

Evaluating the Public Health England and Business in the Community Employer Toolkits

Assessing awareness, perceptions, and impact



About the Work Foundation

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

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

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Executive summary

Public Health England (PHE) commissioned the Work Foundation to evaluate the ‘suite’ of PHE Business in the Community (BITC) Employer Toolkits:

- Mental Health Toolkit for Employers (2016)
- Musculoskeletal Health Toolkit for Employers (2017)
- Suicide Prevention and Postvention Toolkits for Employers (both 2017)
- Drugs, Alcohol and Tobacco Toolkit for Employers (2018)
- Sleep and Recovery Toolkit for Employers (2018)
- Physical activity, healthy eating and healthy weight (2018)
- Domestic Abuse Toolkit (2018)

Methodology

The research aimed to:

- assess awareness and perceptions of the Toolkits among businesses of different sizes and sectors;
- explore the potential impact of the Toolkits on employer practice;
- strengthen the evidence base underpinning the effectiveness of the Toolkit suite;
- provide recommendations for improvement; and
- inspire more businesses to use the Toolkits to improve workplace health.

The evaluation involved quantitative and qualitative research with organisations that have used the Toolkits, comprising a telephone survey of 53 organisationsⁱ, 28 qualitative interviews, and an Employer Forum (involving nine employers)ⁱⁱ.

Context of the study

PHE collaborates with employer networks and representative organisations (e.g. Federation of Small Business, Make UKⁱⁱⁱ, Trades Union Congress) to co-develop resources that promote and support employer-led workplace-based action, such as, among others, the Employer Toolkits.

The Employer Toolkits form part of PHE’s Health and Work programme, which is guided by the ‘whole system’ approach^{iv}. This approach recognises that a person’s health is determined by a broad range of factors, of which all and each must be addressed in order to improve it. Workplace-based factors include: (i) **organisational culture**; (ii) **the physical working environment**; and (iii) **opportunities for support**^v.

The individual Toolkits were designed to meet the following PHE Health and Work programme objective: **supporting action in the workplace to enable people with health issues to access, retain or return to employment**. They focus on a number of health and wellbeing issues (informed by intelligence drawn from PHE employer networks/representative organisations), thereby addressing a gap in employers’ awareness and knowledge.

ⁱ The sample (n = 71) was built through consultation with PHE and BITC networks. It should be made clear that many of the 53 organisations that took part in the survey, as well as the interviews, were involved – to varying degrees – in the development of the Toolkits.

ⁱⁱ The majority of the survey respondents/interviewees (i.e. roughly 60%) had been involved to some extent in producing the Toolkits, by providing content, case studies, feedback, etc. As such, it is likely that the study population had a level of awareness of the Toolkits that is not representative of the business population at large.

ⁱⁱⁱ Formerly EEF – the Manufacturer’s Organisation

^{iv} Public Health England. (2016).

^v Ibid.

Purpose of the Toolkits

According to stakeholders involved in the development of the Toolkits, the resources aimed to:

1. Improve employers' awareness, understanding and knowledge of salient employee health and wellbeing issues and the business benefits that can be derived from addressing them.
2. Produce changes in attitudes towards health and wellbeing at work.
3. Result in changes in health and wellbeing policy and practice to improve employee health and wellbeing.

Principal findings

The principal findings are grouped into three sections:

- (i) the study's populations perceptions of the Toolkits;
- (ii) the Toolkits' impact on employer policy and practice; and
- (iii) the ways in which the Toolkits could be improved.

Perceptions of the Toolkits

In the main, the Toolkits were perceived by the organisations studied as **repositories of information and best practice**, providing compelling statistics communicated through infographics and access to additional resources.

Furthermore, they were considered to be attractive resources in terms of their design and appearance, comprehensiveness, clarity and recognised as being from a reputable source. Although a number of interviewees described the Toolkits as **practical tools enabling organisations to put processes in place**, others did not necessarily view them as tools which can drive changes in policy and practice.

Impact on employer policy and practice

Within the scope of the proposed aims of the Toolkits, it was found that, to some extent, they were used by employers to support **awareness-raising campaigns and sessions** on a range of staff health and wellbeing issues. Furthermore, they were used to **change attitudes**, e.g. convince senior management of the need to act.

In a select few cases, the Toolkits played a role in **informing and directing employer policy**. For example, one organisation had used a specific Toolkit to redesign several aspects of health and wellbeing policy (though they had been quite heavily involved in the production of the Toolkit, which could have played a part in this).

Additionally, a significant number of employees had made **changes in practice** based on the Toolkits, particularly the Mental Health Toolkit, for example in designing and distributing an employee survey, or transforming the role of line managers, empowering them to better manage mental health issues in the workplace.

Further, the Toolkits proved useful in ways which were not anticipated by stakeholders involved in their development. Across the range of small and larger organisations that were studied, the Toolkits were primarily used as a means of **'sense checking' or reviewing existing policy**.

Areas for improvement

There were six main areas where study participants felt the Toolkits could be improved.



The Toolkits, averaging 58 pages, were generally considered to be too long. Furthermore, study participants felt that the Toolkits' target audience could have been clearer, e.g. targeted at organisations of a certain size or in a certain sector. They were also perceived as too rigid, making them difficult to adapt to organisations' specific contexts and situations.

There was clear demand for an 'overarching' or 'general' toolkit that was not condition-specific. The lack of diversity in the case studies included in the Toolkits, with the majority coming from large organisations, was also noted. Finally, the most common area where study participants felt improvement was needed was around the promotion and dissemination of the Toolkits.

Recommendations to improve the Toolkits' impact

This section provides recommendations on how to address the areas where study participants felt the Toolkits could be improved, including Toolkits' length, target audience, format, promotion and dissemination, and the need to create a 'general', overarching toolkit.

Reduce Toolkit length

This can be done by:

- Developing 'Toolkit summaries' which are longer than the two-page infographic summaries that currently exist for six of the eight Toolkits in the suite, but are shorter than the Toolkits themselves.
- Improving the visibility and awareness of the existing two-page infographic summaries and developing these for the two Suicide-related toolkits.

Identify and target a specific audience

This could be achieved without significantly altering the Toolkits' content, for example by:

- organising case studies by size and sector;
- providing sector-specific statistics – and clearly signpost them;
- accounting for employers being at different stages in the employer 'journey'. Some employers do not need to be persuaded of the need to act (i.e. the 'business case') and primarily want information on *what* to do and *how* to do it;
- recognising that people at different levels within an organisation will use the Toolkit in different ways; and

- Identifying/appointing ‘champions’ or advocates specific to certain sectors to promote the value of engaging with the Toolkits.

Move from static to interactive format and media

Providing the Toolkits in a more interactive format (i.e. not PDF) should be explored to (i) enable organisations to customise the Toolkits and tailor them to their circumstances and (ii) to ensure the Toolkits’ content is kept up-to-date.

Improve promotion and dissemination of Toolkits

This can be achieved by:

- Consistent promotion via PHE and BITC social and media channels, and relevant trade publications, particularly on relevant ‘awareness days/weeks’ pertaining to the issues the Toolkits cover.
- Better use of networks to target and reach specific audiences through their preferred channels;
- Stronger engagement and endorsement from various member and representative organisations

An overarching ‘general’ Toolkit

Given the perceived similarities between the various Toolkits in terms of their advice and guidance, there was clear demand for a ‘general’ Toolkit which sat ‘above’ the existing condition-specific products in the suite.

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1. Introduction

Public Health England (PHE) has commissioned the Work Foundation to evaluate the co-produced PHE and Business in the Community (BITC) Employer Toolkits, referred to as 'Toolkits' hereafter. PHE is an executive agency of the Department of Health and Social Care, and a distinct organisation with operational autonomy. PHE provides government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific expertise and support. BITC is the oldest and largest business-led membership organisation dedicated to responsible business. BITC was created nearly 40 years ago by HRH the Prince of Wales to champion responsible business.

Since 2016, PHE has worked with BITC to produce an interconnected suite of Toolkits addressing several work-related health issues:

- Mental Health Toolkit for Employers (2016)
- Musculoskeletal Health Toolkit for Employers (2017)
- Suicide Prevention and Postvention Toolkits for Employers (both 2017)
- Drugs, Alcohol and Tobacco Toolkit for Employers (2018)
- Sleep and Recovery Toolkit for Employers (2018)
- Physical activity, healthy eating and healthy weight (2018)
- Domestic Abuse Toolkit (2018)

1.1. Research aim and objectives

1.1.1. Aim

The research uses a mixed methods approach to assess the use and subsequent impact of the Toolkits.

1.1.2. Objectives

1. Assess awareness and perceptions of the Toolkits among businesses of different sizes and sectors
2. Explore the potential impact of the Toolkits on employer practice
3. Provide recommendations for improvement
4. Strengthen the evidence base underpinning the effectiveness of the Toolkits
5. Inspire more businesses to use the Toolkits to improve workplace health

1.2. Report outline

The report is structured as follows:

- Chapter 2 puts the Toolkits in the wider context of PHE's Health and Work programme.
- Chapter 3 provides a detailed overview of the research methods used and implications for the findings and conclusions of the research.
- Chapter 4 addresses the first objective of the research, i.e. assess awareness and perceptions of the Toolkits among businesses of different sizes and sectors.
- Chapter 5 addresses the second objective, i.e. explore the potential impact of the Toolkits on employer practice, and, in doing so, addresses the fourth objective: strengthen the evidence base underpinning the effectiveness of the Toolkit suite.
- Chapter 6 addresses the third objective, i.e. provide recommendations for improvement, and, in doing so, addresses the fifth: inspire more businesses to use the Toolkits to improve workplace health.
- Chapter 7 provides a discussion of the overall research findings and conclusions.
- Chapter 8 offers detailed recommendations on how the Toolkits can be improved as well as for future evaluations of them and their impact.

2. Setting the context

This chapter puts the BITC/PHE Employer Toolkits in the context of PHE's broader Health and Work programme. It outlines how the Toolkits align with wider PHE interventions and what the stakeholders involved in the design and production of them hoped to achieve alongside broader activities. It draws on PHE strategy documents⁶ and findings from six interviews conducted with stakeholders involved in the design and production of the Toolkits⁷.

2.1. PHE's Health and Work programme

In the UK, over 76% of people are in employment and spend the majority of their waking hours in work^{8,9}. Work is a key determinant of health¹⁰. Good quality work (i.e. work that is safe, gives people control, support and reasonable demands, etc.¹¹) is beneficial to health, whereas poor quality work is harmful, sometimes more so than unemployment, to an individual's health and wellbeing^{12,13}. Health is a significant barrier to accessing and retaining employment, particularly in relation to mental health issues, musculoskeletal health and disabilities¹⁴. Therefore, to improve adult health, it is vital to "engage employers and ensure that workplaces are safe and health-promoting"¹⁵.

PHE supports action in the workplace to enable people with health issues to access, retain or return to employment. To meet this objective, PHE promotes a 'holistic' approach to health in the workplace, drawing on the World Health Organization's definition of good health, i.e. "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"¹⁶.

The rationale for this objective is the evidence demonstrating the 'return on investment' generated by workplace health interventions¹⁷. Indeed, the evidence suggests that such interventions can lead to savings in the form of reduced sickness absence, presenteeism (i.e. working at reduced capacity due to illness), reduced staff turnover, and improved productivity^{18,19}.

The Health and Work programme is guided by the 'whole system' approach (see Figure 1 below) recognising that a person's health is determined by arrange of factors and thus to protect and

⁶ Public Health England. (2016). Strategic plan for the next four years: better outcomes by 2020. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/516985/PHE_Strategic_plan_2016.pdf

⁷ For more details see Chapter 3

⁸ Office for National Statistics. (2019). Employment in the UK: June 2019. Retrieved from:

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/employmentintheuk/latest>

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

¹⁰ Dahlgren, G., & Whitehead, M. (1991). *Policies and Strategies to Promote Social Equity in Health*. Stockholm: Institute for Future Studies.

¹¹ There is no universal definition of 'good' work but it typically comprises these components. See the following for further discussion of what constitutes good work: Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post-2010. The Marmot Review*; Coats, D., & Lekhi, R. (2008). "Good Work": *Job Quality in a Changing Economy*. London: The Work Foundation; and Siegrist, J., Benach, J., McKnight, A., Goldblatt, P., & Muntaner, C. (2010). *Employment arrangements, work conditions and health inequalities. Report on new evidence on health inequality reduction, produced by Task group 2 for the Strategic review of health inequalities post 2010*.

¹² Waddell, G., & Burton, A. (2006). *Is Work Good for Your Health and Well-Being?* London: The Stationery Office.

¹³ Butterworth, P., Leach, L. S., Strazdins, L., Olesen, S. C., Rodgers, B., & Broom, D. H. (2011). The psychosocial quality of work determines whether employment has benefits for mental health: Results from a longitudinal national household panel survey. *Occupational and Environmental Medicine*, 68(11), 806–812.

¹⁴ Work Foundation & Public Health England. (2017). Health and work infographics. Retrieved from: http://www.theworkfoundation.com/wp-content/uploads/2017/03/Health_and_work_infographics.pdf

¹⁵ Public Health England. (2016).

¹⁶ World Health Organization. (2019). Constitution. Retrieved from: <https://www.who.int/about/who-we-are/constitution>

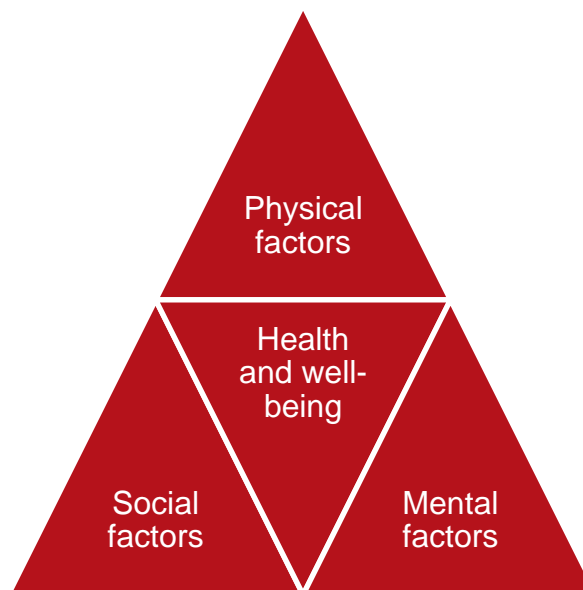
¹⁷ Society of Occupational Medicine. (2017). Occupational health: the value proposition. Retrieved from: https://www.som.org.uk/sites/som.org.uk/files/Occupational_health_%20the_value_proposition.pdf

¹⁸ Black, C. (2008). *Working for a healthier tomorrow*. London: The Stationery Office.

¹⁹ Waddell, G., & Burton, A. (2006).

improve it one must address all of them. In a workplace setting, this accounts for: (i) organisational culture; (ii) the physical working environment; and (iii) opportunities for support²⁰.

Figure 1 - The 'whole system' approach



2.1.1. The approach

PHE works with employer networks and representative organisations such as the Federation of Small Business, Make UK²¹ and Trades Union Congress to co-develop business-to-business resources based on evidence that promote and support employer-led workplace-based action. This has led to the production of employer-facing tools, e.g. the 2017 'workplace health needs assessment'²², and, most recently, an interconnected suite of Toolkits, in partnership with BITC.

2.2. The Toolkit suite

The Toolkits aim to support PHE's Health and Work programme by supporting action in the workplace to enable people with health issues to access, retain or return to employment. They aim to do this by raising awareness, changing attitudes and ultimately changing behaviour on topics which employer representative organisations have indicated to PHE that businesses struggle with, thus addressing a 'gap' in employers' awareness and knowledge.

Whilst there is no single definition of the term 'toolkit', they are commonly understood as a means to translate evidence into practice using templates and guidelines and are intended to impart knowledge and facilitate behavioural changes^{23,24}. They are becoming increasingly popular amongst practitioner communities²⁵ and often in the context of workplace health²⁶.

²⁰ Public Health England. (2016).

²¹ Formerly EEF – the Manufacturer's Organisation

²² Public Health England. (2017). Workplace health needs assessment. Retrieved from: <https://www.gov.uk/government/publications/workplace-health-needs-assessment>

²³ Pala, I. (2014). BMC Medical Informatics and Decision Making. *BMC Medical Informatics and Decision Making*, 14(1).

²⁴ Yamada, J., Shorkey, A., Barwick, M., Widger, K., & Stevens, B. J. (2015). The effectiveness of toolkits as knowledge translation strategies for integrating evidence into clinical care: A systematic review. *BMJ Open*, 5(4).

²⁵ Joseph Rowntree Foundation. (2018). Improving fringe benefit schemes for low earners. Retrieved from: <https://www.jrf.org.uk/file/51839/download?token=ZaNPYoll&filetype=full-report>

²⁶ Recent years have seen the development of Macmillan's 'work and cancer' toolkit, NHS Employers' 'health and wellbeing' toolkits, the Royal College of Nursing's 'healthy workplace toolkit', the British Heart Foundation's 'health at work' toolkit, and Kingston University's 'return to work' toolkit (see <https://returntoworkmh.co.uk/>).

2.2.1.1. The rationale for each Toolkit

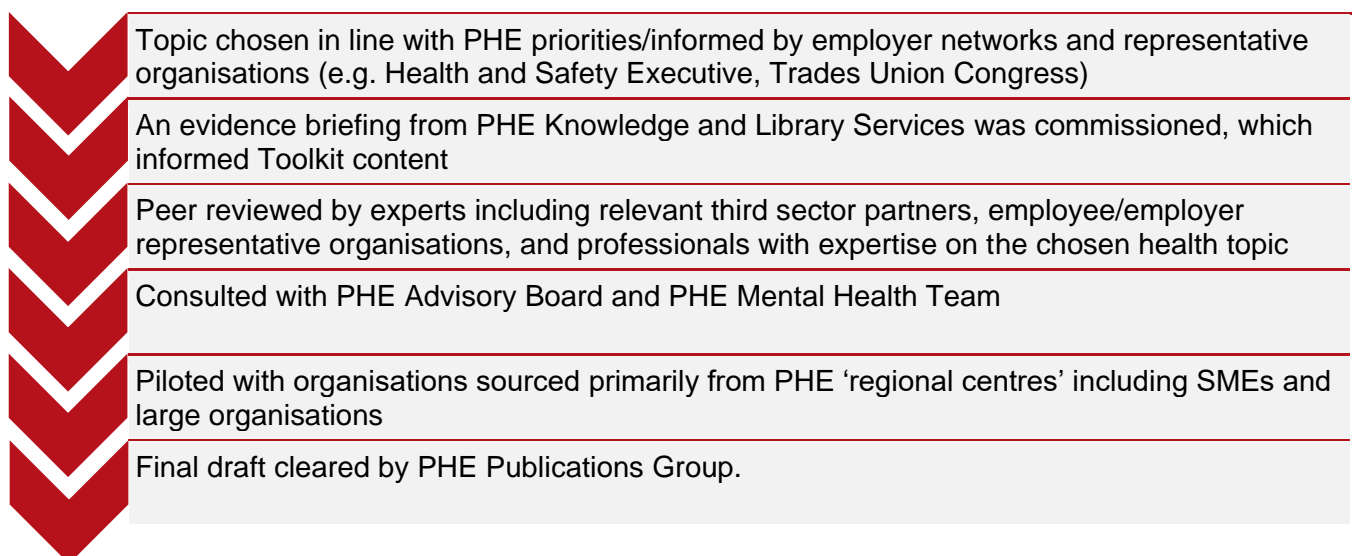
Each Toolkit addresses a different topic and has a different rationale for its creation. For instance:

- **Mental Health Toolkit** – sought to address the need for a single source of evidence-based, reliable information on mental health and work, in a crowded marketplace.
- **Musculoskeletal (MSK) conditions Toolkit** – motivated by the fact that MSK conditions are the leading cause of sickness absence in the UK²⁷.
- **Suicide prevention and postvention Toolkits** – motivated by: (i) an Office of National Statistics report highlighting its impact on work²⁸; and (ii) the fact suicide is the biggest killer amongst working age²⁹ men³⁰.
- **Drugs, Tobacco and Alcohol Toolkit** – addressing another facet of mental health (i.e. addiction).
- **Sleep Toolkit** – coincided with the launch of the Sainsburys ‘Living Well’ index³¹ which emphasised the importance of sleep for health and wellbeing.
- **Physical Activity Toolkit** – promotes physical exercise as a way to improve mental and physical health and tackle obesity.
- **Domestic Abuse Toolkit** – the result of ‘horizon scanning’, anticipating the House of Commons domestic abuse review³².

2.2.2. Toolkit development process

PHE oversaw the process of the development of the Toolkits, while BITC provided input from the perspective of the business community. The communications agency, Forster Communications, was sub-contracted to author the Toolkits. For an overview see Figure 2 below.

Figure 2 – Toolkit development process



²⁷ Office for National Statistics. (2017). Sickness absence in the UK labour market: 2016. Retrieved from: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2016>

²⁸ Office for National Statistics. (2017). Suicide by occupation, England: 2011 to 2015. Retrieved from: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015>
²⁹ 20-49 years

³⁰ University of Manchester (2015). National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. Manchester: University of Manchester

³¹ <https://www.about.sainsburys.co.uk/about-us/live-well-for-less/living-well-index>

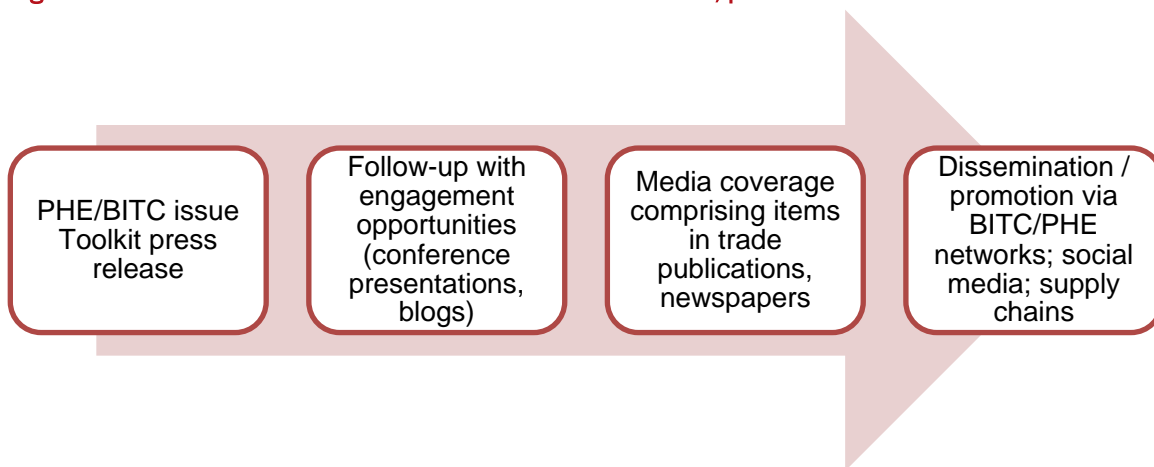
³² Home Affairs Committee. (2018). Domestic Abuse. Retrieved from: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/1015/1015.pdf>

Forster undertook interviews with experts to collect best practice and source evidence in addition to PHE-sourced material. For example, with the MSK and Suicide toolkits, expertise was drawn in from specialist organisations, such as the Samaritans and the Arthritis and Musculoskeletal Alliance, to support with the content and writing.

2.2.3. Toolkit promotion and dissemination

A number of activities were carried out to promote and disseminate the Toolkits (see Figure 3 below). PHE's communications team worked with BITC to issue press releases, presentations at conferences and the publication of online blogs. Promotional activity resulted in media enquiries from trade publications and the Toolkits being promoted online such as in HR Magazine³³. The Toolkits were also promoted and disseminated via PHE/BITC networks and social media. Furthermore, two members of the Health and Work Advisory Group (the Federation of Small Business and Make UK) agreed to distribute the Toolkits via their networks, in addition to NHS Employers.

Figure 3 – Overview of activities associated with dissemination, promotion and outreach



2.3. Toolkit content and structure

Each Toolkit was published as a PDF, hosted on BITC's website. They all follow a similar structure and were, on average, 58 pages long. They typically have the following structure:

- Introduction – a general outline of the topic and including some key messages regarding its impact on employee health and wellbeing, and in some cases testimonies to the Toolkit's effectiveness (see Appendix for an example).
- Contents page – providing an overview of the Toolkit and the different sections it covers.
- Foreword – from a range of stakeholders including PHE, BITC, clinicians, academics, the business community, and third sector organisations.
- Infographic – which includes statistics highlighting the impact of the issue on employee health and wellbeing, thus supporting the case for action (see Appendix for an example).
- Business case – articulating why organisations should take action – highlighting the benefits of doing so. In some cases (e.g. with the Toolkits on mental health and MSK conditions), this is followed by a 'moral case' for action, appealing to social justice.
- Checklists – step-by-step guidelines on what employers should do. This is supplemented with practical advice on how to act, i.e. to make changes in policy and practice (see Appendix for an example).
- Case studies – from a range of organisations spanning different sectors and sizes, as well as a section on additional relevant resources that are signposted to.

³³ HR Magazine. (2016). BITC launches free mental health toolkit. Retrieved from: <https://www.hrmagazine.co.uk/article-details/bitc-launches-free-mental-health-toolkit>

3. Methods

This chapter provides an overview of the research methods, the composition of the study population and limitations.

3.1. Study design

The evaluation was adapted to accommodate the following constraints:

1. The Toolkits are publicly funded and are required to be freely available which limits the information PHE/BITC can collect on who uses them³⁴.
2. Due to the lack of management information held (i.e. the details of individuals/organisations that have downloaded/used the Toolkits and ways in which they have been used), the initial research design (comprising a random sample of 200 organisations) was not considered feasible³⁵; thus, the study had to be re-designed to accommodate this, making full use of the employer sample that could be built via PHE/BITC networks.

3.2. Stage One: evaluation framework development

The purpose of developing an evaluation framework was to construct a 'logic chain' which sets out the Toolkits' potential pathways of impact. The logic chain draws on HM Treasury's Green / Magenta Book's 'theory of change' pathway^{36,37}, outlining (i) the rationale/problem to address, (ii) inputs, (iii) activities, (iv) outputs, (v) (anticipated) outcomes and (vi) (anticipated) impacts.

The logic chain was built using evidence collected from interviews carried out with six stakeholders who were involved in the design and production of the Toolkits to ascertain their policy intent and the underpinning logic chain. Interviewees included personnel from: PHE; BITC; Forster Communications (the agency sub-contracted to design/develop the Toolkits); and a principal contributor to one of the Toolkits³⁸.

The logic chain, arising from these interviews, is provided in the Appendix. We revisit the logic chain in Chapter 7, incorporating the findings from the evaluation into it.

3.3. Stage Two: primary research

The second stage involved quantitative and qualitative research with organisations that have used the Toolkits. This comprised a telephone survey with 53 organisations³⁹, qualitative interviews with 28 organisations and an Employer Forum with nine organisations.

³⁴ Consultation with PHE personnel

³⁵ Following the project initiation meeting between the Work Foundation and PHE, it was apparent that it would be very difficult – if not impossible – to achieve a sufficiently robust sample to support the originally proposed survey of 200 employers that are aware of/have used the Toolkits. As such, the study had to be re-designed to accommodate the lack of 'management information' held by PHE/BITC.

³⁶ HM Treasury. (2018). The Green Book. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/685903/The_Green_Book.pdf

³⁷ HM Treasury. (2011). The Magenta Book. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/220542/magenta_book_combined.pdf

³⁸ This number of interviews was considered sufficient to reach a 'saturation point' (i.e. it was felt that additional interviews would not uncover new/further insights).

³⁹ The sample (n = 71) was built through consultation with PHE and BITC networks. It should be made clear that many of the 53 organisations that took part in the survey, as well as the interviews, were involved – to varying degrees – in the development of the Toolkits.

3.3.1. Telephone survey

This was a 10-minute Computer Assisted Telephone Interviewing (CATI) survey with organisations who had interacted with the Toolkits in some way.

The sample (n = 71) was built through consultation with PHE and BITC networks. Surveys were carried out with 53 organisations, achieving a response rate of 75%.

The survey aimed to find out more information about these organisations, determine their awareness of the Toolkits and how they had used them.

3.3.2. Qualitative interviews

All 53 organisations which participated in the survey were invited to interview. Interviews were conducted until no new information related to the aims and objectives of the research was being observed, i.e. the point of data saturation was reached⁴⁰. In total, 28 interviews were carried out with organisations of different sizes and sectors (see Appendix for further information).

The majority (23) were sourced from the survey sample, with the remainder (five) being sourced from PHE/BITC and wider networks.

All interviews were conducted by members of the project team via telephone, recorded and transcribed with participants' permission, and then analysed.

The interviews aimed to explore the impact the Toolkits had had on employer policy and practice, generate recommendations for improvement and explore awareness and perceptions of the Toolkits.

3.3.3. Employer Forum

An Employer Forum, comprising nine employers of different sizes and sectors, sourced from the Work Foundation's networks, was consulted twice, once during a face-to-face meeting in February 2019, and subsequently through email and telephone.

The forum aimed to explore how the Toolkits could be improved and thus generate recommendations for improvement.

3.4. Study population

This section describes the composition of the study population and its limitations, which must be considered in assessing the evaluation findings. Further reflection is provided throughout the report.

3.4.1. Survey respondents and interviewees

The majority of the survey respondents and interviewees (approximately 60%) were involved in producing the Toolkits in some way by providing content, case studies and feedback. As such, the study population had a higher level of awareness of the Toolkits than the business population generally, which introduces bias. For example, research participants may have been more inclined to engage with the Toolkits more extensively than if they had not contributed to their development.

Most survey respondents and interviewees had heard about the Toolkits directly through PHE/BITC. Therefore, it is possible that these organisations were more aware of staff health and wellbeing issues and potentially more receptive to resources like the Toolkits.

⁴⁰ Ezzy, D. (2002). *Qualitative Analysis Practice and Innovation*. London: Routledge.

Finally, the majority of survey respondents and interviewees (over 75%) worked in large organisations (i.e. employing 250 people or more) which is not representative of the average sized business as 96% of businesses have fewer than 10 employees⁴¹. To some extent, this was anticipated, given that larger organisations are, generally speaking, more likely to have the necessary resources and time to engage with (i) research of this nature and (ii) employer-focused resources like the Toolkits. As such, the study population's level of engagement with the Toolkits is not necessarily representative of the business population at large.

3.4.2. Employer Forum participants

Forum members were sourced from the Work Foundation's networks. None were involved in the development of the Toolkits or had an existing relationship with PHE/BITC. The proportion of large organisations was significantly smaller, comprising 55% of Forum participants. This pool served as a more representative sample of employers, in part compensating for some of the limitations of the survey and interview samples.

⁴¹ Rhodes, C. (2019). Business statistics. London: House of Commons.

4. Findings: awareness and perceptions of the Toolkits amongst the study population

This chapter details the awareness and perceptions of the Toolkits among businesses of different sizes and sectors.

4.1. Awareness of the Toolkits

For context, data provided by BITC suggests the Toolkits were downloaded 26,000 times between May 2016 and March 2018⁴². These data give no indication, however, of who downloaded them and whether the number represents unique downloads. This is because the Toolkits are publicly funded, limiting what information can be collected on end users.

Research conducted in 2018 by YouGov indicates that 18% of 'HR decision makers' ($n = 500$) and 8% of 'senior decision makers' ($n = 591$)⁴³ had 'heard of the PHE BITC Toolkits for Employers'⁴⁴. 41% of HR decision makers had heard of the Toolkits through word of mouth. Awareness in large organisations (i.e. 250+ employees) was almost three times greater (32%) than in small organisations with fewer than 50 employees (11%).

4.1.1. Awareness among our study population:

As Table 1 (below) shows, over a third (36%) of survey respondents heard about the Toolkits via BITC. Just over a fifth (21%) heard about them through workplace health and wellbeing-related networks and events. Comparatively fewer (15%) were made aware of them through PHE⁴⁵.

Table 1– How survey respondents heard about the Toolkits

Source	Number	Percentage
Business in the Community (website, emails, membership)	19	36%
Other	11	21%
Public Health England (networks, emails)	8	15%
Word of mouth (either inside or outside of the workplace)	6	11%
Forster Communications (emails, personal connections)	5	9%
Google internet search	3	6%
Media (newspapers, trade publications, internet articles, etc.)	1	2%
Total	53	100%

Awareness amongst Employer Forum members was low as the majority had not heard of the Toolkits or engaged with them in a meaningful way.

Thus, the majority of our study population were made aware of the Toolkits via BITC or PHE themselves (through its website, memberships and networks). This reflects how the sample was sourced and as such could be considered a limitation. Businesses outside of these networks may, like members of our Employer Forum, not be aware of the Toolkits. However, it is difficult to say on the basis of these data alone.

4.2. Perceptions of the Toolkits

In this section we primarily draw on the findings from the interviews and note, where relevant, findings from the Employer Forum and, though to a lesser extent, the survey (the rationale being that the qualitative components provided richer and more detailed insights).

⁴² Information provided via email correspondence by Public Health England

⁴³ Comprising an online interview administered to members of the YouGov Plc UK panel of 800,000+ individuals who have agreed to take part in surveys

⁴⁴ Information provided via email correspondence by Public Health England

⁴⁵ As the majority of interviewees (23) were sourced via the survey sample, the above findings can reasonably be said to apply to them.

4.2.1. Toolkits' perceived purpose

The purpose of the Toolkits was to give employers practical and accessible information on growing public health and wellbeing issues that may affect their business, with a business case for action, and signposting to appropriate resources and support⁴⁶. They were designed to enable employers to translate evidence into practice⁴⁷.

The Toolkits were, primarily, viewed as repositories of information and best practice. A diversity and inclusion manager at a large multinational saw the suite of Toolkits as “resources that are available for people to use with examples of best practice”⁴⁸. Others agreed, describing the Toolkits as “informative documents”⁴⁹, providing “access to numerous resources”⁵⁰ and “data to back up action”⁵¹.

Several interviewees, however, saw the Toolkits as more than merely providing information. For example, an HR professional at a large public sector organisation discussing the Domestic Abuse toolkit, claimed that it is “more than just information – it gives practical advice to better support people going through domestic abuse”⁵².

A small number of interviewees described the Toolkits' purpose as primarily raising awareness. For example, a director of a small voluntary organisation suggested that the Toolkits “help inform people to understand the issue, raising awareness and understanding”⁵³.

4.2.2. Toolkits' perceived strengths

Having explored what was believed to be the purpose of the Toolkits, we now consider what were considered to be the Toolkits' particular strengths.

4.2.2.1. Credible, trustworthy and evidence-based

Most interviewees perceived the Toolkits as evidence-based and valued PHE's reputation as a trustworthy source.

PHE's involvement convinced Toolkit users that they were not commercially driven: “it's not somebody trying to sell you something”⁵⁴. This was considered to be a strength over other resources, e.g. workplace health accreditations schemes.

BITC's involvement was also considered a strength, with one interviewee suggesting it gave them confidence that the Toolkits were “well thought through, considered and robust”⁵⁵. The CEO of a small membership organisation felt that:

*having BITC and PHE championing this space, they could have championed something else. ... having organisations with their reputations involved is really, really welcome and it's very important*⁵⁶.

The fact PHE and BITC produced the Toolkits was valued; it sends a signal to employers that health and work is an important area.

⁴⁶ Findings from the (unpublished) Stage One Interim Report

⁴⁷ Ibid

⁴⁸ Interview participant 1001

⁴⁹ Interview participant 1067

⁵⁰ Interview participant 1003

⁵¹ Interview participant 2002

⁵² Interview participant 2001

⁵³ Interview participant 1067

⁵⁴ Interview participant 1003

⁵⁵ Interview participant 1038

⁵⁶ Interview participant 1012

4.2.2.2. Design and appearance

Several interviewees appreciated the design and appearance of the Toolkits, described by one interviewee as “*aesthetically pleasing*”. According to an HR professional in a large public sector organisation, this gave the Toolkits an advantage over similar tools:

There is a lot of guidance out there, but the Toolkits try to use much more effective and direct communication techniques such as graphics, professionally designed, reflecting data effectively⁵⁷.

Thus, the well-designed, aesthetically appealing nature of the Toolkits and their use of infographics to convey information was considered a particular strength which distinguished them from similar resources.

4.2.2.3. A comprehensive ‘one stop shop’

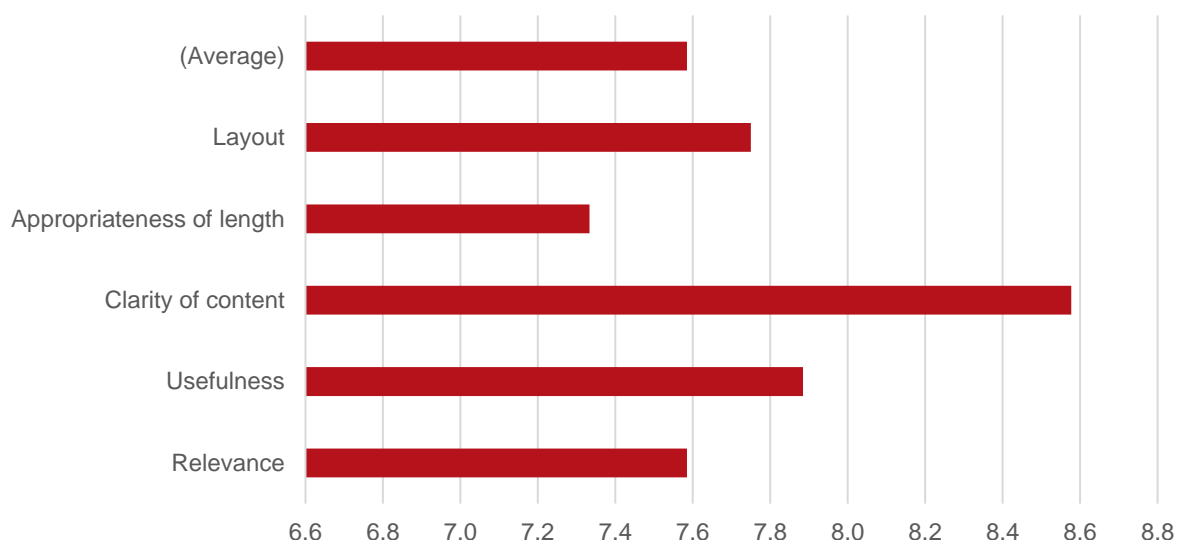
Another consistent theme was the perceived comprehensive nature of the Toolkits. For example, an occupational health manager in a large public sector organisation praised the Sleep toolkit for the fact that it “*brings lots of resources under one roof*”⁵⁸. Some interviewees therefore considered the Toolkits to be a ‘one stop shop’ of resources, providing “*up to date facts and figures*”⁵⁹ and useful case studies⁶⁰ with signposting to other helpful resources⁶¹.

4.2.2.4. Clarity of content

Several interviewees suggested that the clear manner in which the Toolkits present information helped demystify staff health and wellbeing issues. Clarity was valued particularly by micro organisations (employing between 1 and 10 people).

This interview finding is corroborated by the survey findings. Survey respondents were asked to rate the Toolkits, on a scale of 1-10, with respect to their (i) layout, (ii) appropriateness of length, (iii) clarity of content, (iv) usefulness and (v) relevance. The highest rating was recorded for ‘clarity of content’ (with a score of 8.6 for all Toolkits) – see Figure 4 below. Responses to the survey’s open-ended question on what respondents liked about the Toolkits provides further support, with more than a quarter (26%) citing the Toolkits’ clarity.

Figure 4 – Survey respondents’ perceptions of the Toolkits



⁵⁷ Interview participant 1013

5. Findings: the potential impact of the Toolkits on employer practice

Having assessed perceptions of the Toolkits, this chapter considers their impact, and potential impact, on employer practice. Not all participants had yet fully engaged with the Toolkits and it is still valuable to explore how they intended to use them⁶².

As with the previous chapter, we primarily draw on findings from the interviews, however we also note relevant findings from the survey and Employer Forum where applicable.

5.1. Toolkits' impact on employer practice

This section looks at the various ways in which the Toolkits have impacted on employer practice – and the extent to which they align with their anticipated outcomes (as outlined in the initial logic chain – see Appendix). Before doing so, however, it is helpful to get an overview of the Toolkits most commonly used by the study population and their levels of engagement with them.

Figure 5 (below) shows which Toolkit the survey population had engaged most with. Almost a third of the sample (30%) had mainly used the Mental Health toolkit. This is understandable given that it was the first of the series to be published in 2016, and the topic continues to receive widespread interest on a societal level⁶³. The second most commonly used Toolkit was Suicide Prevention (17%), closely followed by Sleep (15%). Almost 80% of respondents (42) had used more than one Toolkit.

Figure 5 – Toolkit most used by survey respondents

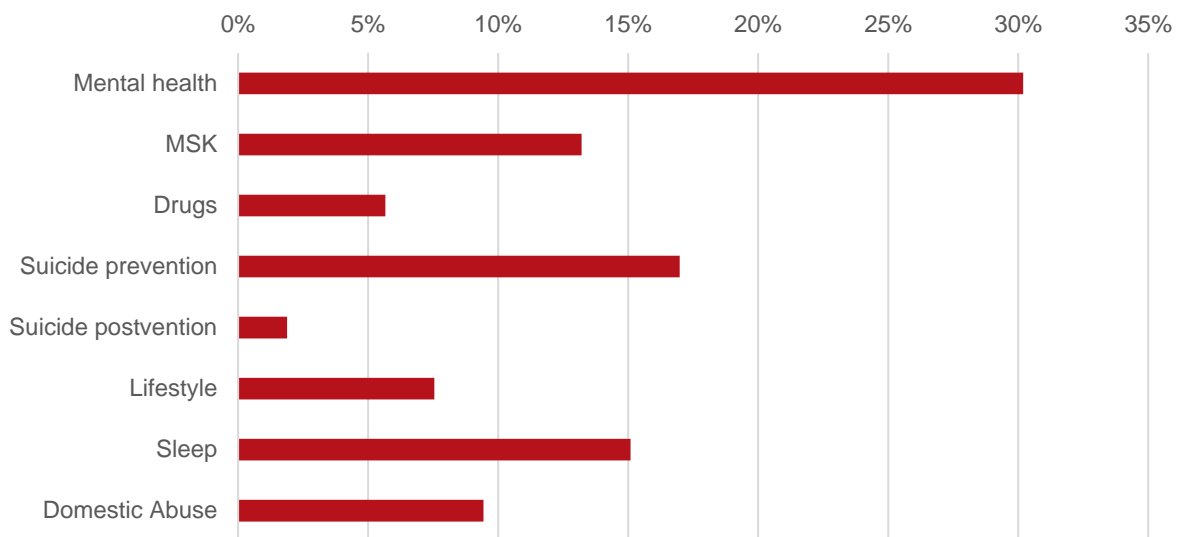


Figure 6 (below) shows the ways in which survey respondents used the Toolkits. As mentioned earlier, 60% said they were involved in producing them, which has implications for how the findings are interpreted. Over 50% of respondents suggested they used the Toolkits to inform health and wellbeing interventions and to raise awareness, with a third (34%) saying it supported presentations to senior management arguing for changes in policy (i.e. to secure 'buy in'). Finally, a quarter (25%) used the Toolkits to inform changes in policy.

⁶² Four case studies illustrating how the Toolkits were used/their impact on employer policy and practice are provided in the Appendix

⁶³ It is also the Toolkit that respondents to a 2018 YouGov survey⁶³ said they were most familiar with.

Figure 6 – How the Toolkits were used



In the following sections, we explore the interview findings, which complement and give meaning to these survey results outlined so far. An overview of the ways in which the Toolkits impact on employer practice is provided in Figure 7 below.

Figure 7 – Toolkits’ impact on employer practice



5.1.1. A ‘sense-checking’ mechanism

Most interviewees used the Toolkits as a mechanism for ‘sense checking’ or reviewing their existing policies and procedures against information in the Toolkits. This applied to interviewees working in both large and small organisations and across the different toolkits.

For example, a diversity and inclusion manager of a large private multinational said they had used the Domestic Abuse Toolkit to:

ensure our house is in order – so we had it on our radar and we looked at it more as a ‘sense-check’ to what we’re doing to make sure there were no gaps that we missed⁶⁴.

An HR professional at large public-sector organisation used it in much the same way, which they described as “*basically a ‘mapping exercise’ between current policy and the Toolkit, looking for gaps in ours*”. Thus, the information in the Toolkit was useful for ensuring that organisations’ existing policies on domestic abuse were sufficient.

This approach was not exclusive to the Domestic Abuse toolkit. The head of health, safety and wellbeing at a large private sector organisation suggested that the information in the Suicide Prevention toolkit served as “*vindication*” that they were taking the right approach⁶⁵. Other interviewees working in similar roles for large organisations, commenting on the Sleep and

⁶⁴ Interview participant 1038

⁶⁵ Interview participant 1041

Mental Health toolkits respectively, suggested they give “*reassurance that we’ve looked at things from different angles*”⁶⁶ and that “*you’re aligned with other thinkers and peers out there*”⁶⁷.

Some small organisations used the Toolkits in a similar manner. For example, the director of a small voluntary organisation used the Suicide Prevention toolkit to review “*our policy on suicide prevention, it was part of the background discussion*” (see Case Study 1 below for more information)⁶⁸.

These findings may be a reflection of how the sample was sourced (i.e. through PHE and BITC). We might expect such organisations to have an existing interest in staff health and wellbeing and, therefore, policies in place.

Case Study 1 – How the Toolkit on suicide prevention shaped policy and practice

This case study describes how Glyn Evans, in his capacity of Wellbeing Lead for the Farming Community Network, engaged with the Toolkits generally and particularly the Toolkit on suicide prevention.

The small, voluntary organisation understood the Toolkits generally to be a useful way of helping inform employers about important and salient staff health and wellbeing issues, i.e. raising awareness and improving understanding, as well as providing a means of how to address these issues. The Toolkits’ effectiveness in doing this was in part due to their aesthetically pleasing and logical design – and as a result they were considered to be easily navigable and ‘user-friendly’.

The Toolkit on suicide prevention proved to be particularly useful when the Farming Community Network reviewed its own health and wellbeing policy and how it addressed this particular issue. The Toolkit served as a way of ‘sense checking’ existing policy against something they perceived to be of a good and reliable standard – in part due to PHE’s sponsorship of the resource. This gave them assurance that their policies were up to date and could be considered good practice.

As well as serving as a means of reviewing their existing policy with respect to suicide prevention, they also used the Toolkit more actively: it informed attempts to raise awareness of the issue through staff training sessions, by drawing on the infographics and their “sobering” statistics.

As well as raising awareness, the training sessions, drawing on guidance provided in the Toolkit, aimed to equip staff with the knowledge and tools they needed in order to be better able to support themselves as well as their colleagues – and to present to senior staff when necessary.

⁶⁶ Interview participant 1003

⁶⁷ Interview participant 1001

⁶⁸ Interview participant 1067

5.1.2. Raising awareness and changing attitudes

Over 50% of survey respondents used the Toolkits as a means of raising awareness, while 34% used them to make the 'case for change' and secure senior buy-in. These findings were reflected in the interviews.

5.1.2.1. Awareness-raising campaigns and sessions for staff

Interviewees from a range of organisations used the Toolkits to raise staff awareness mainly through campaigns but also training sessions. The director of operations at a small private company used the Sleep Toolkit to develop an internal campaign to raise awareness of the importance of sleep, culminating in an interactive training session with an external sleep consultant (see Case Study 2 overleaf for further information)⁶⁹.

Similar findings were reported by an occupational health specialist working in a large public-sector organisation with a large proportion of night shift workers. The Toolkit, particularly its infographics, were printed as posters to raise awareness and "*normalise these issues and surprise staff so that they would do something about it*". This organisation also used Toolkit materials as handouts to line managers.⁷⁰

The Mental Health Toolkit was used in a similar way: a 'wellbeing champion' at a large public-sector organisation used it to "*enliven awareness sessions*" ... "*drawing on its facts and figures and advice*"⁷¹. Furthermore, a senior member of staff at a large public-sector organisation described how the Domestic Abuse toolkit inspired a 'domestic abuse awareness week', culminating in an internal conference, with the infographics displayed as posters⁷².

The Toolkits were also used in more passive ways to raise awareness. For example, several large organisations uploaded the Mental Health⁷³, Domestic Abuse⁷⁴ and Suicide Prevention⁷⁵ toolkits to the staff intranet and promoted them via internal communications.

5.1.2.2. Getting senior 'buy in'

The Toolkits were frequently used to support presentations to senior management, raise their awareness and convince them of the need for action. For example, a diversity and inclusion manager at a large multinational found the case studies "*particularly helpful with getting buy-in and building the business case*"⁷⁶. Other aspects of the Toolkits, e.g. examples that "*show the differences you can make by implementing changes suggested in the Toolkits*", were considered valuable by the head of operations of a small private company⁷⁷ in convincing senior management of the need to take action.

Specifically, case studies were considered an effective means of "*lobbying senior leadership for funding*" illustrating how peer organisations had tackled certain issues, such as staff wellbeing and the improved financial 'bottom line' through reduced sickness absence⁷⁸. Infographics also served as "*something they can grasp immediately and therefore help with getting buy-in, to make the case for action*"⁷⁹.

⁶⁹ Interview participant 1028

⁷⁰ Interview participant 1003

⁷¹ Interview participant 1019

⁷² Interview participant 2004

⁷³ Interview participant 1017

⁷⁴ Interview participant 2001

⁷⁵ Interview participant 1038

⁷⁶ Interview participant 1001

⁷⁷ Interview participant 1028

⁷⁸ Interview participant 1064

⁷⁹ Interview participant 2005

Case Study 2 – Using the Toolkit on mental health

This case study describes a large firm's application of specific sections of the Mental Health Toolkit to support its existing internal mental health services. The specific sections include Step Two of the step-by-step guide, the infographics and the case studies.

This firm is a large advisory and accountancy business with thousands of employees across the UK. Its dedicated wellbeing team sits within the HR department and provides formal, medical services for workers dealing with mental health issues. On top of these formal services however, a more informal network has been established through senior management initiative. The network is linked to the established HR services but offers different entry points. Rather than being based on a point of contact between individual and the wellbeing team, this network connects people dealing with mental health issues across the different departments of the business. Participation in the network is entirely voluntary. The workforce is broadly informed of its existence and those who wish to join can do so.

The non-HR senior manager from whose mind the network originated found great use for the Mental Health Toolkit in establishing the informal network. They indicated that the Toolkit provides a comprehensive, well evidenced body of information discussing practices and policies that are "more than just a passing fad". Particularly the infographics page and the case studies were helpful in making a case for additional mental health supports. As the senior manager is by now very familiar with the Toolkit, they are able to sift through the comprehensive evidence quickly and provides brief, tailored digests for colleagues and staff who approach them with queries.

The Mental Health Toolkit is structured as a step-by-step guide to developing, implementing and monitoring policies and their effects. Particularly helpful for this case was, Step Two - 'build your approach'. This focuses on creating an evidence base for potential interventions by offering practical advice for firms to investigate mental health issues and needs among employees. For example, the Toolkit provides hyperlinks to online tools which can be used to support employee surveys. Furthermore, Step Two emphasises the importance of setting goals, which stimulated the business to identify a desired outcome of an intervention and how progress towards this goal can be monitored. In this case, the senior manager in charge of the network used Step Two to develop a staff survey, which aimed to sensitively take the temperature around mental health support needs and allowed them to index what colleagues needed and wanted out of the network and furthermore helped in setting objectives for the network's functioning. The survey was issued over a consecutive number of years, which allowed the administrator of the survey to monitor progress over time.

In terms of progress towards the desired outcomes, the mental health network has leadership backing, but requires additional commitment and further development to evolve what is in place and to expand on it. The senior manager in charge of the network indicated that good policy on mental health issues in the workplace is not something to be installed in one go and then never thought of again, but is rather an iterative process. Everything takes time and requires reinforcement.

5.1.3. Changes in policy and practice

As the survey findings outlined above show, 25% of respondents used the Toolkits to inform and direct changes in policy, over 50% used them to inform health and wellbeing interventions, and 26% used them as part of staff training. In this section, we explore the interview findings, demonstrating how the Toolkits were used to support changes in policy and practice.

Case Study 3 – Changing shift work

This case study describes the use of the Toolkit on sleep in supporting a review of shift work of security staff in the University of Sunderland.

Initially, Susan Wynn, the Occupational Health Manager in the HR team of the University, which is responsible for nearly 2,000 support staff across two different sites in England, came across the full range of the BITC Toolkits. She passed on those that were most relevant to members of the workforce where she knew they would be best placed.

As such, the Sleep and Recovery Toolkit landed on the desk of the management of the security team which had night work. Staff often worked consecutive nights, up to as many as seven nights in a row. Management used the Toolkit to underpin and structure a review of the shift pattern. They shared information on sleep and the effects of shift work with the workers and consulted with them. Over a period of time, workers and management together discussed different potential shift patterns.

Finally, through significant engagement with HR and management, initial worker resistance to a change in the shift pattern took a turn, culminating in a decisive popular vote in favour of implementing a new pattern of working two nights plus two days, followed by four days off.

This selection of the new shift pattern saw staff working much fewer consecutive nights, which was hoped to contribute to better quality sleep. The new schedule was implemented in March 2019 and reportedly has proven very successful and popular.

5.1.3.1. Changes in policy

A minority of interviewees suggested they used the Toolkits to make changes to existing policy (see Case Study 3 above for an example of how the Sleep toolkit changed company policy on shift work). The head of operations at a small private sector company had used a several of the Toolkits extensively, the Mental Health Toolkit in particular:

we ensured that, with our policies, everything was flowing down from the top – from the leadership – and as a result we completely changed the way we did our annual review – we ripped it up basically based on the Toolkit, putting more emphasis on the role of line managers ... this has been really positive, giving everyone a platform to talk about it [mental health] in a way they're comfortable⁸⁰.

⁸⁰ Interview participant 1028

As such, the Toolkit played an important role in shaping policy and creating a safe environment for employees to talk about mental health issues (see Case Study 4 overleaf for below information).

While other interviewees had not used the Toolkits as extensively, the head of health, safety and wellbeing at a large private sector organisation suggested they had “*used some of the thinking behind the toolkit to inform policy on how to better manage suicide risks in the workplace*”⁸¹. Specifically, they drew on the Suicide Prevention toolkit’s guidance to inform policy, for example putting in place key elements around an education and training programme.

Finally, an HR professional at a large public-sector organisation used the Domestic Abuse toolkit to “*make informed changes to our own guidance on domestic abuse*” and “*facilitate conversations between managers and employees*”⁸².

Case Study 4 – Overhauling company mental health policy

This case study describes how the director of operations in a small, private sector company used the Toolkits – specifically those on the subjects of mental health and sleep – in a number of ways.

The Toolkit on sleep was used to support an awareness-raising campaign and support sessions for staff. Specifically, based on guidance provided in the Toolkit, the company developed an internal campaign to raise awareness of the importance of getting a good sleep for maintaining health and wellbeing. This culminated in an interactive training session with an external ‘sleep consultant’, which was driven and informed by the Toolkit.

In addition, the Toolkit suite generally was considered to be useful in getting senior ‘buy in’ for making changes in health and wellbeing policy and practice. The examples and case studies included in the Toolkits were useful for illustrating, to senior management, the differences that can be made by implementing changes suggested in the Toolkits.

Getting senior buy-in was instrumental in making changes to policy and practice. For example, although they had a well-developed mental health policy in place, the Toolkit on this topic enabled them to overhaul parts of the policy. The company’s annual review process was changed, following guidance in the Toolkit, so that it occurred on a more frequent basis. In addition, the role of line managers was changed, expanding their remit to support employees with their health and wellbeing needs. This manifested in a new format for one-to-one meetings which allowed for a more ‘person-centred’ discussion around personal growth rather than just work, putting emphasis on the importance of mental health and a more holistic approach to management.

These changes would not have taken place had this organisation not interacted with the Toolkits.

⁸¹ Interview participant 1041

5.1.3.2. Potential policy changes

A small number of interviewees planned to use the Toolkits to update existing policy. For example, a diversity inclusion manager at a large multinational intended to use the Domestic Abuse Toolkit to inform policy so that when an employee presents with a domestic abuse issue, the organisation is set up in a way to address it in an appropriate manner⁸³. A manager at a large public sector organisation intended on using the same Toolkit in a similar way⁸⁴.

In addition, an occupational health professional at a large public-sector organisation suggested they planned on using the Suicide Prevention toolkit to serve as a “*deep dive into the issues*” and in turn enable us to deliver “*training for HR and business partners, as well as put in place guidance for managers*”⁸⁵. They attributed the fact they had not yet done this to “*other priorities*”.

Thus, the Toolkits were seen as a potentially useful means of updating existing policy and providing guidance for managers. Amongst the reasons why relatively few interviewees had used them to actually change policy was due to a lack of time/capacity.

5.1.3.3. Changes in practice

A significant proportion of interviewees had made changes in practice due to the Toolkits. This was the case for both large and small organisations and several of the Toolkits.

The Toolkit most commonly used in this manner was Mental Health. A senior manager at a large private sector organisation used it to develop an employee survey to collect data on mental health issues in the workplace. The Toolkit’s checklist made it “*easy to set objectives knowing that we could monitor our progress against them*”⁸⁶.

An occupational physician at a large public-sector organisation, used the same toolkit to develop a wide-ranging ‘action plan’, involving:

*complete re-evaluation for leadership and management from the top down to ensure that mental health is included in through staff support programmes*⁸⁷

The impetus for this was the emphasis the Toolkit placed on the role of line managers. This inspired the head of operations at a small private company to change the way that line management meetings were conducted. Previously held every six months, they now took place more often and:

*with a new format so they’re more person-centred around personal growth rather than just work – so more holistic, emphasising the importance of mental health*⁸⁸.

In line with Toolkit guidance, line managers also received training, thus empowering them to *support their employees*⁸⁹.

Another way in which the Mental Health toolkit changed employer practice, reported by a health and wellbeing specialist at a large private company, involved

*placing more importance on getting managers through the mental health training. We didn’t put enough emphasis on it before, but the data in the Toolkits convinced us that it has to be mandatory and as a result we’ve really pushed to ensure people do it*⁸⁹.

⁸⁴ Interview participant 1009

⁸⁵ Interview participant 1037

⁸⁶ Interview participant 1064

⁸⁷ Interview participant 2005

⁸⁸ Interview participant 1028

⁸⁹ Interview participant 2002

The Toolkits reaffirmed the importance of ensuring line managers are equipped with the skills needed to handle staff health and wellbeing issues.

Finally, beyond the Mental Health toolkit, a director at a small voluntary organisation explained how they used the Suicide Prevention toolkit to “*train their workforce*”, equipping them with the knowledge and tools they need to be able to better support themselves and each other⁹⁰.

5.1.4. Evidence of longer-term impacts

While some interviewees were able to point to longer-term impacts, e.g. improvements in sickness absence, they often attributed this to their organisation’s wider wellbeing strategies, and as such could not definitively say it was due to the Toolkits⁹¹. For example, a senior manager at a large private sector organisation pointed out, it was “*very difficult to say whether the Toolkit has had long-term impacts as it was not the only resource used*”⁹², while a director of a small voluntary organisation noted:

*We use them [the Toolkits] as part of a whole resourcing process, resourcing ourselves and the organisation. They stand alongside other resources too, of which there are many... so really it’s part of a package of resources we use to inform our work*⁹³

While none of the interviewees had conducted evaluations of policies or practices taken from the Toolkits, some, including an occupational health professional at a large public sector organisation, had conducted evaluations of interventions that the Toolkit in part inspired, e.g. awareness campaigns⁹⁴.

Others were unsure of exactly what to measure:

*It’s difficult to give categorical “yes” or “no” particularly for something like mental health because how do you really measure it? Reductions in sickness absence? The number of times people conversations, etc. – it’s difficult to measure*⁹⁵

Thus, not only was it difficult to isolate longer-term impacts that could be attributable to the Toolkits, interviewees also found it difficult to know what to measure.

⁹⁰ Interview participant 1067

⁹¹ Interview participant 1041

⁹² Interview participant 1064

⁹³ Interview participant 1067

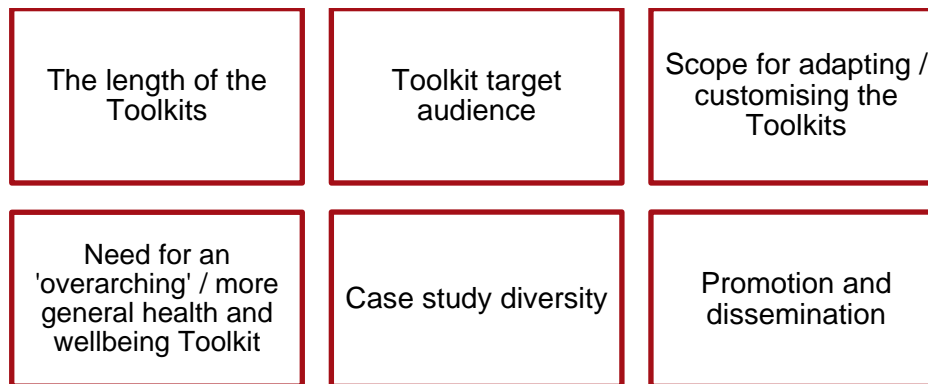
⁹⁴ Interview participant 1059

⁹⁵ Interview participant 1001

6. Findings: areas for improvement

This chapter details areas where study participants felt the Toolkits could be improved. See Figure 8 below for an overview.

Figure 8 – Overview of areas for improvement



6.1. The Toolkits' length

One area of improvement suggested by a significant number of study participants concerned the Toolkits' length. They are, on average, 58 pages long (though have become shorter over time).

One interviewee – the head of health, safety and wellbeing at a large private sector organisation – suggested the Toolkits would benefit from being “*shorter, cutting off a lot – at least 20% – without losing the sense of it*”⁹⁶. Employer Forum members expressed similar views; one, who worked for a large membership organisation with experience producing employer-focused tools, argued that “*as soon as it gets above 5-7 pages people skim ... worried something this long with a massive amount of info will get lost*”⁹⁷.

These qualitative findings are corroborated by our survey findings. Respondents were asked to rate the Toolkits, on a scale of 1-10, with respect to their (i) layout, (ii) appropriateness of length, (iii) clarity of content, (iv) usefulness and (v) relevance. The lowest rating was recorded for length (with a score of 7.3 for all Toolkits compared to an average of 7.8 – see Figure 4 above).

6.1.1. Toolkit summaries

The addition of summary documents to accompany the Toolkits was considered another area for improvement. It was felt this would enable people to “*dip into the additional detail if they wanted or needed to*”⁹⁸. An HR professional in a large public sector organisation echoed these views, calling for “*very concise summaries in addition to the full document*”⁹⁹.

Two-page summaries do in fact exist for the full suite of Toolkits (except Suicide Prevention and Postvention) and are available on the BITC website. Interviewees, however, were largely unaware of them.

⁹⁶ Interview participant 1014

⁹⁷ Employer Forum member TB

⁹⁸ Interview participant 1043

⁹⁹ Interview participant 1013

6.1.2. Complexity and use of space

In addition to summaries, interviewees called for more simplicity. An Employer Forum participant, a CEO of a small organisation, suggested that *“PHE should be more focused on more simple messages. Simplicity is key – with an emphasis on practicality”*¹⁰⁰.

Furthermore, one interviewee – the head of health, safety and wellbeing at a large private sector organisation – suggested that the Toolkits could be more economical with space:

*When opening the document there’s a whole page from the CEO of Unilever, a whole page from the Samaritans, a whole page from someone from PHE – they’ve given three pages away, but when you’re a business you want to get straight into it, can’t afford to give so much space away*¹⁰¹

Thus, the amount of space given to forewords, particularly from health experts, was considered excessive.

6.2. The Toolkits’ target audience

A significant number of study participants felt that the Toolkits could be improved by being clearer about their target audience. Though nominally aimed at “businesses of all sizes”¹⁰², we found evidence that stakeholders involved in the design and production of the Toolkits were divided on this¹⁰³. Interviewees were divided too.

6.2.1. Organisation size

There was evidence that study participants were confused about what size organisation the Toolkits were aimed at. Some felt they were *“perfect for SME businesses that are starting on a health and wellbeing journey”*¹⁰⁴ and perceived them to have less appeal with large organisations with *“initiatives and programmes already in place”*¹⁰⁵. Others questioned how SMEs would handle a “60-page document [the Suicide Prevention toolkit]”¹⁰⁶, with a programme manager at a large public sector organisation suggesting that the Toolkits *“did not look like a product that is relevant to SMEs in terms of guidance”*¹⁰⁷.

As such, several interviewees felt that the Toolkits would benefit from *“defining and tailoring content for a specific audience, e.g. a certain business size”*¹⁰⁸. Some Employer Forum members, e.g. the CEO of a small organisation, suggested that for SMEs the *“Toolkits would get lost in all other info they get”*¹⁰⁹. Thus, it was suggested, by an occupational health professional at a large public sector organisation, that BITC/PHE should be:

*stratifying them and targeting them and thinking about the size of organisations. A large multinational organisation in the public sector has very different needs to a local, private sector SME*¹¹⁰.

Thus, by being clearer about what size organisation the Toolkits were aimed at, content would be more relevant and applicable to employers’ needs, which differ greatly between different sized organisations.

¹⁰⁰ Employer Forum member NS

¹⁰¹ Interview participant 1041

¹⁰² Findings from the (unpublished) Stage One Interim Report

¹⁰³ Findings from the (unpublished) Stage One Interim Report

¹⁰⁴ Interview participant 1003

¹⁰⁵ Interview participant 1004

¹⁰⁶ Interview participant 1013

¹⁰⁷ Interview participant 1027

¹⁰⁸ Interview participant 1022

¹⁰⁹ Interview participant NS

¹¹⁰ Interview participant 1037

6.2.2. Organisation sector

In addition to size, one interviewee suggested the Toolkits should account for different sectors. This was based on the fact that, between sectors, the type of work employees perform varies greatly, e.g. somebody providing home-care in the social care sector compared to somebody providing IT support services in an office environment (to use examples given by the employee, whose organisation included both types of workers, i.e. on and off-site).

Although the use of statistics regarding, for example, the number of people affected by suicide in the workplace, was welcomed, study participants felt that generalised or national statistics would not necessarily get the message across to all employers – some would think “*that’s the UK average – that doesn’t apply here*”¹¹¹. Similar concerns were raised by Employer Forum members.

6.2.3. The employer ‘journey’

Study participants felt that better recognition of the employer ‘journey’, i.e. how sophisticated employers are in their approach to health and wellbeing (i.e. whether they needed to be convinced of the need to act or simply needed the tools in order to do so), would improve the effectiveness of the messages in the Toolkits. This was, in part, perceived to be related to organisation size:

*there are lots of small companies out there that dabble in health and wellbeing but don’t know where to start and if they came across one of the Toolkits it would still be too much information*¹¹².

Due in part to the amount of information in the Toolkits, organisations ‘starting out’ on a journey towards developing health and wellbeing measures who are unsure what to do next – particularly small ones – may be deterred by the comprehensive nature of the Toolkits; “*some people just want basics and to start on that journey*”¹¹³.

On the other hand, some interviewees, e.g. an occupational health professional at a large public sector organisation, felt the Toolkits contained too much irrelevant information for an organisation at the more ‘sophisticated’ end of the spectrum:

*we know the statistics, we understand the business case, we’re well-versed in the importance of focusing on health and wellbeing and the benefits to individuals and the organisation and we know the key metrics, I’m not sure the Toolkits go beyond that*¹¹⁴.

This interviewee already understood the need for action, and so a lot of what the Toolkits are dedicated to was not relevant to them. They wanted more advice and guidance on implementation.

6.2.4. Organisation personnel

Finally, study participants felt more clarity was needed on who, *within* organisations, the Toolkits were for. Some felt that, because the people actually implementing health and wellbeing interventions in organisations, i.e. ‘on the ground’, are rarely senior, they should be targeted at them¹¹⁵. An Employer Forum member suggested an effective approach is targeting a specific type of employee, e.g. a line manager, and designing the resource with them in mind¹¹⁶.

¹¹¹ Interview participant 2002

¹¹² Employer Forum member ASp

¹¹³ Employer Forum member ASp

¹¹⁴ Interview participant 1037

¹¹⁵ Interview participant 1022

¹¹⁶ Employer Forum member AS

Others, however, e.g. an occupational physician at a large public sector organisation, suggested that the Toolkits should be aimed at senior members of staff, who have the power to take action¹¹⁷.

6.3. The Toolkits' adaptability

Related to the need for better targeting was the perception, amongst some study participants, that the Toolkits were too 'rigid' and therefore difficult to adapt to individual organisations' needs. For example, an occupational health specialist working in a large public sector organisation felt that being able to adapt the Toolkit to an organisation's particular needs would enhance its impact. To make their point, they used an example from the Sleep toolkit, which recommended that employees should get between 7-9 hours sleep. However, a significant proportion of their employees worked on call, making that impossible. Thus:

even though it's good generic advice and is good for 'best tips' it doesn't always fit so that's where a template-like toolkit where you can copy and paste the good stuff into your own organisation—that would be better¹¹⁸.

Others agreed: Employer Forum members commented that the 'steps' recommended by the Toolkits do not always follow a logical structure. The Toolkit checklists, though welcome, should be more flexible – accounting for organisations that may have already implemented some of the steps¹¹⁹. It was felt that, above all, a toolkit should be customisable, allowing users to personalise the content and take what they want from it – they were unsure that the Toolkits did that¹²⁰.

6.3.1. Different media/format

It was felt that part of the solution to this problem involved using a more flexible or interactive form of media/format for the Toolkits. Communicating case studies via video was suggested by one interviewee¹²¹. Those that had used the Sleep toolkit, which includes several videos that 'bring to life' the Toolkits' content, welcomed this.

Others suggested that better use of technology, for example utilising an 'app' that can be used on employees' electronic devices, could aid the Toolkits' impact¹²². More generally, there was a perception that the Toolkits were "*quite fixed – they're all PDFs so you can't really adapt and change them*"¹²³. This made it "*difficult, from a navigation point of view, to find where things are and it's difficult because there is so much information*"¹²⁴.

By embracing technology and alternative formats, one interviewee argued that the Toolkits could become "*living documents, to use a blueprint*"¹²⁵. This would, in turn, allow them to be updated as time goes on, preferably on an annual basis. This would in part address another criticism, that the information and guidance given in the Toolkits would become outdated in only a few years^{126,127}.

¹¹⁷ Interview participant 2005

¹¹⁸ Ibid

¹¹⁹ Employer Forum member CF

¹²⁰ Employer Forum member ND

¹²¹ Interview participant 1019

¹²² Interview participant 1013

¹²³ Interview participant 1003

¹²⁴ Interview participant 1064

¹²⁵ Interview participant 2005

¹²⁶ Interview participant 1009

¹²⁷ The Stevenson / Farmer review. (2017). Thriving at work. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf

6.4. An overarching 'general' Toolkit

A number of study participants felt that there was a need for a 'general' wellbeing Toolkit that sat 'above' the other, topic-specific Toolkits in the suite. This was, in fact, something suggested by one of the stakeholders involved in the design and delivery of the Toolkits¹²⁸. For example, the CEO of a small voluntary organisation – who had work and health expertise – suggested that, for individuals with an awareness of work and health issues:

*a specific Toolkit on sleep, for example, is interesting, but if you're the Federation of Small Business or a small business owner – or indeed any employer – it looks like too much info and 'bitty'*¹²⁹.

Furthermore, it was also argued that because “a lot of the recommendations in the Toolkits are about general wellbeing, a merger of them all or an overarching wellbeing toolkit”¹³⁰ would be welcome.

6.5. The use of case studies

It was felt that the Toolkits could be made more applicable to their target audience by using more relevant case studies. Interviews with stakeholders involved in the design and delivery of the Toolkits revealed it was difficult to secure case studies from SMEs. As a result, some questioned the Toolkits' applicability to SMEs¹³¹.

Study participants raised similar concerns. A diversity and inclusion manager at a large multinational pointed out that, above all, they valued case studies from similar organisations, i.e. in the same industry. This, they claimed, helped “put some weight behind something we want to implement”, and in making the case for action to senior staff¹³². A director at a small voluntary organisation made similar comments, suggesting that, ultimately:

*We pick up more on case studies that relate directly to the issues we deal with or the organisations we deal with*¹³³.

As an Employer Forum member (who worked for a large membership organisation) put it:

*A retail organisation is not interested in what happens in the public sector. Frankly, case studies from companies like Tesco are useless if you're a small organisation*¹³⁴.

Again, the applicability of case studies from large organisations for small ones, as well as from private sector to public sector, was raised.

6.6. Promotion and dissemination

The most often noted area of improvement was the promotion and dissemination of the Toolkits. The majority of the survey sample had been made aware of the Toolkits through existing relationships with PHE and BITC and most were unsure if they would have come across the Toolkits through other channels. This potentially speaks to concerns raised by some stakeholders involved in the design and delivery of the Toolkits around the networks used to promote,

¹²⁸ Findings from the (unpublished) Stage One Interim Report

¹²⁹ Interview participant 1012

¹³⁰ Interview participant 1003

¹³¹ Findings from the (unpublished) Stage One Interim Report

¹³² Interview participant 1001

¹³³ Interview participant 1067

¹³⁴ Employer Forum member TB

disseminate and distribute them, namely that they were too narrowly focused on large corporate employers¹³⁵.

6.6.1. Launch and marketing

A significant number of interviewees suggested that the launch and marketing of the Toolkits could be improved. Generally, they felt that the outputs did not have enough publicity or a big enough marketing campaign around them. For example, a health and wellbeing lead for a large multinational had not noticed them being publicised in HR magazines, engineering and business publications, etc.¹³⁶. Some felt that the Toolkits were not promoted enough compared to other workplace health resources. A director at a small voluntary organisation, for example, suggested that with Mental Health First Aid England, you get regular emails and updates, but “*I’ve never seen anything promoting the Toolkits*”¹³⁷. One interviewee suggested that the Toolkits lacked a “*proper promotion strategy*”¹³⁸.

It was also suggested that the audience at the annual Health and Wellbeing at Work conference¹³⁹, where the Toolkits were typically launched, was not broad enough, limiting the Toolkits’ reach, particularly with private sector organisations¹⁴⁰.

6.6.2. Use of networks

More intelligent use of networks was suggested as a means to improve the Toolkits’ reach, particularly with SMEs:

*SMEs look for local sources, trade associations, chambers of commerce, they might ask their friend up the road, must be spread as widely and broadly as possible, they may go to their banks or insurance companies. Not one point of information*¹⁴¹.

An Employer Forum member, who is a small business expert, made similar comments, pointing out that although around three quarters of small businesses are members of some organisation, not one single organisation has a particularly large share¹⁴².

Moving beyond SMEs, it was felt that broader networks should have been utilised to ensure that more private sector organisations were made aware of the Toolkit – as they use different networks to public sector organisations¹⁴³. A health and wellbeing specialist at a large private company argued that advertising needed to “*push the resource in my face*”¹⁴⁴, suggesting that other tools they have used have been more actively promoted by organisations like ACAS, for example. As a result, they were more likely to use those resources.

Study participants suggested that organisations like the Chartered Institute of Personnel Development¹⁴⁵ (CIPD) and Business Disability Forum¹⁴⁶ would have helped reached a wider audience. Indeed, a senior programme manager at a small voluntary organisation suggested that “*I would never have thought about looking up toolkits for workplace health issues from PHE*”¹⁴⁷.

¹³⁵ Findings from the (unpublished) Stage One Interim Report

¹³⁶ Interview participant 1043

¹³⁷ Interview participant 1067

¹³⁸ Interview participant 1029

¹³⁹ <http://www.healthwellbeingwork.co.uk/>

¹⁴⁰ Interview participant 2005

¹⁴¹ Interview participant 1027

¹⁴² Employer Forum member NH

¹⁴³ Interview participant 1017

¹⁴⁴ Interview participant 2002

¹⁴⁵ The Chartered Institute of Personnel and Development is a professional association for human resource management professionals

¹⁴⁶ Business Disability Forum is a not-for-profit membership organisation promoting and supporting the employment of disabled people

¹⁴⁷ Interview participant 1029

7. Discussion and conclusions

This chapter provides a discussion of the overall research findings and conclusions. These should be interpreted with respect to the constraints on the employer population we were able to work with (as detailed earlier in Chapter 3). The chapter culminates in a developed ‘logic chain’, incorporating the evaluation findings.

7.1. Awareness and perceptions of the Toolkits

This section outlines the conclusions from the research in relation to study participants’ awareness and perceptions of the Toolkits.

7.1.1. Toolkit awareness

Due to the lack of ‘management information’ held by PHE/BITC on who uses the Toolkits and the limitations of the study sample, it is difficult to offer definitive conclusions on this on the basis of this research. The sample was sourced through PHE/BITC networks and most interviewees, when asked, were unsure whether they would have heard of the Toolkits if not for their existing relationship with these organisations. Furthermore, awareness of the Toolkits amongst the nine members of the Employer Forum (not sourced through these networks) was low.

Given that a large number of study participants felt the Toolkits needed better promotion and dissemination, one might conclude that awareness amongst employers – generally speaking – would be relatively low. This is consistent with concerns that were raised by some stakeholders involved in the design and production of the Toolkits¹⁴⁸.

For context, YouGov reported a Toolkit awareness of 8-18% amongst a random sample of 1,000+ UK employees¹⁴⁹ and BITC data suggest the Toolkits have been downloaded 26,000 times¹⁵⁰. However, these data offer no insight into who downloaded the Toolkits.

7.1.2. Toolkit perceptions

Study participants largely perceived the Toolkits as repositories of information, though they are primarily intended to be tools to translate evidence into practice¹⁵¹. This suggests they may not be being used as intended. That said, several interviewees saw the Toolkits – particularly the most recent one (Domestic Abuse) – as practical tools to support employees’ health and wellbeing. One might interpret this as some (albeit limited) evidence that attempts to improve the Toolkits over time have had some success.

The Toolkits – above all – were praised for their clarity, something particularly valued by participants working for smaller organisations. This is logical given that such organisations are typically more ‘time poor’ and resource-constrained. The infographics epitomised this, presenting complex information clearly and concisely. The PHE ‘brand’ was also valued.

7.2. Potential impact on employer practice

It is reasonable to conclude that the Toolkits did deliver on some of the outcomes which were anticipated by stakeholders (outlined in the ‘logic chain’ in the Appendix) involved in the design and production of them. There was ample evidence study participants, in a range of organisations, had used the Toolkits to raise awareness of health and wellbeing issues with the aim of changing attitudes. Thus, the Toolkits were, in some respects, considered to be a useful means of ‘winning hearts and minds’.

¹⁴⁸ Findings from the (unpublished) Stage One Interim Report

¹⁴⁹ Comprising 591 ‘senior decision makers’ and 500 ‘HR decision makers’ respectively

¹⁵⁰ Between May 2016 and March 2018

¹⁵¹ Findings from the (unpublished) Stage One Interim Report

They were also considered an effective means of securing senior-level 'buy in', i.e. convincing management of the need for action – an essential 'first step' for achieving organisational change.

In addition to the above, some interviewees (albeit a minority) – representing both private and public sector organisations varying in size – used the Toolkits to inform and direct health and wellbeing policy. One organisation in particular – a small private company – had used them extensively to 'rip up' existing policy and re-shape it using the Toolkits. However, this organisation was quite heavily involved in producing the Toolkits (more so than any other organisation interviewed).

Comparatively more organisations had *planned* to make changes to their policy drawing on the Toolkits, the reason for not yet doing so primarily being a lack of time/capacity. This could indicate that Toolkit users would have benefitted from additional support to implement Toolkits guidance (and some did suggest this).

The Toolkits were more commonly used to facilitate changes in practice. They were used – across a range of organisations – to inform employee health and wellbeing surveys, shape staff training programmes, and most commonly to 'transform' the role of line managers, making meetings more person-centred. This amounts to evidence of the PHE Health and Work programme's aim to embed a 'whole system', i.e. holistic, approach, which is significant.

Mental Health toolkit users were the most likely to report changes in practice. This could be due to several reasons. Firstly, it was the most widely used by interviewees. Second, it is on arguably the broadest topic in the suite, and awareness of the importance of mental health at work has grown rapidly in the UK in recent years (in part evidenced by the recent independent review on mental health and work¹⁵²). Third, it is the oldest in the suite (published in mid-2016), thus giving organisations relatively more time to read, digest – and implement – its guidance.

Given the emphasis that toolkits generally – and these Toolkits specifically – place on achieving practical change, the above findings are significant: they demonstrate how Toolkits across the suite have facilitated changes in policy and practice across a range of organisations.

However, we cannot say, based on this research, what longer-term impacts these changes have had on the organisations studied. None of the interviewees had evaluated any Toolkit-inspired changes, possibly due to their limited awareness of the 'Self-Assessment Toolkits'¹⁵³. Indeed, some participants suggested they were unsure how to measure or track progress against the information and guidance in the Toolkits. That said, we can conclude that the Toolkits, at least to some extent, appear to have been successful in facilitating policy and practice changes that could, in time, have positive impacts on employee health and wellbeing (notwithstanding the highly engaged nature of the study population, i.e. in many cases contributing to Toolkit development).

Some caution is advised, however, given the number of interviewees using the Toolkits in a 'passive' manner – i.e. 'sense-checking' their existing policies against the information and guidance in the Toolkits, possibly reflecting many study participants' perceptions of the Toolkits as primarily 'repositories of information'. This could in part be due to the nature of the sample, with over 80% of interviewees being large employers and many sourced via BITC/ PHE and contributing to the Toolkits' development. We might therefore expect these organisations to be relatively sophisticated (compared to the 'average' UK employer) in terms of their thinking and practice on health and wellbeing.

¹⁵² The Stevenson / Farmer review. (2017).

¹⁵³ Designed as accompaniments to the Toolkits to assist users with implementation by monitoring progress

Given the above it is difficult to make conclusions regarding the extent to which the Toolkits delivered on the longer-term (i.e. manifested over 2-3 years) **impacts** anticipated by stakeholders (and outlined in the 'logic chain' in the Appendix) involved in the design and delivery of them. This is principally due to (i) lack of attempts by interviewees to track these effects, and (ii) the age of the Toolkit suite, with the majority of them being published in 2018.

7.3. Areas to improve

Several areas of improvement were highlighted by study participants. To summarise, these pertained to the Toolkits' length, target audience, the lack of scope for customisation, the need for an 'overarching' / general Toolkit, lack of case study diversity and promotion and dissemination efforts. Further discussion and recommendations on how to address these areas is provided in Section 8.2 below.

7.4. Developed logic chain

Building on the initial logic chain (developed from the interviews carried with six stakeholders involved in the design and production of the Toolkits – see Appendix), an updated logic chain is set out below, incorporating the findings of the evaluation.

The Toolkits can, to some extent, be said to have delivered on the intended 'outcomes' outlined in the initial logic chain. There was also evidence of another outcome – not anticipated by stakeholders – revealed by the research (and highlighted in bold in Figure 9 below) regarding the Toolkits' effectiveness in securing senior level 'buy-in'.

For reasons outlined in Section 7.2 above, it is not possible to make definitive conclusions regarding the Toolkits' contribution to the impacts outlined in the logic chain. These should be focused on in subsequent evaluations.

Figure 9 – Developed ‘logic chain’

Rationale	Inputs	Activities	Outputs	Outcomes	Impacts
<ul style="list-style-type: none"> Address gap in employers’ ‘health and work’ knowledge (i.e. ‘market failure’) Address the lack of tools / resources supporting employee health and wellbeing that appeal to businesses of all sizes Help employers navigate a crowded workplace health ‘marketplace’ – acting as a ‘roadmap’ for employers Encourage a holistic, whole system approach to health and wellbeing Act as a repository for practical, accessible, and reliable information / evidence Support action in the workplace to enable people with health issues to access, retain or return to employment 	<ul style="list-style-type: none"> Costs and resources directed at development The latest and best available evidence on salient workplace health topics Peer review by relevant experts (e.g. Health & Safety Executive and Trades Union Congress) Consultations with expert advisory bodies (e.g. PHE Health and Work Advisory Board) Review and clearance from PHE’s ‘publications panel’ Co-produced with range of stakeholders Example case studies from (SMEs and large) employers Summary infographics with ‘action points’ 	<ul style="list-style-type: none"> Piloting of each Toolkit with SMEs and large organisations (can also be considered an ‘input’) PHE/BITC comms team issue press releases Further engagement through conference presentations / publication of blogs Media coverage (e.g. online and in trade publications) Dissemination / promotion via BITC/PHE networks; social media; large employers’ supply chains Webinars / seminars 	<ul style="list-style-type: none"> Download figures for individual Toolkits YouGov research exploring numbers of businesses aware of the Toolkits with a representative sample of HR and ‘senior’ decision makers Anecdotal feedback collected by stakeholders involved in the design and delivery of the Toolkits and sourced via networks and events / conferences about what actions businesses taking 	<ul style="list-style-type: none"> Improved awareness, understanding and knowledge, amongst employers, of salient workplace health issues, how to address them, and where to look for guidance Changes in attitudes towards health and wellbeing at work, e.g. reduced stigma surrounding health at work Secure senior level ‘buy in’, convincing upper management of the need to take action Changes in policy and practice, e.g. improved health and safety policies, health and wellbeing interventions / staff training informed by tools for implementation and step by step guides included in the Toolkits 	<ul style="list-style-type: none"> Health and wellbeing policies that take a holistic ‘whole system’ approach, reflecting employees’ both in and outside work Sustained increased in business discourse around health and work Sustained improvements in retention of people at work Expediting return to work for people with health conditions Sustained improvements in sickness absence Sustained improvements in employee productivity, i.e. reduced presenteeism Greater numbers of people with health conditions / disabilities in employment

8. Recommendations

The findings outlined above show that the Toolkits (i) are perceived to have a number of strengths and (ii) have facilitated some changes in policy and practice in different types of organisations. This suggests the Toolkits have, to some extent, been successful in ‘supporting action in the workplace to enable people with health issues to access, retain or return to employment’ (PHE’s Health and Work programme objective).

However, the findings must be interpreted with some caution. The evidence this evaluation has been able to provide is limited to a small number of employers. Furthermore, a large proportion of study participants had contributed to the development of the Toolkits in some way, and – despite this – many had *not* used the Toolkits to change policy and practice.

As such, there is scope for improving the Toolkits. The recommendations outlined below are distributed along a continuum. At one end are those that would require PHE to reflect on whether the Toolkits are the most suitable means of delivering on the Health and Work programme’s objectives, and what alternative interventions might look like. At the other end are recommendations designed to make the existing Toolkit suite more effective.

This chapter therefore provides recommendations in three parts. The first focuses on what alternative policies that could deliver on the Health and Work programme’s objectives might look like. The second concentrates on how the Toolkits’ impact can be enhanced. The third, and final, part, considers how the Toolkits’ impact can be better captured and demonstrated by subsequent evaluations.

8.1. Delivering on the Health and Work programme’s objectives

This evaluation found evidence that, in some respects, the Toolkits have contributed to PHE’s Health and Work programme objectives.

However, given the nature of the sample, it is important to consider how the Toolkits could be improved to have a wider impact with a sample that is not already familiar with them (i.e. involving employers that have not contributed to the Toolkits’ development). Thought should also be given to whether toolkits are the most appropriate means of securing changes in employer policy and practice. Indeed, though gaining popularity in recent years, evidence of toolkits’ effectiveness as a knowledge translation strategy is lacking^{154,155}.

As such, consideration should be given to other modes of delivery, i.e. different interventions deployed instead of or alongside toolkits. These should – as the Toolkits were – be co-developed with employers. A ‘one-size-fits-all’ solution is necessarily more limited to certain types of employers. A key consideration is, therefore, what can be done to tailor solutions to different ‘business communities’. Solutions that embrace these differences and the principles of co-production are more likely to have a positive impact. Furthermore, the intervention should have processes/mechanisms for monitoring/measurement ‘built in’ from the start; thus facilitating robust evaluations of effectiveness and impact.

8.2. Recommendations to enhance the Toolkits’ impact

8.2.1. Target audience

While the Toolkits are aimed at employers of ‘all sizes’ and sectors, the findings of this research suggest that targeting a specific audience may enhance their impact. Toolkit content could be stratified to an organisation’s size, sector, level of understanding of health and wellbeing, and

¹⁵⁴ Barac, R., Stein, S., Bruce, B., & Barwick, M. (2014). Scoping review of toolkits as a knowledge translation strategy in health. *BMC Medical Informatics and Decision Making*.

¹⁵⁵ Yamada, J., Shorkey, A., Barwick, M., Widger, K., & Stevens, B. J. (2015).

specific employees. Identification/appointment of ‘champions’ and advocates specific to certain sectors and ‘business communities’ could help facilitate this.

This could be achieved without significantly altering the Toolkits’ content, for example by:

- Organising case studies by size and sector. Case studies from large organisations were not considered relevant to SMEs, just as case studies from public sector organisations were not considered relevant to private sector ones. Organising case studies according to these characteristics will enhance their impact as information from ‘peer groups’ will have more resonance with the target audience
 - More case studies should be sourced from groups that are currently underrepresented, e.g. SMEs
- Providing sector-specific statistics – and clearly signposting to them. Abstract, national-level figures may lack impact/resonance with employers. Sector-specific statistics should be used, to make the issue seem more ‘real’
 - For example, MSK conditions are more prevalent in the manufacturing sector. Making explicit reference to this in the MSK Toolkit could enhance impact with this group
- Accounting for employers being at different stages in the employer ‘journey’. Some employers have a sophisticated understanding of health and wellbeing and do not need to be persuaded of the need to act – they want to know what they can do and how. Other groups, however, will not understand why they should invest in employee health and wellbeing, and thus need to be convinced.
 - The needs of both these groups can be catered for by clear signposting in the contents page (perhaps with an illustration of the employer ‘journey’) which guides employers through the Toolkits, highlighting the bit most relevant to them
- Recognising that different employees will use the Toolkit in different ways. More senior staff will generally be more receptive to the ‘business case’ and rarely involved in implementing changes ‘on the ground’. Mid-level staff, comparatively, will be more likely to implement changes and will value practical guidance more
 - This can be achieved through clearer signposting in the contents page highlighting where employees should look depending on their roles and responsibilities
- Identifying/appointing ‘champions’ or advocates specific to certain sectors and ‘business communities’ to promote the value of and potential benefits to engaging with the Toolkits.

8.2.2. Length

There are two principal ways to address the Toolkits’ length:

- Develop ‘Toolkit summaries’ which are longer than the two-page infographic summaries that currently exist for six of the eight Toolkits in the suite, but are shorter than the Toolkits themselves.
 - For example, reduce space dedicated to forewords, particularly from health and wellbeing experts.
- Improve the visibility and awareness of the existing two-page infographic summaries (and develop ones for the two Suicide toolkits).

8.2.3. Format and media

Providing the Toolkits in a more interactive format (i.e. not PDF) should be explored. This would:

- Enable organisations to adapt the Toolkits’ content to their specific circumstances.

- Ensure that the Toolkits remain up-to-date and ‘state of the art’.

A different format could also potentially accommodate the following:

- A facility for user-provided content, allowing organisations to upload examples of best practice, e.g. case studies, facilitating benchmarking.
 - This would increase the diversity of case studies and ensure the Toolkits remain up to date
- A rudimentary financial model/calculator enabling organisations to explore the costs/benefits of implementing a workplace health intervention
 - This would address concerns that abstract, national-level statistics on the prevalence of health and wellbeing issues lack resonance/impact

The use of different media, e.g. videos, to communicate statistics and particularly case studies could enhance impact.

8.2.4. An overarching ‘general’ Toolkit

Given the perceived similarities between the various Toolkits in terms of their advice and guidance, there was clear demand for a ‘general’ Toolkit which sat ‘above’ the existing condition-specific products in the suite. This would complement the ‘whole system’ approach.

8.2.5. The ‘Self-Assessment Toolkits’

Given that a significant number of organisations had made plans to make changes in policy and practice – but had not yet done so – suggests that the Toolkits’ impact could be enhanced by providing more practical advice and guidance. This could be addressed without significantly altering the existing Toolkits’ content by promoting the ‘Self-Assessment Toolkits’ and expanding them to cover the entire suite.

8.2.6. Promotion and dissemination

The Toolkits should be consistently promoted via PHE and BITC social and media channels, as well as relevant trade publications, particularly on ‘awareness days/weeks’ pertaining to the issues they cover. For example, there is an annual ‘National Suicide Prevention Week’ – the Suicide toolkits should heavily promoted on such occasions.

More targeted use of networks should also be prioritised. To better target SME organisations, thought should be given to the networks/sources that they typically use and trust. This includes local sources such as trade associations, chambers of commerce, banks, insurance companies.

Renewed attempts should be made to secure engagement and endorsements from various member and representative organisations including the Federation of Small Business, Make UK, Trades Union Congress, ACAS, the Chartered Institute of Personnel and Development, Business Disability Forum, Local Enterprise Councils.

Given the crowded nature of the workplace health ‘marketplace’, a sustained media and communications campaign is needed.

Additional ways of ensuring the Toolkits get sufficient exposure could include:

- Hosting the Toolkits on the .gov.uk website.
- Improve their visibility on BITC’s website. They currently do not have their ‘own’ page, sitting alongside other resources dedicated to health and wellbeing.
 - Improved visibility of the ‘auxiliary’ Toolkits (i.e. the ‘Self-Assessment Toolkit’ and infographic summaries) – perhaps with their own separate section.

- Mechanisms for re-contacting Toolkit users should be explored, e.g. requiring an email address when downloading the Toolkits. This could form the basis of a 'management information system' as well as present opportunities for re-promoting the Toolkits in future.

8.3. Recommendations for future evaluations

Future evaluations of interventions/policies (including the Toolkits) designed to deliver on PHE's Health and Work programme objectives should follow the recommendations outlined below.

1. The policy scope of intervention (e.g. Toolkit) – and how it contributes to the Health and Work programme's objectives – must be clearly defined. Once established, the 'logic chain' provided in this report must be adapted so that the activities to be tested and trialled are clear. For example, if some of the Toolkits are to be refined as a pilot, the nature of the refinements should be captured.
2. Having done this, clarity is needed over what, exactly, is being measured, i.e. what 'success' looks like. This should be informed by the outcomes and impacts outlined in the logic chain presented by this research.
3. Once it has been agreed what is being measured, the target audience must be clearly defined and any activities to reach this group carefully monitored. Monitoring information should be collected so that the target population is captured.
4. The performance of the target group – which has been exposed to the 'intervention' (i.e. has used the Toolkits) – must be measured against a set of relevant indicators (where improvement is expected in) using a baseline survey.
 - a. Additional information can also be gained through qualitative methods, generating insight into, for example, the motivators and barriers to behaviour change, i.e. providing context to and explanations for why change occurred (or not)¹⁵⁶.
5. A 'control group' that shares the same characteristics as the target/treatment group must be defined, e.g. if the organisations in the target group are all SMEs operating in the same sector then the control group should be the same, though this group must not have been exposed to/used the Toolkits. There are different ways in which the target and control group can be identified. For example, a random control trial would randomly select both groups and try to stop 'self-selection'. In contrast, if there is a desire to allow self-selection, the control group would need to be matched to the treatment group as closely as possible. Practical guidance on developing a research evaluation framework, outlined by RAND Europe, should be sought¹⁵⁷.

The target group should – ideally – have been 'exposed to' (i.e. used) one specific Toolkit. One of the limitations affecting the present research has been evaluating eight different Toolkits (which although share similarities are also different in a number of ways). Thus, we recommend evaluating the Toolkits separately, as they do not – strictly speaking – constitute the same 'intervention'. This would make it easier and simpler to demonstrate evidence of effectiveness and impact.

¹⁵⁶ HM Treasury. (2011). The Magenta Book.

¹⁵⁷ RAND Europe. (2013). Developing a research evaluation framework. Retrieved from: https://www.rand.org/content/dam/rand/pubs/research_briefs/RB9700/RB9716/RAND_RB9716.pdf

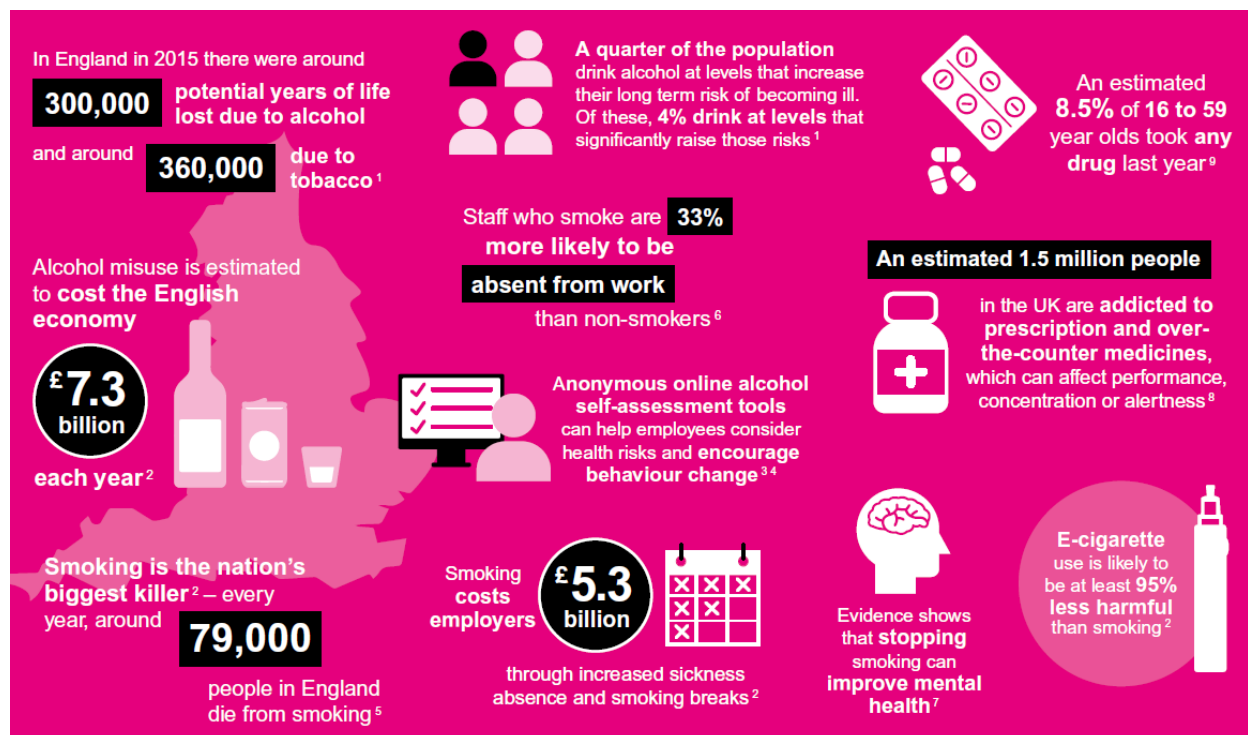
Appendix

Toolkit content and structure

Example of Toolkit contents page (taken from the musculoskeletal health toolkit)

Introduction & forewords		2/ Managing MSK	27	4/ Going further	47
MSK in numbers	3	Prevention, early intervention and rehabilitation	28	Use your supply chain	48
Good MSK health	4	Understanding MSK needs	29	Use business organisations	48
Sickness absence	5	What can go wrong?	30	Tell your story	48
Checklist of actions	6	Prevention	31	Resources for employers	49
What this toolkit will do	7	Avoiding hazards and risks	32	Case studies	53
Foreword by Professor Kevin Fenton	8	Early identification of physical capability problems of employees	32		
Foreword by Professor Anthony Woolf	9	Early intervention	33		
Foreword by Peter Simpson	10	Adjustments in the workplace	34		
The business case for supporting MSK in the workplace	12	Rehabilitation and return to work	34		
MSK health in all types of business	13	Self-management	35		
The moral case	14	Understanding the law	36		
BITC's Workwell Model	15	Potential grants	36		
1/ Be prepared	17	Resources and NHS Guides	37		
Why MSK health matters	18	Checklist	38		
Definitions	19	3/ Knowledge and training	39		
Impact of MSK health on work	20	Knowledge and training for managers and employees	40		
MSK and mental health	21	Line managers	42		
Open communication	22	Training	43		
Creating an open culture	23	Expert views	44		
Beginning the conversation	24	Training in communications	45		
Checklist and useful resources	26	Checklist and useful resources	46		

Example of Toolkit infographic (taken from the Drugs, Tobacco and Alcohol toolkit)



Example of Toolkit checklist (taken from the Mental Health toolkit)

➤ Step 1: Make a commitment

- ☑ There is a clear commitment from the senior level of the organisation that mental health matters and that it will work to promote good mental health, support those that need it and challenge the stigma.
- ☑ This commitment is stated in a form that is visible and understandable to all employees. This may include signing the Time to Change Employers Pledge.
- ☑ The organisation has appointed a senior level employee to be the Mental Health Champion to drive forward this commitment. This Champion is supported by a working group that helps to support the Champion and develop and implement the commitment.

➤ Step 2: Build your approach

- ☑ The senior team understands and acts on all its legal requirements around workplace mental health and risk management – the rights of employees is also communicated to all employees.
- ☑ The organisation has assessed the mental health needs of its employees, understands where improvements are needed and identified clear objectives for development, along with the business case for doing so.
- ☑ Mental health is reflected in all relevant workplace policies and a plan for delivering better mental health is in place, with clear actions that can be achieved and reported back on every six months / year.

➤ Step 3: Positive culture

- ☑ There are effective management standards in place that ensure employees feel supported and valued.
- ☑ The organisation ensures that the workplace environment is conducive to promoting healthy behaviours and limiting the potential for it to cause ill health.
- ☑ There is a system in place, such as risk assessments, to prevent stress.
- ☑ Job design and roles are reviewed so as to ensure they are appropriate and conducive to productive work.
- ☑ Social activities, volunteering and out-of-work activities are actively encouraged and supported by the organisation.
- ☑ The organisation provides appropriate avenues and frequency of communication to keep staff at all levels informed of the approach to wellbeing.

➤ Step 4: Support & training

- ☑ The structure of the organisation ensures that information is freely shared and every employee knows how to access support and who to discuss their needs with.
- ☑ The organisation has recognised the key role in effective line management in driving good mental health and wellbeing.
- ☑ All line managers receive training in mental health and all employees are educated to increase their mental health literacy and to recognise the signs that they may need support.
- ☑ Build mental health awareness into all induction programmes.
- ☑ Performance reviews allow employees to comment on issues that affect their performance and enables training needs to be identified.

Initial 'logic chain'

Rationale	Inputs	Activities	Outputs	Outcomes	Impacts
<ul style="list-style-type: none"> • Address gap in employers' 'health and work' knowledge (i.e. 'market failure') • Address the lack of tools / resources supporting employee health and wellbeing that appeal to businesses of all sizes • Help employers navigate a crowded workplace health 'marketplace' – acting as a 'roadmap' for employers • Encourage a holistic, whole system, whole system approach to health and wellbeing • Act as a repository for practical, accessible, and reliable information / evidence • Support action in the workplace to enable people with health issues to access, retain or return to employment 	<ul style="list-style-type: none"> • Costs and resources directed at development • The latest and best available evidence on salient workplace health topics • Peer review by relevant experts (e.g. Health & Safety Executive and Trades Union Congress) • Consultations with expert advisory bodies (e.g. PHE Health and Work Advisory Board) • Review and clearance from PHE's 'publications panel' • Co-produced with range of stakeholders • Example case studies from (SMEs and large) employers • Summary infographics with 'action points' 	<ul style="list-style-type: none"> • Piloting of each Toolkit with SMEs and large organisations (can also be considered an 'input') • PHE/BITC comms team issue press releases • Further engagement through conference presentations / publication of blogs • Media coverage (e.g. online and in trade publications) • Dissemination / promotion via BITC/PHE networks; social media; large employers' supply chains • Webinars / seminars 	<ul style="list-style-type: none"> • Download figures for individual Toolkits • YouGov research exploring numbers of businesses aware of the Toolkits with a representative sample of HR and 'senior' decision makers • Anecdotal feedback collected by stakeholders involved in the design and delivery of the Toolkits and sourced via networks and events / conferences about what actions businesses taking 	<ul style="list-style-type: none"> • Improved awareness, understanding and knowledge, amongst employers, of salient workplace health issues, how to address them, and where to look for guidance • Changes in attitudes towards health and wellbeing at work, e.g. reduced stigma surrounding health at work • Changes in policy and practice, e.g. improved health and safety policies, health and wellbeing interventions / staff training informed by tools for implementation and step by step guides included in the Toolkits 	<ul style="list-style-type: none"> • Health and wellbeing policies that take a holistic 'whole system' approach, reflecting employees' both in and outside work • Sustained increased in business discourse around health and work • Sustained improvements in retention of people at work • Expediting return to work for people with health conditions • Sustained improvements in sickness absence • Sustained improvements in employee productivity, i.e. reduced presenteeism • Greater numbers of people with health conditions / disabilities in employment

Study participants' characteristics

Survey respondents

Organisation size	Number of respondents	% of respondents
Large	44	83%
Medium	3	6%
Small	4	8%
Micro	2	4%

Organisation industry	Number of respondents	% of respondents
Agriculture, forestry & fishing	1	2%
Business admin & support services	2	4%
Construction	1	2%
Education	3	6%
Finance and insurance	8	15%
Health	5	9%
Information and communication	2	4%
Manufacturing	2	4%
Mining, quarrying and utilities	6	11%
Other	4	8%
Professional, scientific and technical	7	13%
Public Admin	10	19%
Retail	1	2%
Transport & storage (inc postal)	1	2%

Organisation sector	Number of respondents	% of respondents
Private	28	53%
Public	19	36%
Voluntary/third	6	11%

Interviewees

ID	Organisation size ¹⁵⁸	Industry	Organisation sector
1000	Large	Finance and insurance	Public
1003	Large	Mining, quarrying and utilities	Public
1004	Large	Finance and insurance	Public
1005	Large	Information and communication	Private
1006	Medium	Professional, scientific and technical	Voluntary/third
1014	Large	Professional, scientific and technical	Public
1015	Small	Business admin and support services	Private
1017	Large	Public Admin	Private
1018	Large	Public Admin	Public
1019	Large	Mining, quarrying and utilities	Private
1027	Large	Public Admin	Private
1029	Micro	Other	Private
1034	Large	Construction	Private
1036	Large	Finance and insurance	Voluntary/third

¹⁵⁸ Large = 250 > employees; Medium = < 250; Small = < 50; Micro < 10

ID	Organisation size¹⁵⁸	Industry	Organisation sector
1037	Large	Other	Public
1041	Large	Finance and insurance	Public
1042	Large	Education	Public
1043	Large	Manufacturing	Private
1044	Large	Public Admin	Voluntary/third
1059	Large	Transport & storage (inc postal)	Public
1060	Large	Mining, quarrying and utilities	Private
1062	Large	Public Admin	Private
1064	Large	Finance and insurance	Public
1066	Large	Finance and insurance	Private

Employer Forum participants

ID	Organisation size	Organisation sector
ND	Large	Private
ASp	SME	Private
NS	SME	Voluntary/third
TB	Large	Voluntary/third
CF	Large	Private
SH	SME	Private
AM	Large	Private
NH	SME	Private
AS	Large	Private

