioned employers was also mentioned. Thus, partnerships stressed that it had been important to gain direct access to employees where possible, via word of mouth through peers or staff newsletters, for example.

3.3 The perceived impact of Challenge Fund initiatives

3.3.1 Measuring impact

Eight out of ten Fund winning organisations surveyed reported that they were monitoring, in some way, the impact of the Challenge Fund, though all organisations had been required to do so in return for funding. A number of concerns and problems were perceived by project leaders regarding self-evaluation, such as identifying suitable variables to measure, isolating the impact of funded interventions from other factors (such as the introduction of a new sickness absence policy, or reduced job security), and not having baseline information to measure results against. It also transpired from the cases studied in depth that evaluation plans were not always followed through. Thus, there were examples of formal participant surveys being cancelled or substituted with ad hoc conversations, and of delays to, or reduced participation in, repeat health assessments. Reasons for changes in plans included having limited time available for the production and analysis of evaluation tools, finding it hard to engage participants in repeat assessments, and reorganisation within firms (sometimes involving redundancy) which delayed evaluation or made data collection seem inappropriate. There were also signs from the case studies data that evaluation lacked robustness and findings would therefore have limited value. Examples included data not being collected systematically from all participants, and comparisons being made between two sets of health checks results that did not relate to an identical group of staff.

3.3.2 Impacts reported

Respondents to the Challenge Fund Winners Survey were asked to identify their aspirations for their use of Challenge Fund money. Eleven options were offered according to the kinds of effects that were expected by interviewees in the case studies. We have listed these aspirations in Table 3.2 and categorised them as those affecting individual employees, those with an internal organisational focus, those with an external facing focus, and those with a cross-organisation focus (i.e. affecting all tiers of staff). Survey respondents were also asked to assess, at the time of interview, the impact of the Fund in comparison with their initial aspirations. This meant that impressions of the Fund's influence were sought only for those aspirations identified by the respondent.

Table 3.2 Perceived impact of the Challenge Fund compared with initial aspirations

Row percentages

	Citing aspiration		Positive impact		No or negative impact		Too early to say	
	Number	%	Number	%	Number	%	Number	%
a) Employee focus								
Improvements in physical health	48	81	27	56	5	10	16	33
Improvements in mental well-being	58	98	41	71	2	3	15	26
Change in lifestyles	46	78	25	54	5	11	16	35
b) Organisational focus – internal								
Reduction in sickness absence	50	85	22	44	8	16	20	40
Improvements in staff retention	42	71	15	36	6	14	21	50
Improved productivity	43	73	24	56	5	12	14	33
c) Organisational focus – external								
Improved external reputation	31	53	19	61	0	0	12	39
Increase in custom/ business	12	20	1	8	3	25	8	67
d) Cross-organisation focus								
Better staff-management relations	43	73	33	77	4	9	6	14
Increase in knowledge about work and health	55	93	48	87	1	2	6	11
Better workplace culture towards health and well-being	58	98	50	86	2	3	6	10

Impacts with an employee focus

For aspirations with an employee focus the greatest impact reported was on the mental well-being of employees, with 71 per cent of survey respondents who hoped for an effect perceiving a positive difference. The case studies analysis suggested that improvements to mental well-being were experienced by employees as feeling less stressed, more energised and confident. Over half of survey respondents with aspirations to improve physical health or to change lifestyles thought that there had been a positive influence. Examples of changes to physical health or lifestyles as reported by employees in the case studies were weight loss, lowered blood pressure or cholesterol levels, improved muscle tone or posture, altered eating and drinking habits, and reduction in smoking. Multiple benefits were perceived from some Challenge Fund initiatives such as changes to diet resulting from nutritional advice being associated with improved immunity and a boost to psychological well-being.

Impacts with an internal organisational focus

Fewer than half of survey respondents who aspired to reduce sickness absence reported a positive difference, though 40 per cent thought it was too early to draw conclusions. The case study research showed that not all organisations were geared up to measure changes to absence and even where records were kept it was difficult to attribute improvements to Challenge Fund projects. More than half of survey respondents who hoped to increase productivity thought that there had been improvement. Employees taking part in the case studies related improved productivity to feeling refreshed and alert after taking breaks or eating healthily, and feeling energised after exercise.

Impacts with an external organisational focus

Fifty-three per cent of survey respondents had hoped for boosts to their organisation's reputation as a result of taking up the Challenge Fund, and all believed that improvements had either been made or might follow in the future. In contrast, only 20 per cent identified an increase in custom or business as a project aspiration. In large part effects on custom were thought to be more evident in the longer term, with two-thirds of those who had hoped for an impact saying it was too early to comment. There were, however, examples in the case studies of project leaders linking their involvement with the Challenge Fund with an effect on their organisation's reputation (such as where they had attracted excellent new staff), or on their capacity to develop new networks or gain new business (such as partnerships or companies winning new government contracts), which they had not necessarily foreseen.

Impacts with a cross-organisation focus

The most immediate positive impacts reported in the survey appeared to be those linked to aspirations with a 'cross-organisation focus'. The high proportions of positive effects on workplace culture and increased knowledge are particularly notable given that almost all organisations hoped to make a difference in these respects. Case study findings suggest that raised awareness of health issues and changes to culture were evident in employees taking lunch breaks or reducing hours spent at work, as well as employers making decisions to incorporate health and well-being issues into company policies or to continue workplace activities. Partnerships seemed less certain about their effect on workplace culture, unless groups of staff attended activities together or managers were the target of interventions. Partly this uncertainty seemed a consequence of failing to engage employers with projects and thus, delivering to interested individuals rather than to whole workforces. Also partnerships' evaluation methods tended to centre on changes to individuals (such as feedback sessions, repeated health checks) rather than changes in workplace culture, sometimes due to the perception that cultural change would take longer to become evident and could not be captured in a year-long project. Regarding workplace relationships, a view from those managing funded projects was that investing in health and well-being had led to staff feeling more valued by their employer and thus more engaged in their work.

3.4 The perceived difference made by the Challenge Fund

In this section we examine the perceived difference made by the Challenge Fund by assessing views on whether the impacts reported would have occurred without the Fund. This kind of analysis aids understanding about the 'added value' of the Fund.

3.4.1 The perceived difference made to organisations

We asked case study and Challenge Fund survey participants whether the Fund had been a necessary condition for implementing health and well-being initiatives. In other words, would organisations have implemented their projects without the Fund?

Eighty-six per cent of survey respondents thought that the Fund had been necessary for implementing their activities. Some people who were managing projects and who took part in the case studies said they had needed both the idea about putting measures in place to support health and well-being (because they had not considered it before) and the money available. In contrast, some said they had needed just the funds to implement existing ideas.

Fourteen per cent of organisations taking part in the Challenge Fund Winners Survey believed that they did not need the Challenge Fund to implement health and well-being initiatives. Some people managing funded projects said it had been inevitable that they would have chosen to put measures in place, either because their organisation had already been interested in workplace welfare, or because they had recognised the need to respond to external influences, such as pressure from government or competition between firms. However, they considered that their own projects would have had lower impact because they would have attempted fewer interventions, may have been less adventurous about the choice of interventions, or would have spent less of their own money on such projects. Therefore, one way in which the Challenge Fund made a difference was by encouraging organisations to design more ambitious projects. Another example of added value from the perspective of partnerships is given in Box 3.1.

Box 3.1 Case example of added value for partnerships:

One partnership, which acts as an umbrella organisation to promote local businesses, had used the Challenge Fund to expand the services offered to local businesses to encompass health and well-being interventions. They provided a range of activities to boost employee fitness, physical health, mental well-being and diet. The funded project was perceived as a new model of working, to inform the development of, and investment in, future service provision.

> *'... we put our toes in the water with the project, we're deadly serious about trying to move it forward ... and I think we will embed it in* [future work] *and ... in five years' time everybody will head towards us for a certain range of sort of health related products.'*

In thinking about the difference made by their Challenge Fund award some case study interviewees talked about the importance of using public money. Receiving investment from the government was thought to have raised the profile of workplace well-being among management. Remaining accountable to the government as the investor was not only considered useful for encouraging management ownership but also for maintaining project momentum. One view was that projects were more likely to win the support of employees if they originated and were funded externally, rather than if they were perceived to be imposed by management. Another view was that positive impacts on business resulted from being able to show that the organisation had been awarded government funding.

3.4.2 The perceived difference made to employees

Although the overarching aim of the Challenge Fund was to raise employers' awareness of their employees' health and well-being, the case studies data also contains examples of the difference made to employees by the introduction of workplace initiatives. Thus, some people said they had begun new diets or exercise regimes or learned new techniques for managing stress which they would otherwise not have taken up or learned. However, there were also examples of people taking part in activities they would have chosen to do anyway, which in some cases led to an intensification of activity such as eating more fruit or doing exercise for longer or more often. In all cases studied in the case study research there was a feeling that projects failed to reach some people who most needed encouragement and assistance to be healthy. Largely this was because these people had chosen not to take part, though some partnerships felt it had been hard to reach some workers such as those working shifts or who travelled a lot.

3.4.3 'Ripple effects'

Discussions with case study interviewees about the difference made by the Challenge Fund also included examples of 'ripple effects', or impacts which were thought to have resulted indirectly from implementing a health and well-being project. Some people stressed that these impacts would not have come about without first implementing their Challenge Fund project. These ripple effects were described at both the organisational and individual levels and indicated that the Fund had a role in developing enthusiasm and a mindfulness towards health and well-being beyond the funded activities. Thus organisations had:

- paid for extra interventions or tapped into free provision following raised awareness of the issues and availability of support, such as offering staff mental health awareness training or access to a Cycle to Work scheme;
- become involved in local workplace schemes which sustained firms' interest (see Section 3.5 and Box 3.2);
- developed policies or strategies to formalise the employer's commitment to workplace health and well-being, or were considering spending company money on activities;
- in the case of a partnership organisation, run additional initiatives designed to spread good practice in SMEs, such as training for 'health champions' (i.e. staff with responsibility for championing health and well-being issues in the workplace);
- in the case of some SMEs whose staff had taken part in partnerships' projects, started their own workplace activities (including establishing a health champion and providing fruit), or expressed a desire to fund interventions in the future.

Box 3.2 Case example of ripple effects

Since running a Challenge Fund project and being alerted to a local workplace health accreditation scheme, one medium-sized private firm was making a more concerted effort to focus on the health and well-being of its staff.

> *'We've got a health and well-being strategy, an action plan, policies, healthy eating policy ... mental well-being policy ... I wouldn't have thought of health and well-being as an area sort of in HR that could have a real impact, but ... we're really taking it seriously now.'*

There was also evidence of spin off or ripple effects in individuals, where they felt inspired to commit to health and well-being activities of their own, sometimes in addition to those in the workplace. Thus, there were examples of people starting workplace exercise clubs, taking up cycling, or being proactive about protecting health through lifestyle changes or by consulting a health practitioner.

Furthermore, the survey of organisations in contact with a Co-ordinator produced interesting findings about a possible 'halo effect' on organisations who were aware of the Challenge Fund, some of whom had submitted expressions of interest or full applications but did not win an award. Organisations which had known about the Fund were more likely to have started new health and well-being initiatives and formed new networks and partnerships, compared with those which had not heard of the Fund.

3.5 Sustainability

This section explores the sustainability of workplace health and well-being activities and the sustainability of any effects made on individuals or workplaces. In case study interviews, sustainability of activities and their impact were often discussed together. For example, when some people talked about continuing particular interventions post-funding they also made assumptions about the impact of taking part being sustained. Therefore, rather than attempt to disentangle interventions from effects, we consider the sustainability of both together, by exploring the facilitators and barriers to sustainability. Analysis of the case study data identified four inter-related categories of factors affecting sustainability: project-related, organisation-related, employee-related, and external factors. Another factor – funding arrangements – cut across these four categories and will be discussed separately.

Before exploring which activities were set to continue and why, it is worth noting that at the time of the Challenge Fund Winners Survey (spring 2011), 63 per cent of initiatives were expected to continue and ten per cent were undecided. In particular there were high continuation rates for mental health initiatives (80 per cent) and health promotion activities (74 per cent) with lower rates for eating initiatives (47 per cent) and various therapies such as acupuncture or osteopathy (37 per cent).

3.5.1 Project-related factors

The case studies findings show that indications of success, such as having the desired effect, appearing to be beneficial or being popular with participants, were reasons for continuing with activities. Thus, there were examples of activities continuing because they had made an impact, were enjoyable and had boosted worker morale, including team building activities, therapies such as osteopathy or back massage, and nutritional advice. Perceiving an intervention as an essential and effective response to staff needs was also a reason for continuation, such as supervision for staff in high pressure jobs. Activities which had led to the attainment of skills or knowledge (such as time management techniques or information about health issues) were expected by some participants to have an enduring impact, though it later became apparent that skill and knowledge retention depended on refresher sessions or consolidation at a later stage.

3.5.2 Organisation-related factors

Management commitment to workplace health and well-being emerged from the case studies as an important facilitator in sustaining activities and impacts. As shown in Section 3.4.3, some businesses had written new policies or strategies using their Challenge Fund experiences as foundations, to encompass their commitment to health and welfare in the years to come. Even where firms had not formalised their intentions in writing, some project leaders spoke of a new focus on health and well-being which would inform decisions in the future. The enthusiasm of certain staff was also thought to be key, such as where the continuation of activities, and sometimes the company's commitment, was thought to depend on the efforts of those who had led projects. Partnerships' continued enthusiasm for workplace well-being was evident in plans to implement new services and efforts to win new contracts to deliver health and well-being initiatives.

Enduring impacts were linked to activities that had necessitated a permanent change to the work environment (such as cycle racks or new places to spend break times) or which had become embedded in workplace practices (for example, forums for staff dialogue, inclusion of stress awareness in training schedules, yearly health checks). There was some concern that individual motivation might lapse if activities did not become established or routine within the workplace. However, there was evidence that some changes to lifestyle (such as healthy eating or exercise

regimes) were sustainable without support from a workplace initiative, particularly where changes could be accommodated in daily routines and where repeated information and encouragement throughout projects had created a habit.

At the time of the second round of case study interviews, some organisations were in the process of restructuring, or had experienced a rapid expansion in custom and staffing. Restructuring leading to staff redundancy or the prospect of new ownership left uncertainty about further health and well-being activity. Trying to maintain a focus on health and well-being against a backdrop of change and growing workloads was difficult for a company which had expanded to a second site with a new workforce. In contrast, increases in business and profit led one company to feel able to invest more in staff health and well-being.

3.5.3 Employee-related factors

As shown above, some employers were taking responsibility for ensuring a sustained focus on health and well-being in the workplace. However, there were also views amongst managers and staff that employees should be responsible for their future well-being to a large extent. Case study findings suggest that individuals' levels of motivation for, and interest in, health and well-being were key to sustained activity and impact. Thus, personal commitment explained some people's maintenance of newly-established exercise or diet regimes. On the other hand, sustained engagement in activities was not assured where people were unwilling or unable to prioritise them in routines because of a lack of time or perceived inconvenience.

3.5.4 External factors

Some partnerships which took part in the case studies argued that continued government promotion of workplace health and well-being was essential for persuading employers to pursue the agenda. It was also noted that market forces might urge organisations to take greater responsibility for worker welfare, in order to remain competitive in business and to retain or compete for highly skilled employees. A number of Fund winning firms were involved with local workplace health and well-being initiatives, either prior to or as a result of their contact with the Co-ordinator and Challenge Fund. These schemes were considered by firms to be a good model for maintaining momentum and interest because they provided a structure for embedding activity over a number of years, facilitated access to a variety of free-to-use resources, encouraged the development of long-term strategies, and awarded formal accreditation to be reviewed regularly and which firms perceived as attracting business. Networking with local stakeholders had also supplied organisations with a steady stream of information and ideas to keep health and well-being on the agenda. Partnerships too had plans to link up with other organisations to strengthen the possibilities for winning further funding and delivering services in the future.

3.5.5 Cross-cutting factor: funding

The question of whether activities needed funding and how this need would be met was important for determining the sustainability of activities. Thus, the Challenge Fund Winners Survey found that a lack of funding was cited in over 50 per cent of the instances where an initiative would not continue and in 70 per cent of cases where a decision had not yet been made. Funding emerged from the analysis of the case studies and Challenge Fund Winners Survey as a cross-cutting factor relating to the content of projects, to organisations' and employees' decision making, and to external opportunities for financial support.

In general the case studies findings showed that there was a willingness amongst organisations to continue activities that were either of no financial cost or of low cost, such as accessing free

information about health issues. Organisations appeared to make exceptions by funding more costly initiatives if they had been particularly beneficial, such as health checks or nutritional advice. The Challenge Fund Winners Survey indicated that some form of funding was generally needed, though there was variation depending on the type of activity. For example, nearly all eating and physical exercise activities set to carry on required funding, whilst 27 per cent of mental health and 45 per cent of staff support initiatives did not.

Thirty-seven per cent of activities set to continue would be supported by internal funding although this figure may be an under-estimate given that a quarter of continuing initiatives had not been allocated funding at the time of the survey. The possibility of using internal funds was perceived as dependent on organisations' financial status, on building a business case, and on management recognising the benefits of investing in health and well-being.

According to the survey, employees were expected to contribute personally to few workplace activities, though they would be asked to pay towards the cost of a quarter of continuing physical exercise initiatives. In addition, an implied assumption was that where firms did not sustain workplace activities, individuals would bear the cost themselves in order to continue them. There was evidence from the case studies that the introduction of nominal participant fees at the end of the funded period was not always off-putting, though the cost of more expensive activities, such as gym membership, was considered unaffordable by some employees.

External funding had been secured for very few initiatives (12 out of the 145 continuing) at the time of the survey and we do not know the funding source in these cases. Some people interviewed for the case studies hoped to utilise evidence of initiatives' effectiveness to mount a case for external funding, though the short project length was considered a hindrance to demonstrating impact and winning funding.

3.6 The role of the Co-ordinator in the Challenge Fund

Co-ordinators were required to keep in touch with Challenge Fund projects in their area, scrutinise quarterly progress reports, and keep DWP informed about the projects. According to organisations involved in the case study research, Co-ordinators were perceived as a source of general information about health and well-being and in some cases had provided assistance to shape project design and form project 'milestones'. Co-ordinators had also been contacted by organisations for reassurance about delays, about prospective changes to projects, or with regard to the regular progress reports required by DWP. For some organisations, the Co-ordinator had facilitated links to health and well-being resources, or to networks of local stakeholders or Challenge Fund winners. The importance of this facilitative role in ensuring commitment to the health, work and well-being agenda was especially evident where an organisation had been introduced to a local scheme which had focused their efforts since. However, there were also organisations which had had limited contact with their Co-ordinator, having only one face-to-face meeting or a phone call at the outset.

3.7 Overall views on the Challenge Fund

In general there was broad agreement among Co-ordinators, public health personnel and representatives of Fund winning organisations that the Challenge Fund had been effective in stimulating activity. Co-ordinators felt that the Fund had been useful for engaging employers who were looking for a solution, and in demonstrating what could be achieved from a modest budget. The Fund bidding process had also brought to light organisations that were keen to engage on workplace well-being, with whom the Co-ordinator could then work. Senior public health personnel pointed to the Fund's value in providing case studies of what does and does not work, which in turn might build interest and generate further investment (see case examples in Boxes 3.3 and 3.4).

Box 3.3 Case example of what worked

The provision of free fruit in the workplace of a small private firm had the effect of making people think about their diet and health in general. Staff began to monitor what they ate and talk with each other about healthy meals. Overall, providing fruit was felt to be a simple intervention that had real benefits in raising awareness and changing behaviour.

> *'I think it gets people ... thinking "yeah I will have a fruit instead of a biscuit." ... So, even if you're not talking about doing the exercise, the actual dietary side of things has actually really started to improve I think.'*

Box 3.4 Case example of what did not work

One small service sector firm had not identified a need for health and well-being activity but had accepted an approach from a stress management practitioner to deliver workshops to the firm's staff if a Challenge Fund award was won. The provision of stress workshops did not resonate with staff at any stage of implementation. In part, this was because staff did not feel workplace stress was a relevant concern.

> *'(We) didn't understand why we were having the stress management 'cause everyone gets stressed, but everyone manages it, in their own way so, you know, you think well ... what are you going to learn from it?'*

Staff also resented taking part because they were paid according to the amount of work they completed and so lost out financially when they spent time in stress workshops rather than doing their work.

> *'... they're skilled men and if they can make money, why shouldn't they? ... So, they probably just want to be ... working than to have to down tools ... go into the* [Challenge Fund activity].*'*

However, a view shared by some Co-ordinators, senior public health personnel and case study interviewees was that short-term funding was not necessarily the most effective way of encouraging long-term change or embedding sustainable practices. Some senior public health personnel felt that more sustainability could be achieved through connecting organisations to existing resources, such as local accreditation schemes (see Section 3.5). Another view was that funding posts (such as the Co-ordinator) was a more effective use of resources than making awards to individual firms.

3.8 Conclusion

There is evidence that the Challenge Fund was meeting some policy objectives by stimulating new health and well-being activity, addressing organisations' concerns about mental health in the workforce, and kick-starting activities that were planned to continue beyond the period of funding, with some organisations expecting to commit some of their own resources to doing so.

There are a number of lessons that might inform policy thinking about Challenge Fund type initiatives in the future.

Relatively small pots of money for a specific purpose or government agenda can kick-start new thinking and action, as well as support the aims of organisations who already share a commitment to the agenda. Funding from an external source can add value to projects which may otherwise be implemented, and therefore lead to greater impact.

Although being able to trial initiatives effectively cost-free can give organisations confidence to commit to an agenda, short-term funding does not necessarily guarantee sustainable change. Sustainable practice may result, however, where funds lead to a permanent change in the physical environment, where the benefits to individuals and organisations are noticeable and considered worthy of investment of time and money, where the financial cost of interventions is low or can be met by available funding, and where local schemes providing free-to-use resources and ready-made structures for embedding activity over time are in place.

Flexibility in project design and operation is needed to suit organisational circumstances and changes over time. Some of the ways the Fund was administered were thought to hamper flexible working, such as restrictions on the use of monies, the timescale for expenditure, and the availability of just one year's funding. However, there were also indications that freedom in design and implementation should not be at the expense of offering organisations expert advice about the feasibility of projects that might otherwise become burdensome in practice.

Interventions that appear to be popular are those which are relevant to individuals, which attract the support of people who are influential to others (such as managers or GPs), which are free to access and which can be accommodated conveniently in work or leisure routines.

Measuring the impact of the use of funds can be important for future decision making in organisations, but can be challenging for organisations who are inexperienced in monitoring and interpreting impact and who have no baseline measures to compare against.

4 Culture and behaviour towards workplace health and well-being

4.1 Introduction

As mentioned in Chapter 1, Dame Carol Black's review recognised the importance of addressing workplace cultures in the promotion of a healthier workforce:

> *'A shift in attitudes is necessary to ensure that employers and employees recognise not only the importance of preventing ill-health, but also the key role the workplace can play in promoting health and well-being.'*
>
> (Black, 2008, p.10)

In the Government's response to the Black Review (Department for Work and Pensions (DWP) and Department of Health (DH), 2008, p.26) this view is reflected in the assertion that achieving improved health among the working population requires not only practical interventions but also a change in perspectives towards health and work. Furthermore employers have to be persuaded of the need for ongoing commitment and investment in education, training and practical programmes of activity to secure sustained, improved health within the workforce.

There are of course different interpretations of what workplace 'culture' entails. It is neither a clear nor an easily operationalised concept. Within this study we explored two related aspects of 'culture' derived from the analysis in the Government response to the Black Review (DWP and DH, 2008): attitudes towards workplace health and well-being and activities designed to promote them. In other words, we explored what people thought about health and well-being and what they did about it.

We also attempted to obtain some indication of how attitudes and behaviour had changed during the time of engagement with a Co-ordinator or receipt of a Challenge Fund award.

4.2 Exploring the potential for culture change on health and well-being

In both surveys respondents were asked which of three statements best described the culture within their organisations before contact with a Co-ordinator or before receiving a Challenge Fund award. Responses give an indication of the challenge facing Co-ordinators in promoting greater awareness of and activity on workplace health and well-being.

Table 4.1 Culture towards health, work and well-being prior to start of Co-ordinator and Challenge Fund initiatives

Statements re: culture within firm/ organisation	Public sector organisations		Private sector		Third sector small/ medium organisations	All organisations	Challenge Fund Winners
	Large	Small/ medium	Large firms	SMEs			
	%	%	%	%	%	%	
Little recognition	11	5	12	7	9	9	17
General interest	46	36	24	32	39	38	56
Good awareness	44	59	64	61	53	52	27
Total number of respondents	110	39	25	31	59	279	59

Source: Survey of organisations in contact with a Co-ordinator and Challenge Fund Winners Survey.

Large public sector organisations were least likely to report 'good awareness' in contrast to private sector organisations. The contrast between the data from the survey of organisations in contact with a Co-ordinator and Challenge Fund winners is striking. Fifty-two per cent of organisations in contact with a Co-ordinator reported good awareness compared with only 27 per cent in the Challenge Fund Winners Survey.

Overall the table suggests that many organisations were aware of the health and well-being agenda but also alert to the opportunities for advancing the agenda further. In particular the findings from the Challenge Fund Winners Survey suggest that it attracted organisations which were generally less engaged with thinking about health and well-being.

4.3 Changes in awareness and attitudes

The exploration of the impact of engagement with a Co-ordinator or receipt of a Challenge Fund award was different within the survey of organisations in contact with a Co-ordinator and the Challenge Fund winners. In the former, respondents were asked again to assess the culture within their organisations in mid 2010 and in mid 2011. Table 4.2 presents a comparison in the responses to the questions.

Table 4.2 Level of agreement with statements about workplace culture

	June/July 2010		June/July 2011	
	Frequency	%	Frequency	%
Little recognition of health and well-being in the workplace	26	9	17	6
General interest in health and well-being in the workplace	107	38	69	25
Good awareness of health and well-being in the workplace	146	52	184	66
Don't know	–	–	9	3
Total	279	100	279	100

Source: Survey of organisations in contact with a Co-ordinator.

The overall picture from the table is of increasing awareness of health and well-being among all organisations over a 12-month period. Just over half of respondents said there was good awareness of health and well-being in 2010 but this increased to two-thirds a year later. It was also possible to identify the proportions of organisations who reported an improvement or deterioration in culture towards health and well-being. Just under a quarter (24 per cent) of organisations reported an improvement while ten per cent said that the culture had worsened. The highest level of improvement was recorded among third sector organisations (34 per cent) while a higher proportion of public sector organisations experienced deterioration. Among the sub-group of Challenge Fund winners in the survey of organisations in contact with a Co-ordinator, 40 per cent reported an improvement, compared with 24 per cent for the whole sample.

In the Challenge Fund survey respondents were asked to identify their aspirations for the impact of an award to which 58 of the 59 respondents (98 per cent) responded that their aspirations included 'better workplace culture towards health and well-being'. Of these, 54 organisations (86 per cent) said that having a Challenge Fund award had made a positive impact on their workplace culture.

As mentioned in Chapter 3, partnerships seemed less certain about their effect on workplace culture. From the case study data we see that some partnerships focused their activities more on engaging individual employees in local firms rather than the firms themselves. There was more chance of generating a change in culture in firms if groups of staff attended activities together or managers were the target of interventions.

4.4 Changes in activity and behaviour

Data on changes in activity and behaviour derive principally from the survey of organisations in contact with a Co-ordinator. Table 4.3 presents data on whether respondents reported that their organisations had health and well-being initiatives in place 12 months prior to the research interview (around June/July 2010).

Table 4.3 Were there health and well-being initiatives in place in June/July 2010?

	Organisations in contact with a Co-ordinator					
	Public sector organisations		Private sector		Third sector small/ medium organisations	All organisations
	Large	Small/ medium	Large firms	SMEs		
	%	%	%	%	%	%
Health and well-being activity in place 12 months earlier	86	74	84	58	56	75
Health and well-being activity not in place 12 months earlier	15	26	16	42	44	25
Total number of respondents	110	39	25	31	59	279

Source: Survey of organisations in contact with a Co-ordinator.

In June/July 2010 there was some health and well-being activity already going on in a high percentage of large organisations in both the public and the private sectors. The percentages for SMEs in the private sector and third sector are much lower though still above 50 per cent (Table 4.3).

Respondents were asked the same question in relation to the time of the research interview (June/July 2011). In this way we generated a measure of change over a period of 12 months.

Table 4.4 Health and well-being initiatives in place, changes between 2010 and 2011, by organisation type

Column percentages

	Organisations in contact with a Co-ordinator					
	Public sector organisations		Private sector		Third sector small/ medium organisations	Number (and %) of organisations
	Large	Small/ medium	Large firms	SMEs		
	%	%	%	%	%	%
Level of activity unchanged	82	65	83	57	52	192 (71%)
Increase in activity	9	14	13	30	35	48 (18%)
Decrease in activity	6	11	0	0	3	12 (4%)
No activity ever	4	11	4	13	10	19 (7%)
Total number of respondents	110	39	25	31	59	279

Source: Survey of organisations in contact with a Co-ordinator.

As Table 4.3 shows, 75 per cent of organisations in contact with a Co-ordinator were engaged with some form of health and well-being activity in June/July 2010. A year later, in a majority of these organisations (71 per cent) levels of health and well-being activity were unchanged, and in a small proportion (seven per cent) contact with a Co-ordinator failed to kick-start any activity at all. Around a third of SMEs and third sector organisations said that their health and well-being activity had increased. Any decreases in activity appear to be almost wholly within the public sector. In neither of the private sector groups was a reduction in activity reported.

Box 4.1 Changing culture via contact with a Co-ordinator

A senior officer in a large public sector organisation explained that via two meetings and exchange of emails in which the Co-ordinator provided information and gave advice about how to access free health and well-being resources, he thought that the Co-ordinator had contributed to a change in culture (‘*galvanising us into action*’). Her input encouraged them to focus on and prioritise health and well-being and to make changes that they would not necessarily have thought of such as tightening up sickness absence procedures: *‘… it was an input that just made us raise this thing up the agenda.’*

We also found that the sub group of Challenge Fund winners in the survey of organisations in contact with a Co-ordinator were more likely to report an increase in activity (42 per cent) compared with other respondents (15 per cent), reflecting the finding from Chapter 3 of the potential of the Challenge Fund as a policy lever to stimulate health and well-being activity. Respondents were asked not only about current activity but also whether there were plans in place for future health and well-being activity. The question was asked in relation to mid 2011 and a year earlier. Table 4.5 presents an analysis of the changes over this 12-month period.

Table 4.5 Plans to introduce health and well-being initiatives, changes between 2010 and 2011, by organisation type

Column percentages

	Organisations in contact with a Co-ordinator					
	Public sector organisations		Private sector		Third sector small/ medium organisations	Number (and %) of organisations
	Large	Small/ medium	Large firms	SMEs		
	%	%	%	%	%	%
Continuing plans to introduce initiatives	78	69	82	43	53	171 (67%)
Increase in plans to introduce initiatives	5	9	9	4	28	29 (11%)
Reduced plans to introduce initiatives	10	11	5	14	9	24 (9%)
Still no plans to introduce initiatives	7	11	5	39	11	31 (12%)

Source: Survey of organisations in contact with a Co-ordinator.

Table 4.5 shows evidence of continuing commitment to health and well-being activity in the future across a majority (two-thirds) of the organisations in the survey and an increased commitment in one in ten organisations. Third sector organisations appeared to be the most committed to more activity. In contrast one in ten public sector organisations seemed to be scaling back their activities between 2010 and 2011 and in four in ten SMEs there were no plans to introduce health and well-being initiatives in 2010 or 2011. However, this does not imply that no activity was actually going on, only that there were no plans for more.

Examples of how changes in culture were perceived in the workplace, taken from case study data, included staff talking together about health, managers reporting raised awareness of how their actions might create stress on staff, staff noticing more workplace well-being activities and feeling valued by their employer.

Box 4.2 Changing culture via the Challenge Fund

One Challenge Fund winner was a service industry company employing 150 staff. Some of the award was used to fund the company's participation in the Global Corporate Challenge, an inter-company walking competition. The manager responsible for the Challenge Fund award thought that their participation had contributed to a change in culture towards health and well-being in the company. Previously the company had promoted some health and well-being activity because 'it looked good', but this had changed.

'... more individuals are interested in it now, and it's more structured and it's more strategic, rather than being ad hoc.'

4.5 Sustained changes in culture

In the survey of organisations in contact with a Co-ordinator respondents were asked about the impacts of their contact with a Co-ordinator and whether it was likely that these impacts would be sustained. Changes in culture were indicated by increased awareness of the health and well-being agenda, commencement of new activities, and improvements to health and well-being policies. Table 4.6 presents an analysis of whether organisations thought that these impacts would be long lasting.

Table 4.6 Views about whether impact of contact with Co-ordinator would be long lasting

Row percentages

	Views about whether impact would be long lasting (% of organisations)				Total (N)[1]
Impact	**Definitely**	**Possibly**	**No**	**Don't know**	
Increased awareness of the health and well-being agenda	66	30	3	–	207
New health and well-being projects or initiatives	57	39	3	1	143
Improved health and well-being policies	59	34	4	3	108

[1] N refers to the number of respondents from the total sample of 279 who mentioned each impact.

It appears encouraging that for the majority of organisations the impacts on awareness, new health and well-being activity and health and well-being policies are expected to be long lasting. Furthermore, only a very small percentage (three to four per cent) of impacts were thought not to be long lasting. The interpretation of this table is not straightforward, however, as there are no benchmarks against which to assess the responses. It is a matter of judgment whether the figure of 66 per cent for organisations saying the positive impact of awareness will definitely be long lasting is seen as satisfactory or not. It might be seen as a sufficiently high percentage, but alternatively focus might be drawn to the 30 per cent who responded that the positive impact will only possibly be long lasting. Similarly, where some action had resulted from contact with a Co-ordinator (in 51 per cent of the sample, 143 organisations) around six in ten said the impact would last but four in ten said that this was only possible.

The views of some of the Challenge Fund winners in the case studies are also relevant here. There were some suggestions that a change in culture was more likely to be maintained if activities were in some way embedded in the organisation's operations, for example by developing a health and well-being strategy, incorporating health and well-being into routine training plans, maintaining active participation in networks, or working towards a health and well-being award. There were also suggestions that employees doing activities together contributed to sustained culture change, more so than where participation was more individually focused. In contrast, there was a feeling in some organisations that health and well-being received less attention and became less of a priority for managers and staff when major changes to the organisation were occurring (such as contraction or a change of ownership).

4.6 Conclusion

The Black Review and the Government's response (DWP and DH, 2008) saw achieving a positive change in workplace health and well-being culture as crucial to the sustainability of health and well-being activities and impacts – a goal that can be seen as underpinning the explicit objectives of the Co-ordinator and Challenge Fund initiatives. The evidence of this chapter suggests that both initiatives produced a change in culture in many organisations and that, in the view of the survey respondents, these changes were more likely to be long lasting rather than temporary in the majority of cases.

5 Conclusion and lessons for the future

In this final chapter we draw together findings that address the key policy interests of the Department for Work and Pensions (DWP) and the Department of Health (DH) and draw together the lessons that can be taken forward by government departments, public health policy makers and by the business community.

5.1 Context

As mentioned in Chapter 1, one of the challenges for this study has been to collect data that can in some way measure the impact of the Co-ordinators' activity and the Challenge Fund. This task was made harder by the lack of any clear, quantified targets set by government. What we have been guided by, therefore, has been the more generalised policy aims. We were also asked by the DWP to focus on the extent to which the two initiatives succeeded in: (a) engaging with small and medium sized enterprises (SMEs) and (b) addressing the issue of mental health and mental well-being.

To recap, the aims of the Co-ordinator role were to develop and encourage partnerships between employment and health networks, co-ordinate strategies and activities within and across regions and countries, and promote best practice, particularly in SMEs. The Challenge Fund had an explicit focus on SMEs and local partnerships, and aimed to promote innovative approaches to health and well-being, particularly in relation to mental health.

Early in the study it was hoped that evidence would emerge of how health and well-being changes in individual organisations were reflected in, for example, reductions in sickness absence (and presenteeism) or reductions in people going onto long-term sickness benefit. However, as we have documented in the report, examples of data collection within organisations that would allow such an assessment were extremely rare.

In reviewing the achievements of the Co-ordinators a number of contextual factors should be kept in mind. The major changes to the structure of public health in England created uncertainty and disruption. The ongoing adverse economic environment hampered some of the Co-ordinators' work, some found it hard to engage businesses whose energy and time were focused on survival, and the sustainability of Challenge Fund activities was affected by some of the harsher effects of the economy, such as restructuring, contraction and changes of ownership. Health, work and well-being was a relative newcomer to the national public health agenda, which has tended to focus more on the more familiar areas of smoking, alcohol and drug use, nutrition and obesity, sexual health, pregnancy and early years health, and disease prevention. Co-ordinators spent a lot of effort trying to embed health, work and well-being in public health plans.

5.2 Reflections on methods, analysis and findings

For any research project it is appropriate to reflect on the nature of the evidence presented and to be aware of any effects of research design and data collection on the findings and conclusions.

This study collected data from a range of informants, using a variety of methods, and used a systematic approach to analyse qualitative data from in-depth interviews. Taking into account the timescale and resource constraints, and the design of the policy initiatives, measurement of

perceived impact (as opposed to net impact measured in, for example, a randomised controlled trial) was the most appropriate methodology for the study. We attempted to explore perceived impact in a number of different ways through the surveys of organisations in contact with Co-ordinators and the follow-up qualitative interviews, in the Challenge Fund survey and case studies, and in the interviews with Co-ordinators. That the findings have been generally consistent suggests that we have been able to identify real impacts, even if it is not possible to quantify or estimate their costs and benefits. The study was also formative in nature, that is to say emerging findings were shared with the Co-ordinators and helped to shape their practice.

The results from the analysis cannot, however, be generalised to all organisations having contact with a Co-ordinator, as there was no natural population of such organisations from which we could draw a sample. Our use of an exercise in which Co-ordinators logged all their contacts for three two-week periods did generate a sampling frame but it is not possible to claim any representativeness for it.

In designing the research instruments there were initial concerns about asking questions about organisations' approaches to health, work and well-being a year prior to the interview, as it is known that periods of this length can negatively affect respondents' powers of recall. However, feedback from the pilot surveys did not raise any concerns, and in the main stages of data collection respondents did not appear to struggle with such questions.

Finally, in drawing conclusions about the impact of the Co-ordinators we should note that the final round of interviews with them took place around six months before their funding expired. We could not, therefore, collect data from them on the perceived impact of their activities in the final months of their tenure. As a consequence, some of their impact is very likely not to be reflected in this report.

5.3 Key achievements compared with policy aims

In this section we focus on the impacts of the Co-ordinator and Challenge Fund initiatives compared with the policy aims summarised already. In this section we summarise achievements from the perspectives of the organisations in contact with Co-ordinators.

5.3.1 Strategic aims

As we have reported in Chapter 2, the Co-ordinators placed a deliberate emphasis in the initial period of their appointments on developing strategic functions, an emphasis that for many continued throughout the period of the study. Hence, we see evidence that Co-ordinators worked to develop and encourage partnerships between employment and health networks and evidence of some achievements here. Early work establishing relationships with a range of organisations such as chambers of commerce, local authorities, universities, CIPD offices, Jobcentre Plus offices, Regional Development Agencies and regional business networks, continued to develop, but Co-ordinators also made efforts to build links between existing networks. Where gaps were perceived attempts were made to create and support new networks (for example, between local authorities or between large organisations). There was considerable progress in engaging businesses and employers: conferences, meetings and events had been held in most regions. Chapter 2 also documents the increasing range of strategic activity with the public sector, including working with Primary Care Trusts (PCTs) to help them assess needs in the workforce, set goals and measure outcomes, and advising Strategic Health Authorities (SHAs), Local Enterprise Partnerships and emerging Health and Well-being Boards.

There is of course no absolute standard that we can apply to say that the strategic dimension of the Co-ordinators' role had been achieved completely. There is ample evidence though of Co-ordinators carrying out the sorts of activity set out in their job descriptions that were assumed to be ways of advancing the health and well-being agenda.

5.3.2 Engaging small and medium sized enterprises

When we look at engagement with individual firms and organisations, particularly small and medium sized organisations (the third of the Co-ordinators' overall aims listed above) the evidence is less clear cut. Examples of achievements to promote health and well-being in firms and organisations included the development of a Workplace Well-being Charter (as a national resource for all public, private and voluntary sector organisations) establishing health at work accreditation schemes and strengthening and promoting tools for employers to self-assess where their organisation stood under sets of standards, and what their needs might be. However, the extent of direct contact with SMEs had not, by Co-ordinators' own assessments, matched what they saw as the aspirations of government. As Table 1.2 showed, 39 per cent of Co-ordinator contacts were with large public sector organisations (principally NHS organisations) while only 11 per cent were with private sector SMEs.

There was a common view that effort at the strategic level (as mentioned in Section 5.2.1) and through umbrella organisations (such as employers' federations, trades unions, trade associations, banks and chambers of commerce) was a better use of scarce time and resources than working directly with firms and organisations. Some Co-ordinators saw opportunities in the future of reaching SMEs through the supply chains of larger (particularly public sector) organisations.

5.3.3 Addressing mental health aims

There has been a recognition in policy debates on disability, sickness absence and work that mental ill-health is one of the biggest challenges to be addressed. As noted in Chapter 2, some Co-ordinators had initially found only '*patchy*' levels of interest or awareness of links between mental health and employment and were unclear about how best to respond. Some had found it very challenging to get employers even to engage with mental health issues. However, after a year or so in post a common approach was to include mental health issues within all aspects of work, but without identifying them for specific action. At a more general level, therefore, there was advice and support available for employers in dealing with stress at work, and mental health was included within the tools they were developing such as training modules for managers. Mental health was not though a main focus of their work, especially among Co-ordinators with little professional expertise in mental health.

This approach contrasts somewhat with the evidence from both the survey of organisations in contact with a Co-ordinator and the Challenge Fund work (survey and case studies) that mental health was perceived as a major issue for firms and organisations. It should be emphasised though that the issue of mental health was mainly concerned with workplace stress rather than any of the recognised common or serious and enduring conditions such as anxiety, depression or psychosis. In the survey of organisations in contact with a Co-ordinator, 81 per cent of respondents said stress was an issue for them and among the Challenge Fund winners in the survey the figure was higher at 92 per cent. Furthermore, as Chapter 3 has shown, almost one-fifth of Challenge Fund initiatives were focused specifically on mental health (see Table 3.1), and improving mental well-being was an aim of having Challenge Fund money for all but one of the organisations surveyed (58 out of 59). Findings from the case studies reinforce this emphasis on mental health: relieving stress or feeling happier were expected to be by-products of other types of interventions, such as those promoting physical exercise and improved nutrition.

5.3.4 Changing the culture towards workplace health and well-being

The extent to which the policy aim of promoting a change in culture about health and well-being was being met was explored in Chapter 4. Evidence from the survey of organisations in contact with a Co-ordinator and the Challenge Fund survey and case studies suggests that positive impacts on culture (assessed against levels of awareness of workplace health and well-being and by actual activity) were being made and that most of these changes were expected to be long lasting.

5.4 Stakeholder assessment of achievements

Another way of thinking about the impact of Co-ordinators and the Challenge Fund is to look at individual firms' and organisations' experiences. This places a focus on the health and well-being issues that concern organisations rather than the strategic concerns of government. Table 5.1 compares how respondents assessed the health and well-being problems in their organisations at the time of the research interview in June/July 2011 and also at a point a year earlier.

Table 5.1 Changes in assessments of problems between 2010 and 2011

	Percentage of organisations reporting ...		Number citing problem
	Less of a problem	Increasing problem	
Work-related stress	24	17	218
Presenteeism	35	11	205
Weight issues	23	7	199
Poor diet	25	9	189
Other mental health conditions	21	14	207
Absenteeism	29	11	204
Physical health problems	15	11	210
High levels of staff-turnover	19	17	207

Source: Survey of organisations in contact with a Co-ordinator.

It is not possible from this table to infer any direct causal link between engagement with a Co-ordinator and changes in the experiences of health and well-being problems. We know, for example, from the evidence from employers that absenteeism among the workforce tends to decrease at times of economic uncertainty. However, across all the organisations taking part in the survey there was a net improvement on all problems, i.e. more organisations reported a reduction in problems than reported increases. The table also shows that health and well-being problems can get worse as well as improve. For example, on mental health, we see that nearly one in five respondents reported the perception that problems of work-related stress had worsened, and one in seven said other mental health conditions were a growing problem. Further data from the survey of organisations in contact with a Co-ordinator is presented in Table 5.2. It shows the extent to which respondents thought that contact with a Co-ordinator had resulted in specific outcomes.

Table 5.2 Assessment of extent to which engagement with a Co-ordinator led to positive outcomes

Outcome	Yes – a great deal	Yes – in some ways	No	Don't know	Base= 100%
Formation of new networks/partnerships	31	39	27	3	279
Encouraged us to start new health and well-being projects or initiatives	20	32	46	3	279
Improved health and well-being in our organisation	8	28	57	8	279
Staff are eating healthier food	4	17	66	13	273
Led to a fall in sickness absence rates	2	12	72	14	279
Staff have lost weight	1	9	71	18	273

Source: survey of organisations in contact with a Co-ordinator.

The table reveals some striking contrasts. On the two aims to stimulate networks and partnerships and on generating new health and well-being activity the findings are positive, but on perhaps one of the overarching aims – to improve workplace health and well-being – the results look less impressive, with only one in three organisations reporting a positive outcome. However, it is interesting to note that when the responses were analysed separately for the Challenge Fund winners in the survey of organisations in contact with a Co-ordinator it was found that 77 per cent recorded a positive impact on health and well-being (17 per cent 'a great deal' and 60 per cent 'in some ways'). It is also evident that engagement with Co-ordinators did not appear to have led to major impacts on sickness absence rates or diet which are some of the wider aims of public health and welfare reform rather than specific aims of the two health and well-being initiatives.

Analysis of the impact of having a Challenge Fund award was presented in Chapter 3. To summarise, the proportions of organisations in the Challenge Fund Winners Survey who reported a positive impact on a range of aspirations were generally high. For example, 71 per cent reported a positive effect on mental well-being, 56 per cent on physical health, 61 per cent on external profile, and 44 per cent on sickness rates.

When we look at stakeholder assessments of their engagement with a Co-ordinator we find a very positive picture. As set out in Section 2.5, nearly nine in ten of respondents in the Contacts Survey found their contact useful, and 85 per cent found that contact was either adequate for their needs or exactly matched them.

5.5 Legacy and sustainability

There are two main ways in which we can think about the legacy and sustainability of the Co-ordinator and Challenge Fund initiatives. First, we can look at whether the activities, if not the posts, of Co-ordinators are likely to continue, and secondly whether the impacts of their activities, including via the Challenge Fund, will be sustained.

The funding for the Co-ordinator initiative was initially for two years and was subsequently extended by DWP to March 2012. The rationale for time-limited funding was to stimulate local activity and provide opportunities to explore the usefulness of the Co-ordinator role, with a view to it being subsumed into local bodies.

At the time of the final Co-ordinator interviews in the autumn of 2011 there was a range of discussions about their future role. However, as mentioned in Chapter 2, towards the end of the funding period some Co-ordinators had left their posts or were planning to move back to previous posts. In one region the Co-ordinator had initiated discussions with the Directors of PCTss (some 16-17) in an attempt to create posts equivalent to Co-ordinators in each of them.

Throughout this report we have presented data on whether the impacts of the Co-ordinators' activities and the Challenge Fund were likely to continue, the intention being that by acting as 'catalysts for change' workplace health and well-being would be embedded or 'mainstreamed' within the strategies and plans of public sector organisations, and that private sector employers would include health and well-being policies as a standard part of their 'everyday business'. There was considerable evidence from the study (presented in Chapters 2 to 4) that many activities and networks would continue beyond March 2012, but this was not universal.

5.6 Lessons for the future

In this final section we consider what lessons have emerged from the study that can inform the development of policy on health, work and well-being. These lessons are set out for the three main groups of stakeholders: the DWP, which had the prime policy responsibility for the implementation of the Co-ordinator and Challenge Fund initiatives, public health delivery organisations, and the business community. However, because of the reorganisation of public health and the uncertainties about where responsibility within government will lie in the future, some of the lessons we draw for DWP will have relevance for other parts of central or local government.

5.6.1 Lessons for DWP

There was much evidence that the high level aims of the two initiatives – to influence strategy, stimulate activity and promote sustainable partnerships and networks – were being met. From the experiences of the Co-ordinators, however, there was still a lack of clarity about ownership of the health and well-being agenda and its direction that left them uncertain about how best to implement their roles. Health, work and well-being clearly crosses the current departmental boundaries of employment and health (as evidenced by initial joint sponsorship of the Co-ordinator and Challenge Fund initiatives by DWP and DH). In contrast there are policies that also aim to improve workplace health and well-being, though perhaps not so directly, that lie within the compass of DWP, including the Fit for Work Service pilots and Jobcentre Plus and Work Programme back to work services. The need for effective coordination of policy at government department level is clear.

The evidence on engagement with SMEs is mixed. There are indications (from the accounts of the Co-ordinators and from the Contacts Survey) that the number of SMEs with direct contact from Co-ordinators was small. However, from this study it was not possible to collect data from SMEs who might have had dealings with one of the intermediary organisations (such as NHS organisations) or networks that Co-ordinators were trying to foster. Despite this possibly disappointing finding on the **quantity** of direct contact with SMEs, the evidence of the **quality** of contact with SMEs was largely very positive. The challenge remains, however, for DWP and public health bodies of how to balance direct contact with SMEs with more indirect means.

The high level of concern about mental health in firms and the continuing policy focus on mental health in the workplace suggest that mental health must be a strong focus for any successor of the Co-ordinator role.

There are useful findings from the study about how to present the evidence to employers for investing in health and well-being activities. There is already ample evidence that a healthy workforce is a more productive workforce (for example, in the Black Review, 2008), a message that is prominent in health, work and well-being promotional material. When we look at the findings of what organisations were hoping to achieve through contact with Co-ordinators and by having a Challenge Fund award, we find that many firms shared this view in their desire to improve productivity, reduce sickness rates and improve job retention. However, other motivations were also identified, including better staff-management relations and improved mental and physical well-being for their staff (see Table 3.2). In contrast, wanting health and well-being activity to improve a firm's external reputation or to contribute to increased custom were not widely cited aims. In future, therefore, the argument for investing in health and well-being activity could usefully include these other, less directly commercial, benefits. As we have seen in Chapter 2, the work of the Co-ordinators can also provide many examples of positive impacts that can be used in materials and resources to promote workplace health and well-being.

5.6.2 Lessons for public health

Because of the structural changes to public health in England, some of the lessons for DWP outlined in Section 5.5.1 will also be relevant for local authority officials assuming public health responsibilities in the future.

One way in which reorganisation of public health might prove beneficial is in the opportunities it creates for exploiting existing networks and expertise, such as with local authority trading standards, environmental health, and licensing departments. Through existing links with local business there is an opportunity to maximise the use of the workplace for promoting public health priorities such as smoking, alcohol consumption and healthy eating.

If the Co-ordinator role is continued or introduced within the new public health structures then several lessons should be heeded. Health and well-being is a policy that crosses the concerns of different government departments at national and local level. A cross-government approach is, therefore, essential in linking health, employment and welfare reform. Greater clarity around purpose, objectives and outputs, especially on mental health, should be provided. There is still a need to balance strategic work and contacts with individual organisations. Adequate administrative support should be provided. The opportunity should be taken to establish a new network or networks of Co-ordinators that can serve as channels of information and ideas. The network established during 2010–12 was partially successful, but could have been more useful by having more emphasis on analysis and discussion and less on routine reporting of local activity.

It should also be remembered that the evaluation found no single 'model' of Co-ordinator that can serve as a template for the future definition of the role. Each Co-ordinator adopted their own approaches to prioritising and carrying out their work and developed their role differently.

5.6.3 Lessons for the business community

We have already mentioned that the case to business for investing in health and well-being activity could be reformulated away from purely economic arguments towards more of the aims and aspirations identified by firms and organisations themselves (for better staff-management relations, for example). Benefits from health and well-being activity were more likely when embedded within mainstream, day-to-day practices with clear support from senior management, based on the views and aspirations of staff, and, where appropriate, embraced and supported by human resources departments.

5.7 Final comments

The Black Review makes the compelling case for urgent action from 'politicians, healthcare professionals, employers, trades unions (and) individuals themselves' to improve the health of Britain's workforce (p.5).

The Co-ordinator and Challenge Fund projects have shown that it is possible to promote sustainable change at all levels, from strategic organisations to individual workers within firms and businesses.

Appendix A Description of methods

A.1 Introduction

This appendix presents the research methods used to study the work of the Health, Work and Well-being Co-ordinators and the Challenge Fund. The research was funded by the Department for Work and Pensions (DWP) and was conducted by researchers at the Social Policy Research Unit, at the University of York. The research period ran from October 2009 until April 2012.

In this section the main aims of the research and components of the research design are outlined. Each subsequent section takes as its focus one component of the research, explaining the purpose and main methods used to collect and analyse data.

A.1.1 Aims of the study

The research was designed as two complementary components to reflect that Health, Work and Well-being Co-ordinators and the Challenge Fund can be treated as distinct policy instruments.

The Co-ordinator component was designed to meet the following research objectives:

- to describe the role/operation of the Co-ordinators, and identify the similarities and differences of the delivery models chosen;
- to investigate the (perceived) impact of the Co-ordinators on the levels of health and well-being amongst the organisations engaged;
- to identify whether Co-ordinators succeeded in promoting the health, work and well-being agenda amongst key stakeholders and firms, and whether sustained cultural change was achieved;
- to understand to what extent and how the Co-ordinators have developed relevant health and work partnerships/networks amongst key stakeholders and agencies;
- to understand the sustainability of the actions/systems the Co-ordinators will put in place after the start-up funding for the posts has come to an end.

The Challenge Fund component of the research was designed to meet the following aims:

- to explore the application and selection process of the Challenge Fund;
- to understand motivations of firms and partnerships behind applications to the Challenge Fund, their attitudes to health and work, and the role of the Co-ordinator in supporting applicants;
- to describe the types of employers that received an award and the initiatives funded. Identify successes and barriers to implementation of the initiatives within firms;
- to investigate the additionality of the Challenge Fund and (perceived) impact on employers and partnerships including well-being indicators (e.g. sickness absence, presenteeism, employee morale and engagement, productivity). Identify the business case for implementing the health and well-being initiatives;
- to understand the impact of the Challenge Fund on employees;
- to understand changes in awareness of and attitudes to health and work, and the culture within beneficiary organisations.

A.1.2 Research design

The research design was aimed at meeting the research objectives outlined in Section A.1.1 and collecting data from a number of main stakeholders including:

- Health, Work and Well-being Co-ordinators;
- Regional Directors of Public Health;
- policy makers within the DWP;
- organisations that had had contact with Co-ordinators;
- Challenge Fund award winners;
- employees of Challenge Fund winners.

A summary of the methods used for the study is presented in the table below.

Table A.1 Summary of research design

	Element of research design	Scale and timing of fieldwork
Exploring the work and impact of the Co-ordinators		
1	Depth interviews with 11 Co-ordinators	Three waves of interviews were held in: – spring 2010 (face-to-face – autumn 2010 (face-to-face) – autumn 2011 (telephone)
2	Depth interviews with 11 senior public health officials	One set of face-to-face interviews in autumn 2010 (but see notes below)
3	Depth interviews with three key DWP policy makers	One set of face-to-face interviews in autumn 2010
4	Survey of organisations in contact with Co-ordinators	279 organisations surveyed. Telephone interviews took place in summer 2011
5	Follow-up depth interviews from the survey of organisations in contact with a Co-ordinator	19 telephone interviews carried out in early autumn 2011.
Exploring the use and impact of the Challenge Fund		
6	Survey of Challenge Fund winners	59 Challenge Fund winners surveyed in spring 2011 by telephone.
7	Case studies of Challenge Fund winners	Two waves of depth fieldwork in: – summer 2010 – summer 2011

The remainder of the appendix sets out in more detail each of these research components.

A.2 Interviews with key DWP policy makers

As useful background to the work with other stakeholders, depth interviews were held with three key policy and implementation officials in the DWP. The focus of the interviews was to collect data on DWP objectives for the Co-ordinator and Challenge Fund initiatives; how they were designed; how effectiveness might be assessed, and experiences of the initial stages of implementation.

Three interviews with key DWP policy makers took place in February 2010. Interviews were conducted by the two researchers who subsequently had the main responsibility for the series of interviews with Co-ordinators and senior public health personnel. A short general topic guide was used (Appendix B) to enable exploration of the topics described above, in each case focusing on

those areas in which each policy maker had particular responsibility and knowledge.

Policy makers gave permission for the interviews to be audio recorded, and recordings were transcribed.

As explained above each interview covered slightly different ground. The transcripts were not analysed thematically. Rather, members of the research team read the transcripts and discussed the information within. The material provided important contextual and background information for the overall evaluative research, and directly informed the design of the topic guides for the series of interviews with Co-ordinators and senior public health personnel.

A.3 Interviews with Co-ordinators

It was recognised and expected that the work of the Co-ordinators and their impact would change over the two-year period they were in post. It was decided, therefore, to interview Co-ordinators on three occasions to provide a longitudinal perspective on their aims, activities and achievements during the life of the initiative. The first interview was to be in the early months after their appointment to learn about early experiences and plans and aspirations for the future; the second after about a year in post, to concentrate on achievements so far and changes made to their activities; and the third towards the end of their tenure to focus on a retrospective view of their work and impact and on the sustainability of health, work and well-being activity.

Data were collected in three waves of in-depth interviews. Data extraction from transcripts from the recorded interviews was managed, in each case, by the researcher who conducted the interview, using thematic charts based on a Framework approach. The details of how each wave was conducted are set out below.

A.3.1 Wave 1

Wave 1 in the series of qualitative interviews with Co-ordinators took place during March and April 2010. Members of the research team had already met some of the Co-ordinators at the launch of the initiative in 2009, and at subsequent administrative meetings. The Co-ordinators were expecting to be approached by a researcher from SPRU, and were able to make appointments relatively quickly for a research interview.

One Co-ordinator post was shared by two people, and in one region the role was being handed over from a person who had been 'holding' the post pending arrival of the Co-ordinator. As a result of these arrangements, there were 12 interviews overall, in which 13 people took part.

The purpose of these first interviews in the series was to gather contextual and baseline information to enable the research team to follow what happened in each region but also to see the overall picture, and look for general patterns and implications for good practice and sustainability. Two members of the research team conducted the interviews, using a semi-structured topic guide (Appendix C). The researchers steered discussion across areas including:

- details of the appointment, administrative arrangements, and concept of role;
- goals, regional issues, and main activities and experiences thus far;
- experiences of working with the Challenge Fund;
- ways of monitoring progress, and achieving sustainability.

Each interview took place at a government office from which the Co-ordinator worked, and most took between one and a half hours and two hours. The Co-ordinators gave permission for the interviews to be recorded, and recordings were transcribed for analysis.

The researchers took away copies of some of the key documents available, such as Co-ordinators' business plans, activity summaries, and leaflets about other health and well-being initiatives already operating in the region. Following the interviews, some Co-ordinators sent further documents electronically, when they became available.

A.3.2 Wave 2

The second wave of interviews with the same Co-ordinators was conducted at the end of 2010.

The purpose of the second wave of interviews was to gain a picture of developments since the first interview; the Co-ordinators' experiences of progress made, and activities undertaken. There was particular interest in any changes in expectations or goals, and what had influenced these, and any new issues arising.

The interviews were conducted by the same researchers who had met the Co-ordinators in the first wave. The topic guide used in interviews is at Appendix C.

A.3.3 Wave 3

A third wave of in depth interviews was conducted with Co-ordinators at the end of 2011. These interviews were conducted mainly by telephone, apart from two in which the researcher met face-to-face with two people who had been appointed during 2011 when two of the original Co-ordinators moved on to new posts. All the interviews in wave 3 were conducted by one researcher who had been engaged on this series of interviews throughout.

The topic guide used is at Appendix C. The final interview was designed to provide information about the main directions of the Co-ordinators' work during the past year; their views on what had worked well and the contributory factors, and the main challenges they had met. Co-ordinators reflected on their experience of the Challenge Fund and lessons learned from this initiative. They discussed how their work would be sustained beyond the period of DWP funding.

A.4 Interviews with Directors of Public Health

In order to understand the wider regional and strategic contexts within which the Health, Work and Well-being Co-ordinator role and Challenge Fund were being implemented, interviews were conducted with a senior public health official in each of the 11 regions. An intended second wave of interviews (to coincide with the third and final Co-ordinator interviews) was abandoned because of changes in personnel and structural changes in responsibility for public health.

In each region, the relevant individual to speak with was identified with the assistance of the Co-ordinator. In all but one case, the senior official identified for consultation was the Co-ordinator's direct line manager. In the one exception, the respondent was the Co-ordinator's 'second line manager', i.e. the person to whom the Co-ordinator's direct line manager reported. In one region, both the direct and second line manager took part in interviews. Thus, a total of 12 interviews were conducted during this phase of data collection.

Interviews were carried out between March and June 2010. In all but one region, the interview with the senior official took place after the initial interview had been carried out with the respective Co-ordinator.

Interviews were conducted using a semi-structured topic guide (included as Appendix D). Main themes discussed included:

- the respondent's role with the Co-ordinator and Challenge Fund project;
- the fit of the health, work and well-being project alongside other activity on workplace well-being in this region;
- progress in the health, work and well-being project thus far; and
- reflections on the Co-ordinator model for promoting health, work and well-being .

All interviews were conducted face-to-face and took place in the workplace of the senior official concerned. Interviews lasted around 45-60 minutes and all participants gave their consent for the interview to be audio recorded for transcription.

Data extraction from the transcripts was managed, in each case, by the researcher who had conducted the interview, using thematic charts based on a Framework approach (Ritchie, Spencer and O'Connor, 2003).

A.5 Survey of organisations in contact with Co-ordinators

The aim of the survey of organisations in contact with Co-ordinators was to analyse the relationship between the Health, Work and Well-being Co-ordinators and organisations and firms with whom they had made contact. Data were collected on the nature and frequency of contacts between them, the health and well-being issues and problems facing organisations and the changes in these over the course of their contact with a Co-ordinator. The survey was an attempt to measure, as far as possible, the perceived impact of the Co-ordinators from the perspectives of the organisations they were trying to help and influence.

The sample for the survey was generated by asking Co-ordinators to record all their contacts (by telephone, email or face-to-face) over three two-week periods between July 2010 and March 2011. A sample of 473 was generated in this way. The target for achieved interviews was 250 although this was exceeded in practice; 279 organisations eventually took part. In this way it was possible to generate a sampling frame for the survey but it is not possible to claim any representativeness for it

Table A.2 shows details of the responses.

Table A.2 Survey responses

	Number	%
Contacts recorded by Co-ordinators	473	100
Screened out or incomplete interviews – i.e. respondent had no recall of any contact with a Co-ordinator	27	6
Refusals	34	7
No reply to attempts at contact	53	11
Contacts not used (because target reached)	87	18

Of the 386 contacts attempted 272 successful interviews were conducted, producing a response rate of 70 per cent.

The questionnaire used in the survey is reproduced in Appendix E.

A.6 Follow-up depth interviews from the survey of organisations in contact with Co-ordinators

The aim of the follow-up interviews was to explore in-depth issues arising from the survey of organisations in contact with Co-ordinators and other components of the research design. In consultation with DWP the issues identified as worthy of further exploration were absenteeism and presenteeism, workplace stress, diet and weight, organisational culture towards health and well-being, networking, and sustainability. Twenty telephone interviews were to be conducted in autumn 2011.

A.6.1 Selection and recruitment

Responses to the survey of organisations in contact with Co-ordinators were used to select organisations for interview. Only those who had indicated at the end of the survey that they were willing to be contacted again by the research team were considered for selection for interview (235 organisations out of a possible 279).

As well as attempting to recruit an interviewee from each of the 11 regions/countries[5], selection prioritised SMEs according to DWP's interest in Co-ordinators' work with smaller employers. Only 21 respondents from the survey of organisations in contact with Co-ordinators who were willing to be re-contacted were identified as SMEs. Further guidance in the selection process was provided by an 'index of interest' which was drawn up according to the issues for exploration identified by DWP and using survey responses. This index gave organisations a score where they described:

- high levels of absenteeism, presenteeism, work-related stress, poor diet or weight issues;
- an impact attributable to their contact with the Co-ordinator on workplace culture, or networks;
- a higher percentage of positive impacts (attributed to their contact with the Co-ordinator) that would definitely be long-lasting.

We aimed to interview respondents with higher scores where possible and to ensure that each issue of interest was covered. Not all SMEs were considered for a follow-up interview because they did not score highly on the index of interest. Thus, the initial selection of 20 organisations also included a number of larger organisations.

After the initial selection, researchers got in touch by phone with the named contact in each case to invite them to take part in an interview. At this point some people felt unable to spare time and declined to take part. Further selection resulted until 20 participants were recruited. Nineteen people were eventually interviewed; it was not possible to re-contact one person who was unavailable at the agreed date and time of the interview.

A.6.2 Interviews

Nineteen follow-up interviews were carried out in November and December 2011. Table A.3 outlines the characteristics of the participant organisations according to the selection criteria. The table illustrates the coverage of the issues that were of interest to DWP. It was possible for organisations to have more than one identified workplace health problem; to identify an impact on culture and networks, or neither; and to perceive no sustainable impacts. All except two of the 11 regions/countries were represented.

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5 The 11 public health regions in Great Britain are: Scotland, Wales, North East, North West, Yorkshire and Humber, East of England, South East, South West, London, East Midlands and West Midlands.

Table A.3 Characteristics of participant organisations

		Number of organisations
Organisation size	SME	7
	Larger organisation	12
Identified problems	Absenteeism	8
	Presenteeism	8
	Work-related stress	11
	Diet	4
	Weight	5
Identified Co-ordinator impact	Workplace culture	11
	Networks	12
Sustainable impacts		13
Total		19

Interviews were conducted over the phone by two researchers and lasted no longer than 30 minutes. All interviews were audio recorded with participants' permission and then transcribed. The researchers used a semi-structured topic guide (at Appendix F) to steer discussion across the following topics:

- experiences of health and well-being problems (absenteeism, presenteeism, work-related stress, poor diet, weight) and any changes over time;
- participants' perceptions of workplace culture around health and well-being and any changes over time;
- organisations' involvement in networks and partnerships regarding health, work and well-being and whether involvement is long-lasting;
- where a positive impact was perceived to have resulted from contact with a Co-ordinator, whether these impacts were thought to be long-lasting;
- overall views about the usefulness and impact of contact with a Co-ordinator.

A number of themes were identified as emerging from the data and formed the structure for analysis. A pro forma was completed for each case, allowing data to be extracted and summarised under thematic headings. In each case the interviewer also extracted the data.

A.7 Survey of Challenge Fund winners

There were 73 Challenge Fund awards made in early 2010. All the winning organisations were invited to participate in the survey; no sampling procedures were required. Data were collected on the health and well-being issues and problems facing Challenge Fund winners before receipt of an award, the activities and initiatives set up using the Fund, and their perceived impacts and sustainability.

Fifty-nine responses were received. As shown in Table A.4 the survey achieved an 81 per cent response rate overall. There was a higher proportion of single businesses among the survey respondents compared with partnerships. Single businesses are, therefore, slightly over-represented in the survey.

Table A.4 Challenge Fund Winners Survey – response rate

	Total	Number of respondents	Response rate (%)
Single business/organisation	43	38	88
Partnership	30	21	70
Total	73	59	81

The questionnaire used for the survey is reproduced in Appendix G.

A.8 Case studies of Challenge Fund winners

In order to generate a deeper understanding of the use and impact of the Challenge Fund, 12 case studies were carried out of diverse award holders including partnerships and single businesses. Using case study methodology enabled the collection of contemporaneous data from appropriate actors in different fieldwork sites sources in order to generate a deep understanding of the interaction between decision making, implementation and perceived impacts. This methodology was considered to suit in-depth exploration of a selection of Challenge Fund projects because projects were expected to vary considerably in design, delivery and the personnel involved.

The study design allowed for two waves of data collection: The first wave was to coincide with the early period of firms' and partnerships' implementation of funded interventions, with research enquiry focusing on the background to the bid, existing problems with staff sickness or absence (if any), and plans/early experiences regarding use of Challenge Fund monies and expectations about effects. The second wave was planned to take place a year later (in 2011, after the funding had ended) and was intended to focus on impacts and plans for the future.

A.8.1 Case selection and recruitment

The overall aim of the selection process was to choose 12 projects which provided coverage of a range of organisation sizes and sectors and variation in project design, while also including each of the 11 regions/countries. To enable the selection process, DWP provided a database containing information about the sector and size of the 73 Challenge Fund winning organisations, as well as project start and end dates and the amount awarded. Photocopied sections of the winners' original applications were also supplied, which gave an outline of the proposed project activities. Together, these sources of information enabled selection on the following criteria:

- type of award holder: whether the award holder was a single organisation delivering interventions to its own employees, or a partnership organisation making an offer to local employers and employees;
- kinds of health conditions targeted: for example, whether focused primarily on physical or mental health conditions, or both;
- project scale: whether single or multiple interventions;
- kinds of interventions planned: we sought a variety of interventions across the cases studied;
- whether projects focused on impact at the level of the employee or organisational change: organisational or strategic impacts were more likely to be captured in other aspects of the evaluation (notably interviews with Co-ordinators) so priority was given to gathering employee perspectives;

- **plans for self-evaluation**: not all projects had clear evaluation plans in their bids. We did not exclude these from the selection but we purposively chose some with more developed plans as we expected these to offer good opportunities to explore change against a defined baseline and impact according to identified need.

Across all these criteria the intention was to achieve as wide a coverage as possible. So for example, we wanted to ensure that we included some projects that were focused only on physical health, some focused only on mental health and some that targeted both (as shown in Table A.5).

Table A.5 shows the distribution of key characteristics for the 12 projects selected for case study research.

Table A.5 Characteristics of cases studied

		Selected cases
Bidding organisation		
Single organisation delivering internally		
Private	Micro	1
	Small	3
	Medium	2
Voluntary	Micro	0
	Small	0
	Medium	2
Partnership delivering to local employers		4
Scale of interventions		
Single interventions		4
Multiple interventions		8
Health conditions targeted		
Physical		2
Mental		3
Both		7
Total		12
Kinds of interventions delivered		
Physical exercise		
Stress awareness/management support or training		
Healthy eating advice or campaigns		
Raising general awareness of health conditions		
Workplace champions		
Improving workplace environment		
Complementary therapies		
Health and well-being checks or assessments		
Postural advice		
Support for effective professional practice		
Healthcare provision		

After selecting the 12 projects, an approach letter was sent to a named contact at each organisation, to introduce them to the research and invite them to take part. Researchers followed up the letter with a phone call during which the research was explained in more detail and there was opportunity to ask questions. This phone call was also a chance for researchers to gather information about the project so far, which then informed decisions about when to conduct fieldwork and who to involve.

A.8.2 Wave 1 research visits

The first wave of research visits took place between June and October 2010, which was between three and seven months after projects had been due to commence. This variation in the timing of the fieldwork reflected the aim to collect data at an early stage in project delivery and from a range of people involved in each project. Not all projects started on time, were able to engage participants quickly, or had planned for all elements of their project to start in April 2010. Thus, the research team liaised with project teams and timed visits to ensure that early experiences of implementation and expectations about the development of the project would be captured.

Fieldwork primarily involved conducting individual or group semi-structured depth interviews. However, there were occasions when researchers were invited to observe funded interventions or were given documents providing additional information about projects. Interviews involved people who had an integral role in Challenge Fund projects, which typically included personnel responsible for the design and/or operation of the project, employees participating in the project, and providers involved in delivering interventions. SME managers were also interviewed where appropriate. Tailored information flyers were produced by researchers to be distributed amongst employees or service users in order to attract volunteers for the research interviews. To some extent the recruitment of individuals for research interviews was handled by the project leads or named contacts, though researchers pressed upon them the importance of people choosing to take part willingly.

To guide individual and group interviews a core topic guide was designed (see Appendix H). This guide contained key themes and questions about:

- workplace health and well-being issues and culture prior to applying for the Challenge Fund
- how organisations learned about the Fund and their plans for using the sum awarded
- the role of the Co-ordinator in funded projects
- the expected impact of funded activities, including how organisations themselves were assessing impact
- expectations regarding the sustainability of activities and their impacts.

Each researcher was responsible for tailoring the core topic guide according to the participants involved in each interview (e.g. employee group, provider of intervention). All interviews were audio recorded with participants' permission and transcribed.

A.8.3 Wave 2 research visits

Follow-up visits were carried out as near as possible to 12 months after the initial visit – from August–November 2011. The aim was to repeat individual and group interviews with the same participants as at wave 1, asking for their reflections on implementing or taking part in funded activities and any impacts made. Participants were also asked whether activities had been sustained since funding ended, or whether there were plans to sustain or repeat activities in the future.

The research team encountered problems arranging fieldwork where those leading projects had left the organisation, or had many demands on their time and were hard to contact. This led to delays in some cases, and meant that one organisation dropped out of the research. In general fewer people took part in the wave 2 interviews/group discussions than at wave 1. Sometimes this was explained by staff of single organisations having left employment, or facing heavy work demands on the day of the research visit, though re-gaining access to staff also proved hard where managers were unwilling to allow staff time to take part again. In partnership projects not all service users' who had taken part in wave 1 were re-contactable because their contact details had changed.

As at wave 1, researchers conducted individual and group interviews and collected written information (such as project self-evaluation reports) and observed any ongoing activities or interventions (where possible). Most interviews were again conducted face-to-face, but some were conducted by telephone where the interviewer and interviewee agreed this was more efficient. Again, interviews were recorded and transcribed.

A new core topic guide was developed (see Appendix H) with focus on the following topics:

- experiences of project implementation and participation;
- the impact of activities on individuals and the workplace, and facilitators and barriers to doing so;
- the difference made to the organisation by receiving money for health and well-being activities;
- ways in which organisations had measured impact;
- experiences of sustaining activities, or plans to sustain or implement future health and well-being activities.

A.8.4 Analysis

Thematic analysis for wave 1 data was conducted using a separate pro forma for each case. Data relating to each case were summarised in coloured boxes under thematic headings, with separate boxes for different participants. The colour of the box signified whether the data was from a project manager, a group of employees or service users, a provider of a service, or another key informant. This kind of data analysis allowed for comparisons both within cases (comparing data sources) and across cases (comparing cases). These comparisons then helped to describe and explain similarities and differences (e.g. in project design, use of the money and impact made), and ensured that explanations remained grounded in the unique context of the cases studied.

Wave 2 data was entered into the same pro formas, underneath the wave 1 data for each single interviewee or group of participants. Wave 2 entries were made in emboldened font to differentiate the text from the wave 1 data. This approach enabled the building of a narrative over time, within each set of participants, within each case.

For wave 1 and wave 2, the researcher who had conducted the interview in each case also extracted and summarised data into the respective pro forma.

Appendix B Interviews with key DWP policy makers

B.1 Topic Guide (February 2010)

Early discussions with policy makers (February 2010)

- How was the programme (11 Co-ordinators plus Challenge Fund) designed?
  - did you have any input here?
- How did the model for the Co-ordinator and Challenge Fund programme emerge?
  - was there a preceding model?
  - how was the time frame set?
- How does it fit alongside other initiatives in this general area (for example, Fit for Work pilots)?
- What are the most important potential advantages and opportunities of the programme?
  - what are the key features that most interest you?
- Are there any perceived areas of uncertainty or doubt about the initiative?
  - are there any 'risks' attached to the programme? ?
- What are your views on implementation of the programme thus far?
  - do you know what the Co-ordinators are currently doing, day to day?
  - how does this match the intention for their roles?
- How will you judge whether the programme is a success?
  - will other actors see success in the same way?
- How will findings from the evaluation feed into policy?
- how might the Co-ordinators' work be sustained and embedded?

Appendix C
Interviews with Co-ordinators

C.1 Wave 1 Topic Guide (March 2010)

Wave 1 interviews with HWWB Co-ordinators (March 2010)

A. Background (5 mins)

Could we start with some basic background, just briefly.

- When did you come into post as the HWWB Co-ordinator for [region]?
- What were you doing before this?
  - *Any concurrent roles being maintained alongside HWWB Co-ordinator?*
  - *Secondment?*
- Did something in particular interest you about the HWWB Co-ordinator role?
  - *Did you think it presented particular opportunities (personally, professionally, regionally)?*
- Could you briefly describe your working arrangements?
  - *Colleagues: line management structures, immediate colleagues, general support or assistance?*
  - *Facilities: office base, suitable location within region, suitable facilities?*
- Can you explain the way in which the Regional Director of Public Health has been involved in the development of the project?

NB: use the above to establish who will be the most relevant person to speak to in this region in a line manager capacity – RDPH or other.

B. Conceptualising the HWWB Co-ordinator role (25 mins)

The HWWB Co-ordinator role is a completely new role. I'd like to spend a bit of time focusing on the nature of the role.

- How do you perceive the role?
- What do you see as the key purposes of what you're doing?
  - *Aims, objectives, main tasks, philosophy*
  - *Probe meaning of key terms – e.g. catalyst, best practice, innovation*
- What has shaped your understanding of the role?
  - *Official sources, own conceptualisation, local strategy*

- Has your understanding changed at all in the first few months since coming into post?
  - *In what ways*
  - *For what reasons?*
- The HWWB Co-ordinator project is one of a number of current initiatives within a broad health and work agenda, aiming to bring the two closer together. Where do you see yourself as fitting into this picture?
- How much autonomy do you have in this role?
  - *How are you finding this way of working?*
  - *Desirable, concerning, exciting, novel?*
- Have you set any particular goals or targets?
  - *Short-term, interim, overall*
  - *(make a note of main points to return to in Section D)*
  - *(be alert to key terms and probe for meaning)*
- You are one of eleven Regional Co-ordinators. How are you finding this way of working?
  - *Are the monthly meetings helpful?*
  - *Scope for/extent of learning, sharing, support*

C. Your region (10 mins)

It will be useful for us to understand something about each of the eleven regions, in terms of employment and health.

- What is the local labour market like, and employment opportunities?
- Are there any particular health issues that are significant in this region?
- Thinking about the attitudes and practices of local employers on health, work and well-being at the moment, what are the main issues to be addressed?
- *[If not already raised]* One of the particular areas of focus for the HWWB Co-ordinator project is mental health. How is this being approached through the project in this region?
  - *Probe re challenges and opportunities (general/specific to this region?)*
- *[If not already raised]* Another specific area of focus is on small and medium enterprises. How is this being approached through the project in this region?
  - *Probe re challenges and opportunities (general/specific to this region?)*
- Thinking about the two-year project as a whole, how you would like things to look by the end of this two year period of work?
  - *What will be different from now?*

D. Progress towards the aims (10 mins)

If we could think now about progress and success.

- Are you planning to monitor and evaluate progress towards your aims for this region?
  - *Prompt re: key issues identified for change*
- In what ways will you be monitoring progress?
  - *Probe for each mentioned, as necessary*
- How will you know that you're having an effect?
- Are you seeing impacts at this early stage?
  - *How are you identifying/recognising these impacts?*

E. Specific activities (15 mins)

If we could think now more concretely about the work you've been involved with so far

- What kinds of activities have you been undertaking so far? [Probe as necessary, much may have been mentioned already in the course of preceding sections; keep it general]
  - *Publicising the role*
  - *Engagement with local businesses*
  - *Engagement with partnerships and networks*
  - *Challenge Fund*
- How has it been going?
  - *What's working well; what would you highlight as key successes so far?*
  - *Where are the challenges, what are the barriers?*
  - *Have you used/needed particular strategies to engage SMEs?*
  - *How is it working bringing together stakeholders from health and employment sectors?*

I have a few specific questions about the Challenge Fund:

- How are things going with the Challenge Fund in this region?
  - *What involvement have you had so far?*
  - *Has it been as you had expected?*
- What kind of bids have you had in this region?
  - *Views on quality, range, focus*
  - *Do you know yet what the set of successful (first round) bids will look like?*
- How do you plan to work with the Challenge Fund winners?
  - *Support, advice, encouragement, monitoring, challenge*
  - *Organisations vs. partnerships – any differences?*

  - *What wider role, if any, do you see for the Challenge Fund winners within the region?*
- Do you plan to work in any particular way with the non-winners?
- How useful will the Challenge Fund be?
  - *In what ways?*
  - *Any risks/downsides?*

F. Reflections so far – and looking forward (10 mins)

- At this stage, what has been the most positive aspect of the work so far?
- What has been the biggest challenge?
- It is still very early in the project. But do you have any views at this stage about how the work might be sustained beyond the two-year timescale?
- What are you most looking forward to?

Thank you very much. That has covered all of my questions. Is there anything else that you think it would be useful to discuss?

C.2 Wave 2 Topic Guide (November 2010)

Wave 2 interviews with HWWB Co-ordinators (November 2010)

A. Context (5 minutes)

Our previous discussion was in (month) when you had been in the post for (x months). We talked about your views and experiences at what was the beginning of the project. So can I start this time by asking how things are going, generally?

B. Perceptions of role (10 minutes)

You have more experience now of working in this new role of HWWB Co-ordinator.

Have there been any changes or developments in your understanding of the role of Co-ordinator, since we last spoke?

what has influenced your thinking here?

Last time you told me how you saw the purposes of the project in this Region. Have your views changed at all?

if so, what has influenced this?

Have there been any changes in your ideas about what the project here might achieve?

what are they now hoping to achieve?

what has influenced any change in thinking?

Are you working towards any particular goals or targets now?

have these changed since we last spoke?

C. Specific activities (10 minutes)

You will have undertaken lots of different activities since we last spoke. There is not time for a detailed account, and we are getting useful snapshot pictures from the diary component of the research. But it would be helpful to think generally about what you have been doing.

What has been the main focus of your day-to-day activities since we last spoke?

what have been your main achievements?

what has gone well? been a disappointment, or hard to achieve?

What kind of balance have you been aiming at, between all the various things you do?

any changes here? what has influenced these?

reasons for preferred balance; what helps/constrains getting the preferred balance?

How far has there been a focus on mental health issues?

what has influenced developments, progress, ideas?

How far has there been a focus on SMEs?

what has influenced progress, developments, ideas?

D. Working arrangements (5 minutes)

Last time we talked in some detail about practical working arrangements, and it would be useful to look at those again.

Have there been any major changes in practical administrative arrangements, I mean location, team, colleagues/related programmes, administrative support?

reasons; impact

Have there been any changes or developments in the involvement in the project of (X)?

reasons; impact

how have you found the working relationship?

What kinds of contacts have you been having with other Co-ordinators?

monthly meetings; other contacts – developments here

what has been useful here?

E. Progress (10 minutes)

When I last spoke to you the project was in its early days. I would like to think now about progress made since then.

Have you used your action plan/business plan to monitor progress towards your aims?

when finalised; how used

any changes made; reasons, impact

Are you monitoring progress in any other ways?

probe for details, usefulness

Are you using any ways of measuring impact?

probe for details, usefulness

Are you seeing any effects of your work, or impacts at this stage?

probe for evidence

is this influencing how you are working/plan to work?

F. Challenge Fund (10 minutes)

Last time we spoke, the Challenge Fund was just getting going. There had been issues about administration, recruitment and selection of winners. We would like to hear about your views and experiences now that the Challenge Fund projects are underway.

How are you working with the Challenge Fund winners?

activities and inputs

In general, how are things going now?

what is working well

what has worked less well/been problematic – how has this been dealt with

In general, how do developments and progress in the Challenge Fund projects match your expectations?

Have you had any involvement with the non-winners, and those initially interested?

activities and outcomes

How useful do you think the Challenge Fund will be?

in what ways

any risks/downsides

Have your views on the Challenge Fund changed since we last spoke?

what have been the influences here?

G. Reflections (10 minutes)

We can now look back on at least six months in your role.

How are you generally feeling about the work you are doing?

What, at this stage, would you say have been key achievements in the role?

What, at this stage, would you say have been the main challenges?

Are you thinking towards the end of the project?

what are the key issues, for the second year of the project?

How will the work be sustained beyond the project timescale?

action for sustainability that is already underway

further plans and options; key players

likely influences

What are you most looking forward to in the later part of the project?

C.3 Wave 3 Topic Guide (October 2011)

Interviews with HWWB Co-ordinators Wave 3 (October 2011)

A. Working Arrangements (15 minutes)

There have been major structural changes within public health while the project has been running. Last time we spoke you were located within:

_____

_____

Have there been any major changes again since then? location; team; colleagues/related programmes; administrative support.

reasons; impact

Initially, _____ was involved, in the role of line manager. Have there been changes in this role and relationship?

reasons; impact

Looking back, what were the main advantages and disadvantages of the location(s) for your role?

What was most useful and less helpful in the way you worked with (RDPH and subsequent)?

significant times/stages

Again, looking back, what has been most useful and less helpful in your contacts with other Co-ordinators? and DWP?

Co-ordinator meetings; informal contacts; significant times/stages

policy branch

B. Main directions and developments of work (20 minutes)

I last spoke to you in _____ What have been your main activities since then?

Looking back across all your work in the role of Regional Co-ordinator:

What do you see as your main achievements? *how enabled; significant times/stages*

What have been the main challenges? *factors and influences; significant times/stages*

How far does this match your aims and plans at the start of the project?

surprises; disappointments

The HWWB initiative was initially designed with a focus on SMEs. How has this worked out in practice for you?

what influenced developments and progress

main achievements; challenges; disappointments

Another aspect of the initiative, as initially conceived, was to be mental health issues. Looking overall, how did this work out for you?

what influenced developments and progress

main achievements; challenges; disappointments

How will your activities and achievements be sustained?

the work; the role

C. Challenge Fund (15 minutes)

Thinking overall about your Challenge Fund projects, did you work with them in the way you had expected?

working relationships; monitoring their use of money; helping them evaluate and report to DWP

How far did their achievements match your expectations?

did they deliver? what contributed to success? main challenges for projects

Looking overall, how useful was the Challenge Fund?

in what ways? any downsides? what changed?

did it enhance your own role, or otherwise?

any wider impacts?

what was the impact of only having one year's funding?

One initial aim was that Challenge Fund activities would be sustained after funding ended. Did this happen?

within Challenge Fund projects; more widely – employers, public health, community

D. Overall reflections (20 minutes)

At this stage when you look back at the overall HWWB and Challenge Fund initiative:

What have been the key achievements in the role of Co-ordinator?

enabling factors and influences

What have been the main challenges? disappointments? failures?

contributory factors

What are the key learning points?

for DWP

for public health

for employers and business community

for self

For each of these, how will what has been learned be sustained beyond the project funding period?

structures; mechanism; funding sources; personnel involved – clarify what is already in place, and what are currently plans or aspirations

Finally, may I ask about your own plans when the DWP funding ends. Will you still be working in this field?

has experience of the Co-ordinator role and the Challenge Fund projects influenced the work you will go on to do?

Appendix D
Interviews with Directors of Public Health

D.1 Topic Guide (April 2010)

Wave 1 interviews with Senior Public Health Personnel

(April 2010)

A. Your role in the HWWB Co-ordinator and Challenge Fund project

How did you first become involved?

own areas of particular interest and expertise

How does workplace well-being fit within your public health agenda?

What has been your main role with the project?

What are the working arrangements between yourself and (name)?

discussion/consultation, line management, frequency and mode of contacts

Are any other key senior public health personnel involved?

Responsibilities

Probe: involvement of Regional Director of Public Health

B. Work and Well-being in this area

Are there particular issues affecting workplace well-being in this region?

health conditions, mental health issues, labour market , small businesses, geography, delivery of health services, attitudes of health professionals

What do you see as the key purposes of the project here?

aims, objectives, goals

How does the project fit within the broader health and work agenda here?

What does the HWWB Co-ordinator project add to what was happening here already?

What opportunities does the project offer here?

How do you see the Challenge Fund component fitting in?

Are there any particular challenges?

for the project?

for your own role?

Do you have any concerns or areas of uncertainty about this way of working?

Do you have any vision of what might have changed by the end of the two-year initiative?

for businesses? mental health?

C. Progress thus far

How closely involved are you with (name)'s activities?

Involvement with business plan/action plan

Directly involved with administration of Challenge Fund?

Have any particular issues arisen about implementation or administration?

How will you know whether the project is having an effect?

What would you like it to achieve?

do you have specific targets?

Are you seeing any impacts at this early stage?

employee health and well-being

attitudes of health professionals

health service organisation/delivery

employer/business policies, and attitudes

D. Reflections

At this stage, what has been the most positive aspect of the project so far?

How do you see your role with the project developing/changing?

Do you have any views at this stage about how the work might be sustained beyond the two-year timescale?

Thank you very much. That has covered all of my questions. Is there anything else that you think it would be useful to discuss?

Appendix E
The survey of organisations in contact with a Co-ordinator

E.1 Survey questionnaire

Health, Work and Well-being Evaluation

Contacts Survey

FINAL VERSION

CONFIDENTIAL

Social Policy Research Unit

1 June 2011

Contacts Survey

Hi, my name is xxxxx and I work for Ipsos MORI, the opinion research company. We are conducting some research on behalf of the Social Policy Research Unit at the University of York, which is an independent research organisation. They have been commissioned by the Department for Work and Pensions to carry out an evaluation of the work of the Health, work and well-being Co-ordinators. This questionnaire is about the contacts that the Health, Work and Well-being Co-ordinators have made with businesses, partnerships and others. Your contact details have been obtained from a survey of the Co-ordinators' activity during 3 2-week periods between July 2010 and March 2011.

We would just like to ask you a few questions about your contacts with the Co-ordinator in your area [insert name of Co-ordinator], the type and frequency of contact, how useful you have found those contacts, and the impact that they had.

Q101 Can I just check, do you recall having contact with the Health, Work and Well-being Co-ordinator since June 2010?
INTERVIEWER PLEASE PROBE AND REMIND RESPONDENT THAT THE DETAILS OF THE ORGANISATION HAVE BEEN PASSED TO US BY THE CO-ORDINATORS AS SOMEONE WHO THEY HAVE BEEN IN SOME FORM OF CONTACT WITH.

Yes – proceed to Interview – section A, Q1.
No – go to Q102

Q102 If no at Q101.
Please can I speak to the person at this business/organisation who has had contact with the Health, Work and Well-being Co-ordinator?

Yes – go to Q103
No – close interview

Q103 If yes at Q103
INTERVIEWER RECORD CONTACT DETAILS OF NEW CONTACT AND APPROACH THEM FOR AN INTERVIEW

Section A: About you and your organisation

Q1 Can I just check your name is [name]
INTERVIEWER TO UPDATE RECORD IF DIFFERENT TO SAMPLE

Q2 And your job title is [jobtitle]
INTERVIEWER TO UPDATE RECORD IF DIFFERENT TO SAMPLE

Q3 And the name of your business/organisation is [organisation]
INTERVIEWER TO UPDATE RECORD IF DIFFERENT TO SAMPLE

Q4 How would you describe your business/organisation?
READ OUT
Private sector
Public sector
Voluntary/community/not-for-profit organisation
Other (please specify)

Q5 If private sector at Q4
How would you describe the nature of your business/organisation?
READ OUT

Manufacturing
Services
Other (please specify)

Q6 If public sector at Q4
How would you describe the nature of your business/organisation?
READ OUT

Public sector – NHS
Public sector – education
Public sector – Local Authority
Public sector – civil service
Public sector – other (please specify)

Q7 If Voluntary/community/not-for-profit organisation or other at Q4
Could you please describe the type of organisation?

[open ended]

Q8 How would you describe the size of your business/organisation?
READ OUT INCLUDING BRACKETS

Micro (1-9 employees)
Small (10-49 employees)
Medium (50-250 employees)
Large (over 250 employees)

CLOSE INTERVIEW IF THERE ARE NO LONGER ANY EMPLOYEES AT ORGANISATION (i.e. NULL)

Section B: Health and well-being in your organisation

Q9 Thinking back to a year ago, to what extent were the following a problem within your business or organisation? Please answer on a scale from 1 to 5 where 1 is not a problem and 5 is a significant problem.
ROTATE STATEMENTS but force 'Other mental health problems' to come immediately after 'Work-related stress'.
ALLOW DON'T KNOW/NOT APPLICABLE
READ OUT

High levels of absence/absenteeism
People coming into work when unwell, sometimes called presenteeism
High levels of staff-turnover
Work-related stress
Other mental health problems [prompt with 'for example, anxiety, depression etc' if clarification required]
Physical health problems
Poor diet amongst employees
Weight issues amongst employees
Other (please specify)

Q10 Which of the following statements best described the culture regarding health and well-being in your business or organisation a year ago? By culture we mean policies, procedures and initiatives.
READ OUT
ALLOW DON'T KNOW

Little recognition of health and well-being in the workplace
General interest in health and well-being in the workplace
Good awareness of health and well-being in the workplace

Q11 Which, if any of the following statements applied to your business or organisation a year ago? Please answer yes or no to each statement.
FOR EACH ANSWER YES OR NO
READ OUT

There was awareness of specific needs for health and well-being support
Health and well-being initiatives were already in place
There were plans in place to introduce health and well-being initiatives
There was no money available to implement health and well-being initiatives

Section C: Your first contact with the Health, Work and Well-being Co-ordinator

We are contacting you because our records show that you have had contact with [insert name] – the Co-ordinator in your region/country – within the last 12 months.

Q12 ASK ALL
Can you remember when your business/organisation first had contact with the Co-ordinator?
NOTE TO INTERVIEWER: THE Co-ordinator IN THIS REGION IS CALLED: [INSERT NAME]

[Month and year]
Don't know

Q13 How was this first contact made?

At a conference
At a business meeting
At a networking event
By telephone
By email
Other (please specify)
Don't know

Q14 Who initiated this first contact?

You
Someone else in your business/organisation
The Co-ordinator
Don't know

Q15 What was this first contact about?

[open-ended]
Don't know

Section D: Level of contact with the Co-ordinator

Q16 How many face-to-face meetings have you had with the Co-ordinator in the last 12 months?
ALLOW DON'T KNOW
[numeric]

Q17 How many telephone conversations have you had with the Co-ordinator in the last 12 months?
ALLOW DON'T KNOW
[numeric]

Q18 How many emails have you received from the Co-ordinator in the last 12 months?
ALLOW DON'T KNOW
[numeric]

Q19 Would you have liked more, the same, or less [TEXT SUBSTITUTION: face to face/email/ telephone] contact with the Co-ordinator over the last 12 months?

	More	The same	Less
Face-to-face			
Email			
Telephone			

Q20 What was the purpose of your contacts with the Co-ordinator over the last 12 months?
ANSWER YES OR NO TO ALL
ROTATE STATEMENTS, BUT FORCE 'The Co-ordinator contacted me about another issue (please specify)' TO COME AFTER The Co-ordinator contacted me about my Challenge Fund application'
READ OUT
Looking for information or advice regarding health and well-being in my organisation
Looking for funding for health and well-being initiatives
Joining or setting up networks
The Co-ordinator contacted me about my Challenge Fund application
The Co-ordinator contacted me about another issue (please specify)
Attending a conference/event organised by the Co-ordinator
Receiving regular newsletters
Discussion of the Health, Work and Well-being Challenge Fund
Other (s) – please specify

Q21 Have you ever heard of the Health, Work and Well-being Challenge Fund?

Yes – go to Q22
No – go to Q28

Q22 ASK IF YES AT Q21
Did you receive money from the Health, Work and Well-being Challenge Fund?

Yes – go to Q27
No – go to Q23

Q23 ASK IF NO AT Q22
Did you submit an expression of interest form?

Yes – go to Q25
No – go to Q24

Q24 ASK IF NO AT Q23
Could you explain why you did not submit an expression of interest for the Challenge Fund?
[open-ended] then go to Q27

Q25 ASK IF YES AT Q23
Did you submit a full application form?
Yes – go to Q27
No – go to Q26

Q26 ASK IF NO AT Q25
Could you explain why you submitted an expression of interest, but did not go on to submit a full application form?
[open-ended] then go to Q27

Q27 ASK ALL WHO HAVE HEARD OF OR THE HEALTH, WORK , AND WELL-BEING CHALLENGE FUND (YES AT Q21)
Thinking about the contact you have had with the Co-ordinator regarding the Challenge Fund over the last 12 months, how useful would you say this has been?
READ OUT

Very useful
Useful
Not very useful
Not at all useful

DO NOT READ OUT
Not applicable; I have heard of the Challenge Fund but have not had any contact with the Co-ordinator about the Challenge Fund over the last 12 months.

Q28 ASK ALL
Thinking about the contact you have had with the Co-ordinator about things other than the Challenge Fund over the last 12 months, how useful would you say this has been ?
READ OUT

Very useful
Useful
Not very useful
Not at all useful

Q29 ASK ALL
How would you rate the level of support you have received from the Co-ordinator over the last 12 months?
ALLOW DON'T KNOW OR NOT APPLICABLE, BUT DO NOT READ OUT
READ OUT

Exactly right for our needs
Adequate
Not sufficient for our needs

Q30 ASK IF ADEQUATE (CODE 2) OR NOT SUFFICIENT (CODE 3) AT Q29
What (more) could they have done to support you/what additional support did you need?
[open-ended]

Q31 ASK ALL
Thinking ahead, what support, if any, would you like from the Co-ordinator in the future?
[open-ended]

Section D: The impacts of contact with the Co-ordinator

Q32 ASK ALL
Would you say that your contact with the Co-ordinator during the last year has had an impact in any of the following ways? Please specify whether the impact has been a great deal, in some ways, or not at all.
ROTATE STATEMENTS, but force 'other impacts, please specify' to come at end of list
ALLOW DON'T KNOW
READ OUT

	Yes – a great deal	Yes – in some ways	No
Formation of new networks/partnerships			
Improved health and well-being in our organisation			
Made us more aware of the health and well-being agenda			
Helped us to get a Challenge Fund award			
Encouraged us to start new health and well-being projects or initiatives			
Staff are eating healthier food			
Staff have lost weight			
Led to a fall in sickness absence rates			
Improved staff relations			
Improved our health and well-being policies			
Other impacts (please specify)			

Q33 [Populate to ask about each impact specified AS YES A GREAT DEAL/YES IN SOME WAYS in Q32]
And thinking about each of the areas in which your contact with the Co-ordinator has had an impact, do you think this impact or change will be long-lasting?
ALLOW DON'T KNOW

	Definitely	Possibly	No
A			
B			
C etc			

Q34 Thinking about now, to what extent are the following a problem within your business or organisation? Please answer on a scale from 1 to 5 where 1 is not a problem and 5 is a significant problem.
SINGLE CODE FOR EACH
ROTATE STATEMENTS but force 'Other mental health problems' to come immediately after 'Work-related stress'.
ALLOW DON'T KNOW/NOT APPLICABLE
READ OUT
High levels of absence/absenteeism
People coming into work when unwell, sometimes called presenteeism
High levels of staff-turnover
Work-related stress

Other mental health problems
Physical health problems
Poor diet amongst employees
Weight issues amongst employees
[pull any others specified in 'others' at Q9]
Other (please specify)

Q35 Thinking about now, which of the following best describes the culture regarding health and well-being in your business or organisation? By culture we mean policies, procedures and initiatives.
SINGLE CODE
ALLOW DON'T KNOW
READ OUT
Little recognition of health and well-being in the workplace
General interest in health and well-being in the workplace
Good awareness of health and well-being in the workplace

Q36 Thinking about now, which, if any of the following statements apply to your business or organisation? Please answer yes or no to each statement.
FOR EACH ANSWER YES OR NO
ALLOW DON'T KNOW
READ OUT
There is an awareness of specific needs for health and well-being support
Health and well-being initiatives are in place
There are plans in place to introduce health and well-being initiatives
There is no money available to implement health and well-being initiatives

Section E: Overall view of the Co-ordinator

Q37 We are also interested in your overall views of the Co-ordinator and the impact that they have had. To what extent do you agree or disagree with the following statements?

Strongly agree
Tend to agree
Neither agree nor disagree
Tend to disagree
Strongly disagree

ALLOW DON'T KNOW
READ OUT
ROTATE STATEMENTS

The Co-ordinator has really made a big difference
The Co-ordinator has helped us think differently about health and well-being in the workplace
Overall, our contact with the Co-ordinator has not led to any significant changes
The Co-ordinator has helped us to access funds or services we would not have otherwise done
We have been disappointed with the contact with the Co-ordinator
The Co-ordinator has provided information on health and well-being in the workplace

Q38 Do you have any other comments about your contact with the Co-ordinator, the support you have received or the impact that they have had?
ALLOW NOT APPLICABLE/NULL
[open-ended]

Q39 Thank you for helping with the evaluation of the work of the health, work and well-being Co-ordinators. Please be assured that neither ourselves nor the University of York will pass on your individual responses to the Department for Work and Pensions, or any other third party.

The Social Policy Research Unit at the University of York would like to analyse your individual responses, so that they can understand more about the work of the Co-ordinators. Are you happy for us to pass on these individual responses for research purposes only?

Yes
No

Q40 Could the Social Policy Research Unit contact you again for future research?
NOTE TO INTERVIEWER: SPRU WILL BE CARRYING OUT SOME IN-DEPTH INTERVIEWS WITH A HANDFUL OF PARTICIPANTS IN THE NEXT FEW MONTHS

Yes
No

Q41 IF YES AT Q40
Could you confirm your contact details for re-contact purposes?

Address
Email
Telephone

E.2 Construction of an 'overall level of contact' indicator

Using responses to questions 16-18 in the survey on face-to-face contacts, telephone calls and emails, the data were grouped into three categories each:

1 – no use of method of contact

2 – some use (= 1-9 face-to-face, 1-9 telephone contacts, 1-40 email contacts)

3 – large use (= 10+ face-to-face, 10+ telephone contacts, over 40 email contacts)

Table E.1 Face-to-face contact withCo-ordinator

	Frequency	*Per cent*
No face-to-face meetings	19	7
1 to 9 face-to-face meetings	222	80
10 or more face-to-face meetings	38	14
Total	279	100

Table E.2 Telephone calls with Co-ordinator

	Frequency	*Per cent*
No telephone conversations	55	20
1 to 9 telephone conversations	171	61
10 or more telephone conversations	53	19
Total	279	100

Table E.3 Email contacts with Co-ordinator

	Frequency	*Per cent*
No emails	15	5
1 to 40 emails	226	81
More than 40 emails	38	14
Total	279	100

The table below is a 3x3x3 matrix combining the tables above. So, for example we have 2 respondents who apparently had no contact whatsoever (top left cell).

Table E.4 Summary of type and frequency of contacts

		No telephone conversations	*1 to 9 telephone conversations*	*10 or more telephone conversations*
No emails	No face-to-face meetings	2	3	–
	1 to 9 face-to-face meetings	7	3	–
1 to 40 emails	No face-to-face meetings	7	7	0
	1 to 9 face-to-face meetings	37	140	18
	10 or more face-to-face meetings	0	9	8
More than 40 emails	1 to 9 face-to-face meetings	1	8	8
	10 or more face-to-face meetings	1	1	19

Method to generate an indicator of 'overall level of contact':

- Sum the codes (1, 2 or 3) representing the categories of each variable above to derive 'Overall degree of contact with co ordinator'.
- This scale ranges from 3 to 9 the higher the scale value, the more contact.

Table E.5 Overall degree of contact with co ordinator

Overall degree of contact with Co-ordinator	*Frequency*	*Per cent*	*Descriptive label*
3	2	1	Lower
4	17	6	Lower
5	47	17	Lower
6	141	51	Middle
7	36	13	Higher
8	17	6	Higher
9	19	7	Higher
Total	279	100	

Table E.6 Summary of overall degree of contact with co ordinator

Overall degree of contact with Co-ordinator	*Frequency*	*Per cent*
Lower	66	24
Middle	141	51
Higher	72	26
Total	279	100

Appendix F
Follow-up depth interviews from the Contacts Survey

F.1 Topic Guide

HWWB Contacts Survey – qualitative follow-up interviews

Researcher introduction

- Thank you for your time today. We appreciate your taking part in this research.
- This piece of work is part of a wider evaluation of the work of HWWB Co-ordinators and the Challenge Fund, commissioned by DWP. SPRU is independent of DWP.
- We are attempting to find out what can help improve health and well-being in the workplace. We're as interested to hear about the challenges as the successes – both are important for learning.
- You took part in a survey in the summer and kindly said you would be prepared to participate in the research again if necessary.
- We have now analysed the survey data and identified a number of areas where more information and depth would be useful. These are on:
  - Absenteeism, presenteeism, stress at work and diet and weight.
  - Workplace culture around health and well-being and networking.
  - Long term impacts.
- We have selected a small number of organisations from the survey respondents (including you) with whom we would like to explore these areas further.
- The research is entirely voluntary and information will be kept in strict confidence within the research team. We will write a report for DWP at the end of the study which will include the views of the people who have taken part, but we will not identify individual participants or organisations.
- The interview is expected to last for 30 minutes.
- Invite any questions.
- Explain about audio recording and verbal consent.
- Ask for permission to proceed.

First of all, can I check:

- the name of the Co-ordinator(s)
- the kind of business/organisation you work for

Section A – Experiences of health and well-being problems

In the survey we asked you about a range of possible health and well-being problems, including sickness levels (or absenteeism), people coming to work when not fully fit (sometimes called presenteeism), stress among staff, diet and weight. We asked you to say on a scale of 1-5 how bad a problem these things were around the time you had your first contact with the Co-ordinator and also at the time we were speaking to you. 1 meant no problem, and 5 meant a significant problem.

Don't worry about trying to remember what you said – I have your answers here. What I would like to do now is understand a bit more about the changes that you said had taken place.

Absenteeism

INTERVIEWER INSTRUCTION

Select appropriate question using table below. Repeat question for presenteeism, stress at work and diet and weight.

Initial score (Q9 in survey)	Later score (34 in survey)	Question to ask below
1	1	A – No problem -> No problem
	2-5	B – New problem
2	1	C – No longer a problem
	2	F – No change
	3-5	E – Problem worse
3	1	C – No longer a problem
	2	D – Improvement
	3	F – No change
	4-5	E – Problem worse
4	1	C – No longer a problem
	2-3	D – Improvement
	4	F – No change
	5	E – Problem worse
5	1	C – No longer a problem
	2-4	D – Improvement
	5	F – No change

INTERVIEWER INSTRUCTION

In probing responses below we are interested in the reasons behind any change. In analysis we will probably want to distinguish between the following:

- External factors (such as labour market changes)
- Internal action/initiatives by the management/organisation)
- Staff influences
- Role of Co-ordinator

A – No problem -> No problem

You said absenteeism was not a problem before your first contact with the Co-ordinator and still wasn't when we interviewed you. Is that still the case?

- If not, explore reasons for change, and
- Role of Co-ordinator

B – New problem

You said absenteeism was not a problem before your first contact with the Co-ordinator but it was when we interviewed you.

- Explore reasons for change, and
- Role of Co-ordinator
- How is the problem now?

C – No longer a problem

You said absenteeism was a problem before your first contact with the Co-ordinator but not a problem when we interviewed you.

- Explore reasons for change, and
- Role of Co-ordinator
- How is the problem now?

D – Improvement

You said absenteeism was a problem before your first contact with the Co-ordinator but less of a problem when we interviewed you.

- Explore reasons for change, and
- Role of Co-ordinator
- How is the problem now?

E – Problem worse

You gave absenteeism a score of [INSERT SCORE] before your first contact with the Co-ordinator and a higher score when we interviewed you.

- Why do you think this problem has got worse?
- Role of Co-ordinator
- How is the problem now?

F – No change

You gave absenteeism a score of [INSERT SCORE] before your first contact with the Co-ordinator and the same score when we interviewed you.

- Why do you think there has been no improvement?
- Role of Co-ordinator
- How is the problem now?

INTERVIEWER INSTRUCTION

Repeat Section A for presenteeism, stress, diet and weight

Note where there has been a positive impact on any of the five problems above. These will be needed for Section C.

SECTION B – Culture and networking

Culture

One of the aims of the whole health and well-being initiative (INTERVIEWER: reference the Black Review if helpful) is to change the 'culture' of workplaces towards health and well-being. Does this sound familiar/do you think in these terms?

- How would you describe the culture here now? (attitudes, atmosphere, behaviours ...)
- How has it changed between the time of your first contact with [NAME OF CO-ORDINATOR] and now?
- Can you explain how/why the culture is different now?
- Role of Co-ordinator

Networking

We asked in the survey about networks and partnerships around health, work and well-being.

- Can you tell me more about what networks/partnerships you are involved in?
    - How do they work? (e.g. face-to-face, virtual; meetings, newsletters, internet forums)
    - (if networks are not specifically for health and well-being) Are aspects of health and well-being incorporated in these networks? How?
- Usefulness/impact/disappointment
- Perception of whether networks/partnerships are long-lasting
- Role of Co-ordinator

INTERVIEWER NOTE

Survey response to question about Co-ordinator impact on networking will be available as context for discussion.

SECTION C – Sustainability

INTERVIEWER INSTRUCTION

Refer to responses to Section A. For each problem where there has been a positive impact select appropriate question using table below.

Problems	Positive impact perceived	Co-ordinator impact perceived (Q33 in survey)	Question to ask below
Absenteeism	Yes	Yes	A – Survey response
		No	B – No survey response
	No	N/A	No question to ask
Presenteeism	Yes	N/A	B – No survey response
	No	N/A	No question to ask
Stress	Yes	N/A	B – No survey response
	No	N/A	No question to ask
Diet	Yes	Yes	A – Survey response
		No	B – No survey response
	No	N/A	No question to ask
Weight	Yes	Yes	A – Survey response
		No	B – No survey response
	No	N/A	No question to ask

A – Survey response

In the survey you said contact with the Co-ordinator had led to improvements in (problem).

We then asked if this impact would be long lasting so this next question is about sustainability. In the survey you said the impact would [DEFINITELY/POSSIBLY/NOT] be long lasting.

- Can you explain why said you this?
- Do you still think the same?

B – No survey response

We have already talked about improvements regarding (problem). Do you think these will be long-lasting?

- Probe for reasons

SECTION D – Overall assessment of Co-ordinator contact

INTERVIEWER INSTRUCTION

FROM ANSWERS SO FAR SUMMARISE LEVEL OF CONTACT WITH CO-ORDINATOR

For example *'so far you have told me that [NAME OF CO-ORDINATOR] has been involved in dealing with [absenteeism, presenteeism, stress, diet and weight] and in you getting involved in [network/ partnership]...'*

- Has the Co-ordinator been involved in anything else?
- Are you still in contact with [NAME OF CO-ORDINATOR]
    - What is happening?
- Do you need/want help in the future?
- How might a Co-ordinator best support you in the future?

INTERVIEWER INSTRUCTION

End interview. Thank respondent.

Appendix G
Survey of Challenge Fund winners

G.1 Survey questionnaire

Health, Work and Well-being Evaluation

Challenge Fund Winners Survey

FINAL VERSION

CONFIDENTIAL

Social Policy Research Unit

April 2011

Challenge Fund Winners Survey

Hi, is that <name> at <company>? My name is xxxx and I'm calling from Ipsos MORI. We have been commissioned by the Social Policy Research Unit at the University of York to assist with the evaluation of the Health, Work and Well-being Challenge Fund. You should have received a letter from Linda Cusworth at the University of York about the evaluation? We would like to discuss with you your application for funding, how you spent the grant, the impact it had, and your future plans. Your responses will not affect the money you received from the Challenge Fund. Is now a convenient time or would you like to make an appointment?

Section A About you and your business/organisation

Q1. ASK ALL
Did you apply to the Challenge Fund as a single business/organisation, or as a party to a local partnership?
SINGLE CODE
single business or organisation (GO TO Q2)
partnership (GO TO Q5)

Q2. IF SINGLE BUSINESS/ORGANISATION AT Q1
How would you describe your business/organisation?
SINGLE CODE
READ OUT
private sector (GO TO Q3a)
public sector (GO TO Q3b)
voluntary/community/not for profit (GO TO Q4)
other (**please specify**) (GO TO Q4)

Q3a. IF PRIVATE SECTOR AT Q2
How would you describe the nature of your business/organisation?
SINGLE CODE
READ OUT
manufacturing (GO TO Q4)
services (GO TO Q4)
other (**please specify**) (GO TO Q4)

Q3b. IF PUBLIC SECTOR AT Q2
How would you describe the nature of your business/organisation?
SINGLE CODE
READ OUT
NHS (GO TO Q4)
Education (GO TO Q4)
local authority (GO TO Q4)
civil service (GO TO Q4)
other (**please specify**) (GO TO Q4)

Q4. IF SINGLE BUSINESS AT Q1
How would you describe the size of your business/organisation?
SINGLE CODE
DO NOT READ OUT
micro, from 1-9 employees (GO TO Q7)
small, from 10-49 employees (GO TO Q7)
medium, 50-250 employees (GO TO Q7)
large, over 250 employees (GO TO Q7)

Q5. IF PARTNERSHIP AT Q1
How many other partners were involved in your application to the Challenge Fund?
(Interview instruction: Participants can refer to bid document if necessary)
OPEN ENDED TEXT
Allow DK

Q6. IF PARTNERSHIP AT Q1
In your application to the Challenge Fund, how many different employers (that is, businesses or organisations) did you say you would deliver services to? (Interview instruction: Participants can refer to bid document if necessary)
OPEN ENDED TEXT
Allow DK

Section B Before the Challenge Fund

READ OUT
The next section relates to health and well-being in the workplace prior to your application for the Challenge Fund grant.

Q7a. IF SINGLE BUSINESS AT Q1
Before you applied to the Challenge Fund, to what extent were the following a problem within your business or organisation? Please answer on a scale from 1 to 5 where 1 is not a problem and 5 is a significant problem.
SINGLE CODE FOR EACH
READ OUT
High levels of absence/absenteeism
People coming into work when unwell, sometimes called presenteeism
High levels of staff-turnover
Work-related stress
Other mental health problems
Physical health problems
Poor diet amongst employees
Weight issues amongst employees
Don’t know/not applicable

Q7b. IF PARTNERSHIP AT Q1
Before you applied to the Challenge Fund, to what extent were the following a problem within the businesses you work with? Please answer on a scale from 1 to 5 where 1 is not a problem and 5 is a significant problem.
SINGLE CODE FOR EACH
READ OUT
High levels of absence/absenteeism
People coming into work when unwell, sometimes called presenteeism
High levels of staff-turnover
Work-related stress
Other mental health problems
Physical health problems
Poor diet amongst employees
Weight issues amongst employees
Don't know/not applicable

Q8. ASK ALL
Were there any other health and well-being issues that you were aware of, before you applied to the Challenge Fund?
OPEN ENDED
Very well
Null

Q9a. IF SINGLE BUSINESS AT Q1
Before you applied to the Challenge Fund, how well would you say that absences due to ill-health/health conditions were recorded and monitored within your business or organisation?
SINGLE CODE
Very well
Fairly well
Not very well
Not at all
(DO NOT READ OUT) Not sure

Q9b. IF PARTNERSHIP AT Q1
Before you applied to the Challenge Fund, how well would you say that absences due to ill-health/health conditions were recorded and monitored in the businesses you work with?
SINGLE CODE
Very well
Fairly well
Not very well
Not at all
(DO NOT READ OUT) Not sure

Q10a. ASK IF SINGLE BUSINESS AT Q1
Which of the following best describes the culture regarding health and well-being in your business or organisation, prior to your application to the Challenge Fund? By culture we mean policies, procedures and initiatives.
SINGLE CODE
READ OUT
Little recognition of health and well-being in the workplace
General interest in health and well-being in the workplace
Good awareness of health and well-being in the workplace

Q10b. ASK IF PARTNERSHIP AT Q1
Which of the following best describes the *culture* regarding health and well-being in the businesses that you work with, prior to your application to the Challenge Fund? By culture we mean policies, procedures and initiatives.
SINGLE CODE
READ OUT
Little recognition of health and well-being in the workplace
General interest in health and well-being in the workplace
Good awareness of health and well-being in the workplace

Q11a. ASK IF SINGLE BUSINESS AT Q1
Before you applied to the Challenge Fund, were there any initiatives in place at your business or organisation to promote good health and well-being among staff?
SINGLE CODE
yes (**please specify**)
No

Q11b. ASK IF PARTNERSHIP AT Q1
Before you applied to the Challenge Fund, were there any initiatives in place to promote good health and well-being among staff in the businesses you work with?
SINGLE CODE
yes (**please specify**)
no

Section C Your application to the Challenge Fund

Q12. ASK ALL
How did you *first* find out about about the Challenge Fund?
SINGLE CODE
PROMPT IF NECESSARY
from the Health, Work and Well-being Co-ordinator
from a DWP source
via a business network/forum
at a conference
trade associations or bodies
other (**please specify**)

Q13a. ASK IF SINGLE BUSINESS AT Q1
At the time you applied to the Challenge Fund, which, if any of the following statements applied to your business or organisation? Please answer yes or no to each statement.
FOR EACH ANSWER YES OR NO
There was awareness of specific needs for health and well-being support
Health and well-being initiatives were already in place
There were plans in place to introduce health and well-being initiatives
There was no money available to implement health and well-being initiatives

Q13b. ASK IF PARTNERSHIP AT Q1
At the time you applied to the Challenge Fund, which, if any of the following statements applied to the businesses you were working with? Please answer yes or no to each statement.
FOR EACH ANSWER YES OR NO
There was awareness of specific needs for health and well-being support
Health and well-being initiatives were already in place
There were plans in place to introduce health and well-being initiatives
There was no money available to implement health and well-being initiatives

Q14. ASK ALL
What were your reasons for making an application to the Challenge Fund?
OPEN ENDED

Q15. ASK ALL
To what extent do you agree or disagree with the following statements in terms of your perceptions of the Challenge Fund when making your application for funding?
Strongly agree
Tend to agree
Neither agree nor disagree
Tend to disagree
Strongly disagree

The Challenge Fund would help us introduce existing plans for health and well-being initiatives
The Challenge Fund was seen as a way to introduce planned health and well-being initiatives more quickly
The Challenge Fund would help us to add to the current provision of health and well-being initiatives
The availability of the Challenge Fund made us think about introducing health and well-being initiatives for the first time

Q16a. ASK IF SINGLE BUSINESS AT Q1
Did you consult or survey staff before applying to the Challenge Fund? If yes, please specify briefly how you consulted.
SINGLE CODE
Yes (please specify)
No

Q16b. ASK IF PARTNERSHIP AT Q1
Did you consult or survey businesses or staff at those businesses before applying to the Challenge Fund? If yes, please specify briefly how you consulted.
SINGLE CODE
Yes (please specify)
No

Q17. ASK ALL
Did you have contact with the Health, Work and Well-being Co-ordinator before submitting your Expression of Interest to the Challenge Fund?
SINGLE CODE
Yes
No
Not applicable

Q17a. ASK ALL
Did you have contact with the Health, Work and Well-being Co-ordinator before submitting your full application to the Challenge Fund?
SINGLE CODE
Yes
No
Not applicable

Q18. ASK IF ANSWERED YES AT Q17 and/or Q17a
How useful did you find this contact with the Health, Work and Well-being Co-ordinator, in terms of making your application?
SINGLE CODE
very useful
fairly useful
not very useful
not at all useful
Don't know

Section D Experience and views of using Challenge Fund money

Q19a-t. ASK ALL
Can you briefly describe each activity or intervention you used the Challenge Fund money to fund?
WRITE EACH RESPONSE SEPARATELY, AS THESE WILL BE USED IN A LATER QUESTION
PLEASE WRITE IN UP TO TWENTY OPEN ENDED RESPONSES

Q20. ASK ALL
Did these activities and interventions differ from those you proposed in your application to the Challenge Fund?
SINGLE CODE
Yes (please specify differences)
No

Q21. ASK ALL
Did the activities and interventions funded by the Challenge Fund grant target physical or mental health, or a combination of both?
SINGLE CODE
physical health
mental health
both

Q22. ASK ALL
In addition to the Challenge Fund money, did you have any other funding to spend on your health and well-being project (for example from an external source or from your organisation's own funds)?
SINGLE CODE
yes (please specify)
no

Q23a. ASK IF SINGLE BUSINESS AT Q1
After you were made a Challenge Fund award did you consult staff about how to use it? If yes, please specify briefly how you consulted.
SINGLE CODE
Yes (please specify)
No

Q23b. ASK IF PARTNERSHIP AT Q1
After you were made a Challenge Fund award did you consult businesses or staff at those businesses about how to use it? If yes, please specify briefly how you consulted.
SINGLE CODE
Yes (please specify)
No

Q24a. IF SINGLE BUSINESS AT Q1
Were activities or interventions targeted at certain groups of employees, such as managers, shop floor or office staff?
SINGLE CODE
yes (**please specify**)
no

Q24b. IF PARTNERSHIP AT Q1
Were activities or interventions targeted at particular types of employer?
SINGLE CODE
yes (**please specify**)
no

Q25a. IF SINGLE BUSINESS AT Q1
Did you have any difficulties getting staff to engage in the health and well-being activities or interventions?
MULTICODE
ALLOW NULL RESPONSE
DO NOT READ OUT
Timing issues
Location
Perceived usefulness
Issues with where funding was coming from
Staff motivation
Problems getting managers to recruit staff
Other (please specify)

Q25b. IF PARTNERSHIP AT Q1
Did you have any difficulties getting employers to engage in the health and well-being activities or interventions?
MULTICODE
ALLOW NULL RESPONSE
DO NOT READ OUT
Timing issues
Location
Perceived usefulness
Issues with where funding was coming from
Staff motivation
Problems getting managers to recruit staff
Other (please specify)

Q26a. IF SINGLE BUSINESS AT Q1
Were there any factors do you feel particularly helped or encouraged participation by your employees?
MULTICODE
ALLOW NULL RESPONSE
DO NOT READ OUT
timing, for example, during work hours
location
perceived relevance/usefulness
free/low cost
personal motivation and attitude
encouragement from managers/peers/unions/GPs
other (**please specify**)

Q26b. IF PARTNERSHIP AT Q1
Were there any factors do you feel particularly helped or encouraged participation by employers?
MULTICODE
ALLOW NULL RESPONSE
DO NOT READ OUT
Proactive promotion (for example, visiting firms)
Making a business case for health and well-being
Trialling interventions on firms' premises
Free/low cost
Employers' attitudes
Other (please specify)

Q27. ASK ALL
Did you have contact with the Health, Work and Well-being Co-ordinator during the period of funding?
SINGLE CODE
yes
no

Q28. ASK ALL
Would you have liked to have more, less, or about the same contact with the Co-ordinator?
SINGLE CODE
would have liked more contact
the same
would have liked less contact

Q29. IF YES AT Q27
How would you rate the level of support you received from the Health, Work and Well-being Co-ordinator, during the period of funding?
SINGLE CODE
very good
fairly good
neither good nor poor
fairly poor
very poor

Section E Impact of the Challenge Fund

Q30. ASK ALL
Thinking about your hopes and expectations of the Challenge Fund for individual health and well-being prior to the project starting, were any of these among your hopes and expectations?
READ OUT LIST – YES/NO FOR EACH
Reduction in sickness absence
Improvements in staff retention
Improved productivity
Improvements in physical health
Improvements in mental well-being
Change in lifestyles
Better staff-management relations
Increase in knowledge about work and health
Improvement in workplace culture towards health and well-being
Improved external reputation
Increase in custom/business
Any others (up to 3)

Q30a. FOR EACH CODE SELECTED AT Q30
How would you describe the impact of the Challenge Fund on this aim? Would it be...very positive
quite positive
no impact
quite negative
very negative
too early to say

Q31. ASK ALL
Have there been any other impacts of the Challenge Fund that we have not covered?
SINGLE CODE
yes (**please specify**)
no

Q32a. ASK ALL
Are you measuring the impact of the Challenge Fund in some way?
SINGLE CODE
yes (GO TO Q32b)
no

Q32b. ASK THOSE ANSWERING YES AT Q32a
Which of the following methods are you using to measure the impact?
MULTICODE
READ OUT
staff surveys
medical assessments
staff absence data
productivity/performance
other (**please specify**)

Q33a. ASK ALL
Do you feel the interventions/activities would have occurred without the Challenge Fund grant?
SINGLE CODE
yes
no

Q33b IF NO AT Q33a
Please explain the difference made by the Challenge Fund money.
OPEN ENDED

Q33c IF YES AT Q33a
Please explain how the interventions/activities would have taken place.
OPEN ENDED

Section F Future plans

Thinking back to the activities/interventions you described earlier...

INSERT EACH ACTIVITY/INTERVENTION IN RESPONSE TO Q19 IN TURN, AND ASK A) TO E) AS RELEVANT.

Q34a. ASK ALL WHO ANSWERED AT Q20
Will [response to q19a/b/c/d] continue after money from the Challenge Fund runs out?
yes
no
undecided

Q34b. IF YES AT Q34a
Why have you decided to continue with (insert name of activity/intervention)? MULTICODE
DO NOT READ OUT
it has become established/routine
it is popular
it is having the desired effect
other (**please specify**)

Q34c. IF YES AT Q34a
What funding is in place for this?
MULTICODE
DO NOT READ OUT
funding is not needed
to be funded by participants
funding received from another source
internal funding agreed
No funding yet in place

Q34d. IF NO AT Q34a
Why will (insert name of activity/intervention) not continue?
MULTICODE
DO NOT READ OUT
activity/intervention already terminated
no funding available
insufficient take up/lack of interest
activity/intervention did not produce desired impact
activity/intervention has already produced desired impact
alternative way of achieving desired impact
other (**please specify**)

Q34e. IF UNDECIDED AT Q34a
Why might (insert name of activity/intervention) not continue?
MULTICODE
DO NOT READ OUT
activity/intervention already terminated
no funding available
insufficient take up/lack of interest
activity/intervention did not produce desired impact
activity/intervention has already produced desired impact
alternative way of achieving desired impact
other (please specify)

Q35. Thank you for helping us with the evaluation of the health, work and well-being challenge fund. Please be assured that neither ourselves nor the University of York will pass on your individual responses to the Department of Work and Pensions, or any other third party.

The University of York would like to analyse your individual responses so they can understand more about the impact of the fund, are you happy for us to pass on these individual responses for research purposes only?

Yes
No

Q36. Would you be willing to be contacted again for future research?

Yes
No

Appendix H
Case studies of Challenge Fund winners

H.1 Wave 1 Core Topic Guide

HWWB Case Studies

Core Topic Guide (Round 1; Wave 1)

To begin with, could you tell me a bit about the health and well-being of your workforce at the time you decided to apply to the Challenge Fund?

- Any particular problems – i.e. levels of sickness and absence; reduced productivity
- How do you know about these problems? i.e. staff surveys
- Policies, procedures, initiatives already in place to promote health and well-being and manage sickness and absence

How did you learn about the Challenge Fund?

- Why did you decide to make an application?
- How did you decide what to spend the money on? Any consultation with employees, line managers, possible service providers?

What are your plans for using Challenge Fund money?

- What will CF money pay for?
- Who is involved?
- Could you do these things anyway, without Challenge Fund money?
    - if so, how
    - if not, why not
- How does it add to/build on existing activity (if any)?

What has happened so far?

- What have employees and managers made of it so far?
    - Levels of engagement with activities
    - Views/experiences of those who've taken part
    - Views/experiences of those who've chosen not to take part
- Any problems during implementation

How has the HWWB Co-ordinator been involved?

- Support, challenge, steer, monitoring, administration
- Views on involvement

What difference do you think the funded activities will make?

- What were things like before (attitudes, activities available, levels of engagement)?
- What differences are expected to:
    - physical health
    - mental health/well-being
    - absence
    - productivity, output, profit
    - individual attitudes (employees, line managers)
    - wider (e.g. home/family life)

How will you know if the activities make a difference?

- How will differences be determined?
- (How) will differences be monitored and measured?

One of the aims of this initiative (reference the Black Review if helpful) is to change the 'culture' of workplace health and well-being. Does this sound familiar/do you think in these terms?

- How would you describe the culture here (pre Challenge Fund activities)? (attitudes, atmosphere, behaviours ...)
- What differences to workplace 'culture' do you think the funded activities will make?

Are the Challenge Fund activities sustainable?

- Are they designed to be sustainable?
- Are you expecting the differences (in health, well-being, absence, productivity, attitudes, culture) to be sustainable? If so, how?
- What (else) will be done to sustain activities/difference?

Finally, check that we have information about:

- *what the organisation does*
- *organisation size*
- *sector*
- *organisation age*

H.2 Wave 2 Core Topic Guide

HWWB Case Studies

Core Topic Guide (Round 1; Wave 2)

A. IMPLEMENTATION AND PARTICIPATION

Can we start by reviewing the activities or initiatives the Challenge Fund money supported over the 12 months of the project?

Outline briefly the activities occurring or expected at the time of the first visit, then use the following prompts for each activity:

- Whether activities continued or commenced as expected
- Anything different or new since our first visit
- Changes to original plans and why changes were made
- Staff involvement (throughout project) in decisions
- Any problems during implementation

What was the response to the offer of these activities/initiatives?

- Levels of engagement with activities
- Changes in participation over time, and reasons for change
  - including strategies for boosting/sustaining participation: promotion, eligibility, compulsory participation, time and place of activities
- Awareness of facilitators and barriers to taking part
- Whether and how they have engaged people who need the interventions the most
- Feedback from people who've taken part

B. IMPACT

What difference do you think the funded activities have made overall?

- Probe for differences in individuals:
  - physical health and well-being
  - mental health and well-being; ability to manage stress
  - individual attitudes (employees, line managers); including enthusiasm to start own activities outside of CF funded activities
  - wider (e.g. home/family life)
- Probe for differences to workplace/business:
  - absence, staff turnover
  - productivity, output, profit
  - workplace culture (e.g. working routines, relationships, morale)

What in particular has helped to make these differences?

- Probe for:
  - particularly effective activities/initiatives
  - quality of service provision/personnel
  - participant motivation and attitude
  - managerial enthusiasm and commitment

What have been the barriers to making a difference?

- Probe for:
  - (short) length of project
  - ineffective activities/initiatives
  - lack of quality service provision/personnel
  - low level of participation and individual motivation
  - lack of managerial enthusiasm and commitment

When I visited last time we talked about your plans for measuring the impact of the funded activities. What did you do?

- Methods for monitoring and measuring differences
  - Participant feedback
  - Repeated health checks
  - Take-up records
  - External evaluation through a consultant/researcher
    - What were the results of this?
    - Any plans for using the evaluation results
- (How) have you been able to attribute impact to the Challenge Fund activities, rather than other influences?
- When we spoke before your hopes and expectations for the project's impact were … (*outline hopes and expectations*) … have you achieved what you set out to?

Last time I asked why you had bid for Challenge Fund money and this helped us to identify how the offer of money had made an impact on firms. Which of the following impacts do you most identify with? (*show card*)

- enabling planned/desired projects to be implemented by removing financial barriers
- speeding up the implementation of planned/desired projects
- adding to existing health and well-being activity
- kick-starting something new; focusing on employee health and well-being for the first time

Has receiving money from government for health and well-being made any other impacts on the organisation (rather than employees)?

- Probe for:
  - committing to promoting health and well-being in the future
  - spending own money on initiatives
  - widening access to provision already delivered

Question for providers of activities:

What has been the impact on you and your business of being involved with a Challenge Fund project?

- e.g. increased business; raised awareness of their provision in the community; developing new services

C. SUSTAINABILITY

When did the Challenge Fund money run out?

Have you been able to sustain any of the Challenge Fund activities since funding ended?

- Which activities/initiatives have been sustainable? – *ask for each of the activities identified in Section A*.
- Why sustainable/why not? Explore facilitators and barriers to sustainability e.g.:
  - Cost, sources of funding
  - Practical arrangements – time, fit around work and home responsibilities, availability of local providers
  - Activity effectiveness
  - Participant motivation and interest
  - Managerial commitment to promoting health and well-being
- Do any of your initiatives have long-lasting impacts? (e.g. changes to the physical working environment; stress-management techniques which can be re-used as necessary)
  - How do you know?
  - Factors facilitating or hindering an enduring impact
- How do experiences of sustainability match with expectations?

Do you have any plans for further health or well-being activities?

- What is the rationale for these activities?
- Would you be planning these activities if you had not implemented the Challenge Fund project?
- Need for funding and source if known
- Expected impact

How has the HWWB Co-ordinator been involved?

- Support, challenge, steer, monitoring, administration
- Change to involvement over time and reasons for change
- How often has there been contact with the Co-ordinator?
- Views on involvement

D. OVERALL REFLECTIONS

What have you learned from the Challenge Fund project about improving employee health and well-being?

Was the Challenge Fund necessary? Should funding for workplace health and well-being be available again?

What would you do differently if awarded the money again?

- Activities/initiatives implemented; provider selection
- Project promotion
- Self-evaluation
- Sustainability

What would help you to sustain health-promoting activities (as an individual/organisation)?

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This report presents findings from research to evaluate two health, work and well-being initiatives set up following the 2008 review by Dame Carol Black into the health of the UK working age population. The first initiative was the appointment of **Health, Work and Well-being Co-ordinators** in Scotland, Wales and the nine English Regions; the second was the **Health, Work and Well-being Challenge Fund** to provide funding for initiatives to improve workplace health and welfare. This study explores the perceived impact of the projects on health and work practices and on the health, work and well-being agenda, as well as their long-term sustainability. The evaluation included qualitative research with the co-ordinators and senior public health officials, surveys of businesses and Challenge Fund award holders, and case studies of a selection of Challenge Fund award holders. The research was carried out for the Department for Work and Pensions by the Social Policy Research Unit at the University of York.

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DWP Department for Work and Pensions

Published by the
Department for Work and Pensions
October 2012
www.dwp.gov.uk
Research report no. 811
ISBN 978-1-908523-91-4