HealthWorks Homerton:
Creating a healthy workforce in the NHS

November 2010

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HealthWorks Homerton: Creating a healthy workforce in the NHS

Gail Beer
Emma Hill

November 2010

Supported by

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HealthWorks is a joint venture between Coca-Cola Great Britain and Homerton University Hospital NHS Foundation Trust for staff health and wellbeing. It was developed to deliver an effective and sustainable workplace health programme at Homerton Hospital and to create a model of best practice for workplace health. Homerton is the ‘Olympic’ hospital for the London 2012 games, and has the opportunity to become an exemplar site and to outreach to the local community. It could therefore contribute to the health legacy of the London 2012 Olympics resulting in more people involved in sport.

The HealthWorks programme encouraged Homerton Hospital to look more widely at their place within the community. NHS Trusts should not only be a place for healthcare delivery, but a resource for those wishing to stay healthy. HealthWorks is a positive account of private sector involvement in the NHS which we hope will be an inspiration to others.

2020health were engaged to independently evaluate this initiative and to tell its story. We are indebted to Coca-Cola Great Britain who enabled this appraisal to be undertaken with special thanks to Dr Beckie Lang, but also all our partners including Homerton University Hospital NHS Foundation Trust, Interel Consulting, Heart Research UK and RDSI.

Julia Manning
Chief Executive, 2020health
November 2010
www.2020health.org

2020health.org
33 Victoria Street London SW1H 0HW
T 020 3107 7702 E admin@2020health.org
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The Coca-Cola Company has a long and proud record in supporting high profile sporting events. We have recently been involved with the FIFA World Cup 2010 in South Africa and we are looking forward to playing our part in the London 2012 Olympic Games. We recognise, however, that if our involvement is to mean anything, it must be about more than the high profile sporting stars; it must also be about encouraging the wider community to take up a more active, healthy lifestyle.

How many of us start a new exercise regime filled with good intentions but find the pressures of work and family life mean that it is increasingly difficult to find the time?

With all that in mind we approached the Homerton University Hospital NHS Foundation Trust (HUHFT), the Olympic Hospital to offer a partnership to support them in developing a healthy workplace programme. Our hope was to address the barriers that stop people taking up fitness activities and to work towards a model that could be used across the NHS. Thus HealthWorks was born.

This entirely independent report by 2020health charts our journey. It highlights some areas that could have gone better and the major challenges that face anyone taking on such a project; but the overall message is clear: HealthWorks is a success! It has made a real difference to the health of many individuals who work at the hospital and to the mindset and understanding of leadership in the hospital in addressing the challenge of creating a healthy workplace.

Finally it demonstrates the value of a partnership to act as the catalyst and to provide ongoing support to turn ideas into reality. It has been a great learning experience for Coca-Cola Great Britain to work with HUHFT on this project and I am delighted that the team at the hospital has also valued the experience of working with our team.

It only remains for me to thank all those who have worked so hard to make HealthWorks a success and to urge you to read this report and to take the lessons to your own workplace.

Jon Woods
Country Manager,
Coca-Cola Great Britain and Ireland
Striving for higher standards of care and improving the quality of services to our patients, their carers and loved ones is a key objective of all those involved in the delivery of health care. To achieve this we are dependent on maintaining a healthy and happy workforce, because without our staff it would be impossible for the NHS to deliver the care demanded of us by the public.

At Homerton, as an NHS Foundation Trust, we have always recognised the importance of our staff and have been active in ensuring that we demonstrate the value we place on them and the work they do. The recent white paper recognises this importance and gives a commitment to staff that NHS Boards will strive to make improvements to address the issues Dr Boorman raises. We recognise we also have duty to the public to create a healthy workforce that acts as a role model for the community at large and those who represent the future in Hackney.

When Coca-Cola Great Britain (CCGB) approached Homerton, the London Olympics 2012 hospital, to join with them in developing a programme to improve the health and wellbeing of staff, we were delighted to accept as it was a natural next step in demonstrating our commitment to our staff and the Olympics 2012 legacy.

HealthWorks has been a real success at Homerton and has engendered a sense of community and a feel good factor that is impossible to measure in numbers. We have witnessed many of our staff becoming actively engaged in exercise programmes that have not only improved their level of fitness but been fun and fostered a sense of teamwork essential to the delivery of well-run health services. Seeing our Nordic Walkers brave all weathers and our football teams practising after work has become a common sight here at Homerton and encourages others to get involved in new ways.

For our Board, HealthWorks has encouraged us to refocus on how we address health and wellbeing at work and incorporate it into our core objectives. This is not because we think it ticks a box but because it instinctively feels right. HealthWorks will grow and develop at Homerton, it allows staff to shape the activities and encourages them to raise issues and engage in addressing them jointly with senior managers.

Without CCGB’s sponsorship Homerton could not have achieved so much so quickly and with so much fun. Together we hope we have not only made a difference to the staff who have participated, but their friends and family and those yet to participate.

Nancy Hallet
Chief Executive, Homerton University Hospitals Foundation Trust
Being healthy and well at work has become a public health issue which the Government has acknowledged is key to staff in the NHS. The Boorman report has shown that there is a clear link between NHS staff health and patient outcomes. The NHS workforce nationally loses 10 million working days each year due to ill-health absence, and it has been suggested up to a third of these days could be recouped if NHS staff health needs were prioritised.

HealthWorks Homerton is a joint venture between Coca-Cola Great Britain (CCGB) and Homerton University Hospital NHS Foundation Trust (HUHFT) for staff health and wellbeing. It was developed with the objectives of delivering an effective and sustainable workplace health programme at Homerton Hospital and creating a model of best practice. HUHFT was approached because, in its role as the Olympic Hospital in the London 2012 games, it has the opportunity to become an exemplar site and outreach to the local community. It could further contribute to the health legacy of London Olympics 2012 which aims to get more people involved in sport. In the context of the NHS as a whole, HUHFT is one of the smaller hospital NHS Trusts and has 4247 members of staff. For HUHFT this programme was about staff health and engagement in wellbeing. Shani Anderson was employed by HUHFT to implement the programme and is a successful former Olympic athlete with a track record in delivering similar projects.

HealthWorks Homerton is an organisation-wide initiative to encourage greater levels of exercise and healthy eating amongst hospital staff. The programme was developed jointly in consultation with staff. This report evaluates the effects of introducing free gym membership, onsite exercise classes, staff MOTs and a dedicated onsite Lifestyle Co-ordinator. A target group (midwifery) was chosen to measure changes in health indicators such as BMI, eating habits, stress levels and blood pressure. However the results were limited as the sample was small and assesses a relatively short time period from January to June 2010.

Working with a number of research partners employee’s attitudes to health and wellbeing were assessed. Challenges and barriers to helping staff develop and maintain healthy lifestyles were also identified through senior management interviews, staff MOTs, staff workshops and paired interviews. Managers reported that there was a 'good feeling’ about HealthWorks at Homerton.

2020Health were engaged to independently evaluate this initiative, to tell its story, make recommendations for the transferability of the model and the future of corporate involvement in health. This report considers HealthWorks Homerton’s strategic alignment with the NHS White Paper (issued Jul 2010) and the Boorman report (Nov 2009). HealthWorks at HUHFT is still continuing.

Key findings and outcomes

The key findings and outcomes can be divided into two groups. For staff at HUHFT;

- HealthWorks Homerton has had some success in encouraging staff to re-evaluate their health. It has had a positive physical and mental impact on those who have engaged with the programme.
- The greatest benefit of the initiative for staff was that it made them feel valued and made exercise more accessible. On the other hand, the greatest deterrent for staff participating was time constraints due to shift patterns.
- The nominated target group of staff recorded benefits in terms of decreased stress levels and BMI, but recorded negative impact in terms of snacking and eating ‘5 a day.’ Overall the target group had more success than the general NHS Trust population. This would indicate that appointing a target group can be effective.
- Having a dedicated Lifestyle Co-ordinator helped encourage staff to stay motivated. Staff felt that the launch of HealthWorks Homerton was fun and useful.

For HUHFT as an employer;

- Minimal change in staff sickness absence, vacancy or turnover rates.
- Leadership, resource (social and financial) and branding were noted as key elements for the implementing the HealthWorks Homerton programme. Conversely, strategic overview was not seen by HUHFT initially as an essential component of making HealthWorks Homerton a success and responsibility of members for health and wellbeing was less clear.
- The introduction of a Lifestyle Co-ordinator was a key contributor to implementing this programme. The role was pivotal in ensuring strong leadership, providing motivation and communicating with employees.
Given a clean slate HUHFT would focus more on healthy eating, operational processes and clinical engagement, especially of those staff who work outside of 9-5 hours.

Exceptional staff attendance at the health festival that launched HealthWorks Homerton (over 600 people).

HUHFT as an employer is now thinking more about the health and wellbeing of their staff and has a greater understanding of the links between work and health.

Overall there was a 9% uptake of free gym membership (32 out of 374 who signed up) however 89 staff attended one of the participating gyms which represents 2.1% of all HUHFT staff. This is considered poor by the Trust. Overall 181 staff (4.3%) have taken part in a HealthWorks Homerton classes e.g. pilates. The total exercise participation of HUHFT’s workforce is 6.2%, which accounts for any overlap of participants. This number indicates a foreseeable health gain for HUHFT staff, which is seen as positive by the Trust.

In evaluating the programme and whether it met CCGB’s original objectives, 6 key components were recognised and addressed which informed the 10 recommendations. These were:

- Has HealthWorks Homerton changed the NHS Trust’s and employee’s attitude to health and wellbeing?
- Was the project well-managed and planned?
- How well does HealthWorks Homerton align with Boorman’s recommendations?
- Did the programme offer value for money?
- What was the value of Coca-Cola Great Britain’s involvement?
- Is this a model that can be used elsewhere?

In conclusion, the HealthWorks Homerton programme presented an opportunity to engage in the personal health of health care professionals at HUHFT. This initiative, though not unique in its strategic aim of empowering and educating staff to make healthier lifestyle choices (to prevent work-related or lifestyle influenced ill health), offered a good learning opportunity. It was found that in implementing wellbeing initiatives, resource, branding and leadership are crucial. Partners and project leaders need to ensure that local managers understand the relationship between a healthy, happy workforce and the quality of care and performance within the workplace. Good marketing is essential in enabling staff to have access to information both generally on staying healthy and specifically on hospital initiatives. At HUHFT, CCGB’s ideas, resource and expertise were key components in driving HealthWorks Homerton forward.

The HealthWorks Homerton programme encouraged HUHFT to look more widely at their place within the community. NHS Trusts should not only be a place for healthcare delivery, but a resource for those wishing to stay healthy, a role model for the local population and a private sector partner.

**Key Recommendations**

1. Develop a broad vision and strategy for health and wellbeing at work that engages the wider local community and identifies opportunities for partnership.

2. Organisations should have strong Board level leadership with the resolve to support health and wellbeing, with a visible and approachable operational lead similar to HealthWorks Homerton Lifestyle Co-ordinator.

3. That good project management tools e.g. PRINCE2 are adopted for any project development and roll out.

4. In developing any programming there needs to be clear objectives and well-defined metrics for evaluating success.

5. Communication and marketing should have full staff coverage, be highly visible and accessible, and supported by leaders at all levels.

6. All organisation-wide policies should have embedded a commitment to health and wellbeing.

7. Organisations should co-ordinate activities between departments that are able to support health and wellbeing at work in an atmosphere of mutual trust and respect between employer and employee.

8. Design programmes in partnership with staff, to reflect local environments and needs, to maintain continuous evaluation and communication, and to allow for adjustments.

9. In developing a business case, identify full cost breakdowns per head of staff and identify target reductions in sickness absence against costs per head of health and wellbeing programme. These should be evaluated regularly.

10. Ensure that links are maintained with partner organisations and legacy is a key objective for any external sponsorship.
1. Introduction

“It is essential that all NHS Trusts put staff health and wellbeing at the heart of their work”
Prof. Steve Boorman (2009)

This report evaluates the progress of ‘HealthWorks Homerton’, a workplace health and wellbeing programme implemented at the Olympics 2012 Hospital, Homerton University Hospital NHS Foundation Trust (HUHFT). Both the programme and research had been sponsored and designed by Coca-Cola Great Britain (CCGB) in partnership with HUHFT. 2020health were engaged to independently evaluate this initiative, to tell its story, make recommendations for the transferability of the model and the future of corporate involvement in health.

Building on previous research, it presented an example of partnership in providing a wellbeing programme for those who work in the NHS and acknowledged their role as ambassadors for health. The project at HUHFT built on previous work on more informed lifestyle choices and the relationship between ill-health, work and unemployment. This report reflects the requirement for best practice policy development, health promotion and the wider implementation of wellbeing services for NHS staff in the post-White Paper environment.

It should be noted that because the sample size was small and timeframe short, this study was a reflection, rather than an exact quantification, of the overall impact of the HealthWorks Homerton programme, which still remains to be fully assessed. It should be noted that the term ‘HealthWorks’ is adopted to describe the programme at HUHFT in its entirety. This term had not always been employed throughout the project, but it became the adopted name of the wellbeing programme at Homerton. For the purposes of this report we will simply refer to Healthworks Homerton as HealthWorks.

1.1 Background on health, work and wellbeing

Much has been written around health, work and wellbeing and this theme has become prominent on the political agenda. Making public health a priority in society requires that information is available to enable individuals to make healthier lifestyle choices. There has been a huge drive in recent years, through programmes like Change4Life, to help individuals to be healthier and more active.

The London Olympics 2012 is offering a huge impetus for sports participation, aiming to make the UK a world-leading sporting nation. In July 2010 the Coalition Government, in association with Sport England, announced a legacy action plan. This recognises the importance of sport in healthy lifestyles and aims for 1 million people doing more sport by 2012-13. The Department of Health, with the Olympics 2012 health legacy in mind, has set out how Local Authorities and Primary Care Trusts (PCTs) can respond to the needs of
their local population through encouraging more physical activity. This drive for greater physical activity aligns with the public health agenda for reducing the population-wide incidence of coronary heart disease and obesity, hypertension, depression and anxiety.

It is well documented that ill health and long term disease such as stress and musculoskeletal disease, the two most likely health conditions to affect people of working age, are influenced by the social and psychological conditions at work. It has been discussed whether the ability to work should be a clinical outcome of treatment and a greater focus of health services and clinicians. With respect to the health inequalities agenda, as highlighted in the Marmot review, it is evident that low pay, lack of control and quality of work all impact on an individual’s health and wellbeing at work and their ability to work more generally.

Health, work and wellbeing has been addressed jointly by the Department of Health (DH) and Department of Work and Pensions (DWP). The Director for Health and Work, Dame Carol Black, published Working for a Healthier Tomorrow, the first review of its kind, which examined the health of Britain’s working age population. It was estimated by The Confederation of British Industry (CBI) that 175 million working days were lost in 2006 due to sickness absence, at a cost to the economy of £13 billion. Black’s report made a number of recommendations, foremost of which was adoption of a new approach to the relationship between health and work, thus encompassing forward thinking for investment in health and wellbeing programmes.

The Government’s response to Black’s review, Improving Health and Work: Changing Lives, fully accepted the recommendations made and further requested the Department of Health to commission a comprehensive review to gather evidence on the health of NHS staff, and their health and wellbeing provision at work. This independent review built an evidence base, and made recommendations for system-wide improvements in the health and wellbeing of the NHS workforce.

Dr Steve Boorman, Chief Medical Adviser to Royal Mail Group, oversaw the NHS review publishing the final report NHS Health and Wellbeing in late 2009. In an attempt to ‘get its own house in order’ the NHS acknowledged the need to improve the health and wellbeing of its staff. As Europe’s largest employer with 1.3 million employees, the annual cost of staff sickness to the NHS is estimated to be £1.5 billion. The report suggested that if sickness absence rates could be reduced by a third, then a cost saving to the NHS would be £555 million, the equivalent of 14,900 full time staff.

The Boorman report found a clear link between staff health and patient safety, experience and effectiveness of care. For example it was demonstrated that staff wellbeing can impact on the incidence of MRSA. There is much support for the ‘invest to save’ business case which identifies that the benefits gleaned far outweigh the initial outlay for staff focused services.

There are other issues that are influenced by refocusing on NHS staff health and wellbeing, which stretch beyond sickness absence and agency rates. Improved productivity levels is one key example, as it has been a major concern that the NHS despite unprecedented levels of health spending has not led to increased productivity. Public health also needs to have a presence in thinking around NHS staff health and wellbeing. Boorman commented, “It is clear that healthcare in future will have a stronger preventative emphasis than in the past, and if the NHS is to be seen to practise what it preaches it will be important that its own staff take action to reduce their own risk factors and are seen to champion lifestyle improvements”.

Both regulators, the Care Quality Commission (CQC) and Monitor were advised to consider support for staff wellbeing in their assessment processes of NHS organisations, whether checking for standards or deciding about granting Foundation NHS Trust status.

NICE have produced public health guidance for decision makers on supporting behaviour change, as interventions to change behaviour have enormous potential to alter current patterns of disease. Further to this, NICE have produced guidelines on promoting mental health and wellbeing at work which recommend a strategic and sustained approach to mental wellbeing promotion, including board level support and organisation-wide engagement. Some pertinent recommendations that directly relate to staff health and wellbeing programmes are:

- ensure that the approach takes account of the nature of the work, the workforce and the characteristics of the organisation;
- promote a culture of participation;
- raise awareness and reduce potential for discrimination;
- mitigate against and manage risk of stress.

At the same time the Government launched Working our way to better mental health: a framework for action, the first nation-wide mental health and employment strategy. This was designed to improve wellbeing at work for everyone and prioritised better employment outcomes for individuals with mental health conditions.
1.2 About health and wellbeing programmes at work

“Engagement, going to the heart of the workplace relationship between employee and employer, can be a key to unlocking productivity and to transforming the working lives of many people for whom Monday morning is an especially low point of the week.”

Macleod Review 2009

There are a number of aspects that make the workplace a suitable setting for health promotion, and more likely to succeed in health initiatives than for example, local communities. These include the relatively low cost, and the ability to reach a greater number of people (including those who otherwise might not seek professional help). Employers also offer easier access to people because of the concentration of employees geographically and because of consistent communication systems (e.g. NHSmail).

The workplace has unique characteristics that might increase the effectiveness of health and wellbeing programmes, including social support from colleagues and creation of a mutually beneficial environment (e.g. smoke-free premises, improved canteen food). A ‘lack of time’ was frequently stated as a reason for not participating in sports activities and it is not unique to NHS employees. On account of easy accessibility, much less time is required to travel to and participate in exercise classes at work and this removes a potential barrier for many. Another benefit of having these initiatives located at work is that it creates an opportunity to follow-up and evaluate measures, through specific data sets (e.g. sickness absence statistics, staff surveys), to which initiatives in the community would not have access.

Programmes of this kind play an important role in employee engagement, which in turn links to performance. Engaged employees enjoy greater levels of personal wellbeing and are more likely to want to stay with their employer. Sometimes termed ‘organisational citizenship’, it has been shown that public sector employees are more strongly but less frequently engaged than in the private sector. Not surprisingly, engagement varies according to demographics and job types. Typically women are more engaged than men, and older workers are more engaged than their younger counterparts. Strategically, senior management vision and communication is a key driver of employee engagement.

Previous successful programmes have been highlighted by the ‘Healthy Workplaces Awards’ which is designed for companies that can demonstrate a comprehensive approach to improving and maximising the health and wellbeing of their employees. Former ‘big tick’ winners have included the Royal Mail who made a £15m saving in reduction of sickness absence and Foyle Food Group who reduced absenteeism by 15% through making referrals to an occupational nurse. Further to this, ‘Investors in People’ have compiled an extensive Health and Wellbeing good practice database, which has wide-ranging advice for SMEs to large corporations, from how to involve staff groups, to guidance on healthy nibbles at meetings.

1.2.1 The business case

“A growing number of UK employers have recognised employee health and wellbeing as a strategic priority, particularly during challenging economic times.”

Business In The Community Report

A number of studies suggest that as health, like education, is a form of social capital, it can be reasonably anticipated to contribute to labour market success. The basic principles of workplace health promotion rely on the early detection of disease and the impact of behaviour change programs. The cost and effects of sickness absence have been widely reported, but the extent of presenteeism, poor productivity of replacement labour, and extra management costs often go undetected and unreported. It has been surmised that organisations recoup their expenditure on health promotion and wellbeing programmes due to sickness absence reduction, accidents reduction and increased productivity. Conservative estimates suggest that this “process of reciprocity” has a fourfold return on every pound invested. This has led to a business case being put forward for the investment in health initiatives in the workplace. A report commissioned by The Work Foundation analysed how UK demographics, disease trends, and the economy were likely to interact with the nature of employment. This suggested that as the UK workforce in future will be older, with a greater number working in ill-health, interventions in the workplace will become vital for productivity and public health. As a professional report published in July 2010 also illustrated, “a positive work culture is one that provides the cultural foundations of organisations based on the link between wellbeing and performance. By ensuring the psychological wellbeing of the workforce, the workforce reciprocates with high level performance.”
However, reducing sickness absence should be as much about health gain as it is about saving money. It is also necessary for organisations to recognise that good management of sickness absence is a testament of overall how good their management is, and indicative of a healthy organisation and a good employer. Research suggests that successful organisations share the characteristics of a healthy working environment.\textsuperscript{27}

The current economic environment risks increased levels of ill-health amongst employees and those who are unemployed. As fears for job security increase so too will levels of stress and feelings of loss of control. The environment could restrict available resources for employers to invest in workplace health, but continuing support for staff health gives employers a competitive edge, as healthy employees can be up to three times more productive than those in poor health.\textsuperscript{20}

\subsection*{1.3 Setting the scene}

\textit{“The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.”} 
\textbf{Section 3a of the NHS Constitution}

Some aspects of the NHS make it an exemplar for setting the scene of an average workplace. Large numbers of NHS staff are low paid and are sometimes subject to poor working conditions in terms of long shifts, stressful situations and few breaks. Research has shown that those working in human health activities (hospital, medical practice, dental practice and other human health activities) as opposed to other activities and organisations have increased odds of reporting a work-related illness or an injury.\textsuperscript{29} Moreover, NHS workers report more work-related illnesses due to stress, anxiety and depression than any other workers in England. There is often less control in the NHS setting due to variability and intensity of workload. In terms of health and safety there is an above average risk of exposure to physical hazards.

In the current economic climate there is an increasing lack of job security in the public sector. Earlier reports have shown that job security is one of the major determinants of productivity and staff wellbeing. The NHS nationally has its own role to play in the reduction of health inequalities, and supporting its own staff’s health is part of this.

As Box 1 illustrates, the number of NHS working days lost are in excess of 10 million days per year (based on 2006/2007 results). It has been maintained that there are many factors that account for high sickness absence in the NHS. There is a variation in absence management practice and policy. Public sector organisations are less likely to discipline or dismiss employees for absence-related reasons. The NHS also provides more generous occupational sick pay than private sector counterparts. Sickness absence further results in increased avoidable costs including agency fees for NHS Trusts. It has been expressed confidently that there are savings to be made in the NHS sickness absence bill and that the cost of presenteeism can be lessened by employee engagement.\textsuperscript{30} Many NHS Trust Boards are aware of this.

However, this does not take into account the productivity levels. Presenteeism, when an employee presents at work, but is less productive because of poor health and wellbeing, is predicted to cost employers far more than absenteeism. Although levels remain difficult to estimate it has been argued that presenteeism could cost twice as much as absenteeism.\textsuperscript{31} Boorman suggested that over 3.4 million additional NHS staff working days could be made available if staff health needs were addressed.

\begin{box}
\textbf{Box 1}

The NHS in England shows a comparatively high average working days lost per staff. Moreover, NHS workers seem to stay on sick leave longer than other workers. It has been suggested in comparison to other public sector departments, the average working days lost per staff and total days lost per department are higher in the NHS than say the Department of Transport. Although no direct comparable data exists for the NHS in England, for 2006/2007 it was estimated that the average working days lost per NHS employee is around 10.7 days, representing 10,228,163 total days lost.\textsuperscript{32}

The NHS Constitution published in March 2010, in some ways addresses these inequalities. It symbolises the core values, rights and responsibilities for both patients and NHS staff to protect and develop the NHS. For staff providing NHS services, it is a pledge from the NHS to help them deliver quality care and to make the NHS a better place to work. The constitution made clear the expectations the NHS has of its staff and their rights as employees.

The four key rights identified for staff were:

- provision of resources to deliver quality care for patients;
- support which enables them to do a good job;
- worthwhile jobs with opportunities to develop;
- opportunities to improve their way of work.\textsuperscript{33}
\end{box}
1. Introduction

The Constitution states that staff health and wellbeing directly and indirectly impact on all these core themes. Whether it is because happier staff will ultimately lead to better care of patients or by definition a good job means one that is considerate of individual health and wellbeing. The NHS Employers in partnership with NHS staff have committed to exceeding the legal requirements of the Department of Health’s Improving Working Lives Standard (2000), Healthy Workplaces Handbook (2007) and the NHS Staff Council Occupational Health and Safety Standards (2008).34

The Constitution says that staff should receive appropriate support for their health and wellbeing, including their mental health. The NHS currently has in place programmes to safeguard and promote its employees health, including minimum requirements for occupational health service provision,35 and a national gym discount scheme. Some organisations including the Department of Health, NHS Security Management Service, NHS Employers and NHS Plus are supporting programmes e.g. Creating a Healthier NHS; to provide a healthy working environment, improve the health and well-being of NHS staff, and tackle bullying, harassment and stress in the workplace.

1.3.1 Government support

The Coalition Government have kept their election promise of ring-fencing the NHS budget, although this means real term increases of only 0-1%. However with the rising demands on the NHS, this also translates to the toughest efficiency drive in NHS history, with the required savings announced by NHS Chief Executive David Nicholson in excess of £20 billion.36

The White Paper, Equity and Excellence: Liberating the NHS published in July 2010 raises a number of issues that are relevant to NHS staff wellbeing, highlighting public health, taking responsibility for our own health and staff empowerment. The paper states, “Staff who are empowered, engaged and well supported provides better patient care. We will therefore promote staff engagement, partnership working and the implementation of Dr Steve Boorman’s recommendations to improve staff health and wellbeing”.37

This White Paper further states a 45% reduction in management costs, the abolition of Primary Care NHS Trusts (PCNs) and Strategic Health Authorities (SHAs) and the transfer of the commissioning role to GP consortia. NHS organisations are expected to achieve these savings through the quality, innovation, productivity and prevention (QIPP) programme.38 Also relevant to NHS employees is the two-year public sector pay freeze from 2011/12, a review of NHS pensions and it is anticipated that the NHS will employ fewer staff overall by 2014. Part of this report’s evaluation (section 5.5) will discuss how wellbeing programmes are resourced and prioritised and how staff are empowered, engaged and supported in a very different NHS environment.

1.4 About Homerton University Hospitals NHS Foundation NHS Trust (HUHFT)

“To look after our workforce through a time of potentially very significant change, ensuring that their enthusiasm for serving the people in our care does not waver.”

HUHFT Core Objective 2010/1139

Homerton University Hospital NHS Foundation NHS Trust (HUHFT) was established in 1986 and was one of the first NHS Trusts to gain Foundation status in April 2004. It is situated within the East London borough of Hackney, and has grown to meet the demands of a very diverse and expanding population. It is an Acute Services NHS Trust with 465 beds and 350 nursing staff. Homerton provides general hospital services to Hackney and the City of London, and specialist care in obstetrics, neonatology, fetal medicine, laparoscopic surgery, fertility, bariatric surgery and neuro-rehabilitation.

There are approximately 2355 staff at HUHFT with an additional staff bank reserve of 1892. During 2009/10, HUHFT saw over 322,000 patients with 110,000 attendances at A&E, and provided maternity care for nearly 5000 women and their babies. To provide these services amongst others, the NHS Trust has an actual annual income of £180 million.40 Two of the HUHFT’s top ten priorities for 2010/11 are to ‘become an NHS employer of choice and centre of excellence for healthcare professional training’ and to ‘develop an appropriate Olympic legacy’.40 HUHFT had already demonstrated commitment to staff by gaining IWLP Practice Plus status in 2005 and has made efforts to improve the work-life balance of staff in such areas as flexible working, childcare, training and development and stress management.

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i More information in section 1.9

ii For the year 2009/2010.
In the context of the NHS as a whole, HUHFT is one of the smaller hospital NHS Trusts and is unusually situated on a single site. This has inevitably contributed to the creation of the overall culture of the NHS Trust, which has a friendly atmosphere and approach. The senior management team at HUHFT brings a degree of stability to the NHS Trust, with many of the team holding their positions for several years. HUHFT’s Chief Executive, Nancy Hallet, has worked in the NHS for over 30 years, firstly as a nurse. She has been at Homerton since 1993 firstly as Director of Nursing and Patient Services, then as Director of Service Development and as Chief Executive since 2002. This contrasts with other NHS Trusts which have a relatively high turnover of senior management staff, with an average lifespan of only two years.\textsuperscript{41}

In July 2005, London was successful in its bid to host the 2012 Olympic and Paralympic Games, and shortly after that HUHFT won its own bid to become the Olympic Hospital, situated only 3km away from the Olympic village in Stratford. Olympic hospital status means that HUHFT will be the primary medical facility during the 2012 Games. HUHFT has co-ordinated with the Olympic planning team, the Department of Health and other related agencies to ensure that all the health needs of athletes, visitors and residents are met.

In early 2009 HUHFT was approached by CCGB to play another role in creating an Olympic legacy in the form of a health and wellbeing programme for NHS staff.

1.4.1 Health and wellbeing before HealthWorks at HUHFT

To improve the health and wellbeing of NHS staff, the Department of Health funded a pilot project called ‘Creating a Healthier NHS’. This programme links online and offline health questionnaires to tailored lifestyle management programmes, to help staff choose how best to improve their physical and mental wellbeing. The first of 10 sites to start the two-year programme were launched on 18 June 2008. This pilot’s brief was to support the improvement of employee health on the basis that healthy employees are less likely to be absent, more fulfilled at work and more productive. It provided aggregated anonymised data and hoped this would enable the NHS to measure and manage the health risk of their employees.

The pilot contract has been with a company called Vielife, a health and wellbeing service provider,\textsuperscript{iv} and involves:

- initial online health and well-being assessment drive to help to identify health issues in the pilot workforces;
- online and offline information for employees throughout the pilot, on a wide range of health and wellbeing issues;
- a healthy eating programme, to encourage busy staff to make good choices for themselves both whilst at work and at home;
- a strength and resilience programme to help staff identify and manage pressure in the workplace and everyday life.

The plan included a staff re-assessment at the end of the first year to note the improvements that they had made. If needed, they were then able to start two additional lifestyle management programmes. An independent evaluation of the Vielife pilot commenced in May this year, and the Department of Health is now working to understand the outcomes and provide recommendations.\textsuperscript{iii}

HUHFT, throughout the implementation of HealthWorks, was also one of the pilot sites for the Vielife programme. At present, the Department of Health has no plans to centrally fund the provision of Vielife or other health and wellbeing schemes for the NHS, although local NHS organisations may be investing in these schemes.\textsuperscript{12}

When Coco-Cola approached HUHFT about commissioning a health and wellbeing programme, Vielife was identified as a key partner in HealthWorks and was involved in the launch of the programme. However, reportedly, there has been little engagement in the Vielife service from staff. Therefore although 2020health have incorporated Vielife in the context of the evaluation, it has been acknowledged that this pilot is separate from the work that CCGB and HUHFT have undertaken.

\textsuperscript{iii} Concluded August 2010, evaluation not in public domain at time of this report’s publication.

\textsuperscript{iv} Vielife is an international provider of online health solutions and aims to help businesses deliver improvements via people-led health and wellbeing monitoring. This is achieved through assessments, personalised reports and lifestyle management advice.
In addition to Vielife, HUHFT had several other mechanisms in place to engage staff health. HUHFT have reformulated their occupational health department into employee health management services, and strengthened leadership in this department. The Trust also runs schemes such as cycle proficiency, corporate gym discount, badminton sessions and Pilates classes. Netball and football teams have been organised by employees within the NHS Trust. HUHFT has run a number of events over the years which have included coordinating departmental competitions for football and netball and an annual fun run. The classes were coordinated in part through the Corporate Events Office, which also has responsibility for co-ordinating staff benefits.

1.5 About Coca-Cola Great Britain (CCGB)

The Coca-Cola Company is the world’s largest beverage company, refreshing consumers in over 200 countries with over 1.6 billion servings every day. Globally, it is the largest provider of sparkling beverages, juices and juice drinks. The company has a dedicated commitment to supporting good causes across the globe and promoting active lifestyles, both among its billions of consumers and its workforce.

In a landmark first for both organisations, Coca-Cola Great Britain’s (CCGB) partnership with HUHFT developed out of a joint desire to achieve healthy, active lifestyles in a workplace environment. CCGB, an Olympic Sponsor, and HUHFT, the Olympic Hospital joined together for the dedicated purpose of reaching out to the local community that would be foremost in championing the legacy of London 2012.

CCGB’s objective for HealthWorks was to ensure that participants benefited from informed healthy lifestyle choices. They also wanted to deliver an effective and sustainable workplace health programme and create a model of best practice in workplace health. Partnering with HUHFT was a good fit for a company which has a strong heritage in promoting active lifestyles, supporting and developing workplace wellbeing best practice and developing creative partnerships with other organisations. Recognising the important role industry plays as a part of the solution to the UK’s public health policy objectives, CCGB lent its own knowledge of creating engaging workplace wellbeing programmes and marketing expertise to the HealthWorks project.

Reflecting the Company’s status as the longest running global sponsor of the Olympic Movement. CCGB also has a long heritage of supporting initiatives focused on raising activity levels at a community level. In October 2010, CCGB announced a three year partnership with StreetGames, a national charity set up to help young people in disadvantaged communities get active and participate in sports. CCGB is also supporting the London 2012 Olympic & Paralympic Games vision of helping Britain get active by promoting free swimming sessions via its Schweppes Abbeywell natural mineral water brand. This initiative has resulted in over 45,000 people redeeming a free swim in the last year alone.
2. Methodology

2020health’s report evaluates and draws recommendations for good practice from five data sets: (1) a short literature review (2) staff participant and non-participant surveys (3) quantitative data from a target group (4) senior staff interviews and (5) actual programme cost and participation data.

This literature review was based on expert recommendations, selective news streams and self-published, publicly available literature from various organisations. Many of the facts and figures come from current health policy and programme specific searches from the Department of Health, NICE and CQC. Other statistics have been drawn from independent and academic studies. Ideas that emerged from this literature were drawn together to set the tone of the HealthWorks initiative in light of wider policy, strategic aims and previous programmes similar in nature.

The second stage of the research involved analysing the research of two other organisations, RDSI and Heart Research UK (HRUK), engaged by CCGB to carry out the evaluation of the health outcomes for staff at HUHFT. The midwifery unit staff were originally chosen as the target group because of high sickness absence and management issues. Members of staff were selected for both these assessments, according to availability and desire to participate. The assessments consisted of two baseline measurements taken at intervals of 6 months. 2020health’s evaluation of the project was undertaken at the 7th month mark.
Baseline measurements were taken between January and April 2010. These were originally scheduled for January, but due to unforeseen circumstances, including adverse weather conditions and staff sickness, these were instead staggered over 3 months. Measurements were taken again in July 2010 and are scheduled again for January 2011. HRUK consulted with 136 staff in total, 71 and 55 people were interviewed in the first and second consultation periods respectively. It should be noted that of the 136 employees evaluated, only 36 were seen both times from the original target group (the midwifery department which has 358 staff). This amounts to approximately 10% of the initial target group which is a relatively small sample size and not statistically viable, but findings can be used as indicators for future evaluation. HRUK did not question staff as to their participation in the exercise programme developed as part of HealthWorks. It has been noted that the sample was predominantly female and age participation was relatively proportionate across the board.

The next stage of the evaluation was to conduct semi-structured interviews with senior figures from HUHFT including Chief Executive Nancy Hallet and CCGB (see annex 4 for full list of interviewees), and further speak to programme co-ordinators including the public affairs agency Interel Consulting UK (formerly Politics International), market research agency RDSI and healthy heart consultants, HRUK. In each case, interviews took place either in person or over the telephone. Interviewees were encouraged to lead or elaborate on answers. Interviewees were assured that their comments would remain unattributed.

Data was compiled from actual programme costs and staff participation number which were released by Coca-Cola Great Britain and Homerton University Hospital NHS Foundation Trust. These findings were collated and weighed HUHFT’s outcomes against wider guidance including Boorman’s recommendations, elements of good practice policy and PRINCE2 project management methodology. The full list of Evaluation Tools can be found at Annex 2. Further general indicators were used to evaluate this report’s recommendations including cost-benefit, level of sustainability and transferability (i.e. the possible adoption of the programme by other NHS Trusts).

This report’s findings were then double-checked for accuracy by all named parties. The evaluation’s validity was subsequently assessed by an independent policy consultant and a medical sociologist with expertise in public health and health policy. Their peer review was conditional on anonymity, but their comments have been incorporated into this report.

v HRUK is a charity that was founded in 1967 by a working heart surgeon and charity president, David Watson. The charity is dedicated to promoting lifestyle choices that lead to more people having healthier hearts. They run a Healthy Heart accreditation scheme that HUHFT has been involved in.
3. The HealthWorks programme

3.1 Introduction

This section describes the overall planning, project management and implementation of the programme. It includes a review of the baseline assessments carried out by RDSI and HRUK and a review of the activities undertaken as part of the HealthWorks programme. Key elements are explored including:

- the roles undertaken by key managers including an onsite Lifestyle Co-ordinator;
- project planning and engagement with senior team members at HUHFT and integration into other NHS Trust activities with regard to workforce health;
- engagement of the target groups;
- assessment of target groups by external agencies, RDSI and HRUK and the initial findings;
- a description and evaluation of the activities introduced.

3.2 Roles and responsibilities

Throughout the project there were a number of individuals engaged in the management and championing of HealthWorks. A brief description of their role is outlined in Box 2a and the unique biography of the lifestyle co-ordinator given in Box 2b.
**Key roles in HealthWorks programme**

Chief Executive: This role was primarily concerned with the visible leadership and outward championing of the programme. HUHFT’s CEO is well respected and well known throughout the NHS Trust with a very hands on approach, easily accessible to staff and approachable. These attributes are key in gaining staff confidence.

Director of Human Resources: Senior Responsible Officer for the programme, with a remit to coordinate the programme, provide executive oversight and support and report progress to the Board and Executive team.

Deputy Director of Human Resources: Responsible for the detailed project planning and day-to-day management and support of the Lifestyle co-ordinator, also responsible for trouble shooting and unblocking barriers to change.

Lifestyle Co-ordinator: To act as onsite coordinator employed to lead, champion and facilitate the successful delivery of an inclusive workplace wellbeing programme to the staff. The post acts as an information hub for staff, external agencies and contractors on all aspects of the programme. The co-ordinator works directly with the Hospital Workforce and Education Department, sponsors and in partnership with a range of key stakeholders.

Nutrition Communications Manager at CCGB: project design and liaison between Coca-Cola GB and HUHFT.

Political Consultant, Politics International (PI): This role was originally conceived as one of concept development and partner engagement. However, due to an in-depth knowledge of the fitness industry this role quickly expanded into a more practical role where operational activities were required. This was probably as a result of a need to define more clearly roles and responsibilities.

HealthWorks Champions: Departmental staff members with a remit to promote and inform colleagues of HealthWorks initiatives.

**Box 2b**

**Shani Anderson, the Lifestyle Co-ordinator at HUHFT**

Shani first made the Great Britain Athletics Team aged 17 and went on to represent Great Britain for over 11 years. Her accomplishments include competing in the 100m and 4x100m relay at the 2000 Sydney Olympics and winning a bronze medal at the 2002 Commonwealth Games where she was also the England women’s track team captain. In addition to her own training, Shani has become a REPS level 3 qualified Personal Trainer, a UK Athletics certified athletics coach (level 2) and a British Amateur Weightlifting Leaders Association coach.

She has combined her knowledge as a former international athlete with her knowledge as a Personal Trainer to deliver corporate health and wellbeing programmes, primarily to the public sector. Shani has worked with Hammersmith & Fulham Primary Care Trust and the London Borough of Hammersmith & Fulham to design and facilitate their staff health and wellbeing programmes over the past 2 years. She now is the Lifestyle Co-ordinator at Homerton and runs their HealthWorks staff wellbeing programme.
3.3 Project planning and development

The project planning and implementation of HealthWorks changed according to operational requirements rather than being a strategic objective from the start. This has led to small problems in assessing some areas. The history and instigation of HealthWorks is addressed in this section.

The original proposal was first taken by CCGB to HUHFT in February 2009 with the programme receiving official endorsement by HUHFT in June 2009. Further to the endorsement, progress was slow until the appointment and commencement of the Lifestyle Coordinator in November 2009. Momentum increased with the official launch of HealthWorks in January 2010 and the introduction of new classes in early March 2010. An earlier appointment of a Lifestyle Coordinator may have brought forward the programme implementation.

The original concept was to take a NHS Trust wide approach to develop a model of best practice for improving staff health and deliver a sustainable workplace health programme at HUHFT. This would be evaluated using a number of baseline observations and measured against a number of defined metrics. A key component was to implement a range of activities which would encourage a healthy lifestyle and improve health and wellbeing, thereby improving performance at work and attitudes to the workplace and organisation. It might have been helpful to set an objective for percentage of staff participation in exercise as a result of HealthWorks, or setting a target for the number of staff eating ‘5 a day’. Without this it is more difficult to assess the true health gain.

For HUHFT, the best use of resources was to nominate staff that could most benefit. Instead of targeting the whole hospital they chose to refine it to one group. Midwifery services were chosen for this. Senior management at HUHFT reported that this was simply because the midwifery team had above average sickness absence, although other factors are outlined in section 3.4. Ultimately, this decision was reversed to include all staff as it was felt that focusing on one group would not achieve the coverage desired. However the target group remained the focus of the RDSI and HRUK baseline assessments.

As part of the programme CCGB engaged RDSI to make an assessment of the staff attitudes to a healthy lifestyle and identify what changes they would like to see within the workplace to improve their health and wellbeing. These findings would inform the development of the activities required to support the HealthWorks programme. HRUK were employed to make physical assessments of the staff and identify barriers to maintaining and improving health. Both these reviews would be repeated at the end of CCGBs involvement.

3.4 Selecting the target group

The target group selected for the piloting of the HealthWorks programme was midwifery staff. This group was chosen as mentioned in section 3.3 because of an above average sickness absence. However the qualitative research showed subsequent reasons for particularly involving this group in the new initiative, including reports of stress and isolation from mainstream NHS Trust activities. There were a number of management related issues that the NHS Trust felt it needed to address and hoped HealthWorks would be a vehicle by which to engage and value staff.

Midwifery services at HUHFT includes antenatal service for hospital admission and outpatients, delivery suite services, postnatal facilities (ward based), Special Care Bay Unit (SCBU) and community midwives. Midwives rotate between the antenatal, delivery and postnatal wards as well as outpatients, but not SCBU which does not require trained midwives and patients are cared for by specialist nurses. In reviewing the NHS Trusts Balanced Scorecard it has been identified that approximately 378 staff made up the target population and these were a mixture of doctors, midwives, nurses and support staff. The largest staff group are midwives with 87 WTE (whole time equivalent), 34 WTE community midwives, 36 WTE doctors, and 111 WTE SCBU and neonatal nurses.

This target group would be the subject of the RDSI assessment of staff attitudes and the HRUK health checks as initially they were to be the only subjects of the full HealthWorks programme. As previously stated the project scope changed and the HealthWorks programme was expanded to include all staff at HUHFT but initial assessments by RDSI and HRUK were confined to the target group. The follow-up reviews were NHS Trustwide to reflect the changes in project scope.
Engagement of the NHS Trust staff took several forms. The Lifestyle Co-ordinator engaged with individual staff on a day to day basis but there was also a separate event for the target group of staff within the Midwifery Department and then general staff engagement through the launch of the HealthWorks programme. An evening event was organised in November 2009 for midwifery services. The purpose of the event was to introduce staff to the programme and encourage participation. RDSI and HRUK briefings were given. The event was a chance to talk informally and had the additional incentive of a mixicologist on hand to provide non-alcoholic cocktails as part of the other healthy refreshments on offer.

3.5 The HealthWorks launch

The HealthWorks programme was launched in January 2010 with an aim to engage NHS Trust staff in the programme as a whole. The launch in January was a deliberate decision because of the ‘New Year wellness culture’, and it was thought that launching before Christmas may have had a negative impact on involvement. The event ran from 9am to 5pm with a number of different health stalls exhibiting. These included gym membership, with a chance to sign up with the 2 local gyms engaged to support the programme (Kingshall and Fitness First) and the opportunity to have a personal health assessment which including taking blood pressure and BMI. Also present were contacts from Slimming World, Nordic Walking, the Homerton diabetes team, smoking cessation, Homerton stress counselling services and Vielife. The event was interactive, staff could drop in, and a number of free products and information packs were made available. The event was attended by the HUHFT CEO, Nancy Hallet and the then CCGB CEO, Sanjay Guha.

Of the 2335 permanent staff and 1892 bank staff at HUHFT it is estimated that 750 attended the event throughout the day. Of these, 215 members of staff signed up for the Kingshall gym membership and 149 signed up for the Fitness First gym membership. Given the numbers of staff likely to be on duty or available at any one time the number is remarkable. During the course of the interviews the event was acknowledged by all those involved as a real success and the event received positive feedback.

Box 3 - Testimonial

“When I joined Homerton five years ago I was running regularly and considered myself to be very fit. During that time, I have got into bad habits of very early morning starts in the office and working at home in the evening to keep up with my workload. This meant that something had to give, which was my fitness regime. Basically I was too tired to keep fit! I attended the Health Festival event on the 14 January this year where I was weighed, had my BMI checked and my blood pressure taken. I had a tremendous shock when I was advised I weighed 16 stones 4 pounds; my BMI was 32; and my blood pressure was 150/98.

I went to my GP to get the blood pressure levels checked out. She suggested that I should make a few lifestyle changes, diet, join a gym and make an effort to look after me. I avoided taking blood pressure tablets but I do have monthly checks at the GP’s surgery.

I am now watching what I eat, working out four times a week, walking more and I am trying to reduce the circa 60 hours a week working, to somewhere more reasonable but without compromising my contribution.

Last week I weighed 13 Stones 9 pounds and my blood pressure was down to 124/82.

I still have some way to go, but I would like to pass on my heartfelt thanks to the organisers of the Health Launch at Homerton for my wake up call.”

Health Launch attendee and HUHFT employee
3. The HealthWorks programme

3.6 Baseline observations

3.6.1 RDSI

As previously discussed RDSI were approached by CCGB to undertake an evaluation of the target group to ‘ascertain what personal health and wellbeing looked like with the target group (Midwifery), what would engage them in thinking about it, and what opportunities would appeal and motivate them’. CCGB also posed a number of other questions in which RDSI were asked to determine the attitude of staff.

- Does health feature at all in the workplace for this group?
- Do they feel that their health is something they want to think about within work?
- Do they think the hospital, as their employer, should be assisting them with their own health needs?
- What kind of initiatives would engage them to consider their health at work?
- Would they engage in physical activity at work? If so, what, who with, where? What would/wouldn’t work?
- What is the food/drink provision at work? Is there the choice they would want? Do they use vending/canteen/bring food in? What would they like/not like to see?

In the course of their research RDSI demonstrated that staff recognised the links between maintaining health and enhancing their performance at work as well contributing to their personal wellbeing and eventual health outcomes. Staff, whilst recognising the value, and making some efforts to improve health and wellbeing were inhibited by a number of factors including; a lack of routine within the work environment; long days and shift patterns which left them tired; variability and pressures within the work pattern on the midwifery wards and amongst the community midwives which made satisfying some basic needs more difficult and resulted in unhealthy choices; limited motivation; and lastly pressures at home further restricted time available to participate. These pressures meant health and wellbeing taking a back seat for this group.

Staff did recognise other contributors to good health. These included sleep, eating fresh healthy food, drinking water and being stress free. RDSI identified that, where staff did take physical exercise, the benefits they felt kept them motivated. There was an understanding of the role of health workers to lead by example and be effective ambassadors for their patients and the public at large.

It was identified that some staff did feel that their employer, HUHFT, had some responsibility to assist in improving health and wellbeing. Improvements the staff identified included providing access to cool water in the work environment, and providing comfortable areas to take time out when more structured breaks could not take place which should be separate from meeting places for NHS Trust activities. Midwifery staff were skipping many breaks and/or lunch, and the ability to take 10 minutes out was identified as conducive to a broader wellbeing initiative.

RDSI explored exercise habits, in particular how staff accessed the current initiatives and what they felt should or could be made available. Gym membership was spontaneously mentioned by most staff for a variety of reasons. These included greater opportunities for classes and different physical activities, flexibility around work patterns, and that could be attended by individuals or groups. The main inhibitor to using the gym was the cost, which was felt to be prohibitive, especially if individuals could only access it once or twice a week. Accessibility was another issue and staff mentioned that they would like any subsidy to be with a large chain so that they could access the gym nearer to home when not working. Staff seemed to be unaware of the national NHS gym discount scheme and some other Trust run activities.

Although the NHS Trust offered a range of activities as described in Section 1, staff were only aware of them to varying degrees and then only if they had access to the intranet. Access to the intranet is not available to all staff and not all staff can easily access a terminal. Classes run by the NHS Trust were felt to be inconvenient for the shift patterns and costly given that commitment could not be guaranteed due to shifts and changing demands within the work environment that might mean working longer shifts or changing shifts. Furthermore exhaustion was also cited as a cause for non-participation. Vielife was felt to have been unsatisfactory as staff received limited response from the help line, or could not access the internet due to lack of time or availability.

When questioned as to whether they would engage in activity at work and what form that might take, those questioned responded that they thought classes at work would be ‘Fun and different’, would give them the
opportunity to attend with friends and create a more social event, it would be an example of the hospital actively supporting health and wellbeing. Most interest was expressed in dance classes e.g. salsa, and aerobics.

The provision of healthy food was an issue for those staff who were conscious and keen to eat healthily. The canteen offers healthy options but opening times were considered restrictive as it closes at 4pm. The food on offer was unappetising and the salad bar was felt to be depleted and suffered from the heat of the lighting. The costs were prohibitive and outside of canteen hours the venues for purchasing healthy food were limited. Unless staff brought food to work there were distinct limitations. Staff tended to purchase convenience foods either within or outside the hospital.

The main barriers to making healthy choices was time, tiredness and cost. These included time to prepare food before coming to work, time to get to the canteen, time to take breaks, the length of shifts, then time at home and exhaustion after work, costs of healthy food and cost of structured exercise.

Table 1 - HealthWorks timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2009</td>
<td>CCGB approach HUHFT</td>
</tr>
<tr>
<td>Jun 2009</td>
<td>HUHFT sign off on implementing a programme in association with CCGB</td>
</tr>
<tr>
<td>Nov 2009</td>
<td>Lifestyle Co-ordinator starts. Target group selected, and consulted by RDSI</td>
</tr>
<tr>
<td></td>
<td>HealthWorks is created</td>
</tr>
<tr>
<td>Jan 2010</td>
<td>HealthWorks Launched. New classes start at HUHFT</td>
</tr>
<tr>
<td>Mar 2010</td>
<td>More new classes start at HUHFT</td>
</tr>
<tr>
<td>Apr 2010</td>
<td>Completion of HRUk’s baseline assessments</td>
</tr>
<tr>
<td>Jul 2010</td>
<td>Second RDSI consultations and findings</td>
</tr>
<tr>
<td></td>
<td>HRUk’s second health assessment and findings</td>
</tr>
<tr>
<td>Jan 2011 onward</td>
<td>HRUk scheduled health assessments</td>
</tr>
</tbody>
</table>
3. The HealthWorks programme

3.6.2 Heart Research UK

In support of the project HRUK were asked to conduct a Healthy Heart lifestyle check at HUHFT. It was felt necessary to ask an outside organisation, rather than manage the survey in house for two reasons. Firstly there was no capacity at that time within the Occupational Health Department to undertake these health risk assessments, and secondly it was felt that staff would participate more readily if the assessments were not linked to the NHS Trust. It was thought that they might be seen as negative and preaching to the staff, or result in monitoring and/or might be used in a punitive manner however untrue that might be.

The baseline assessments took the form of one-to-one consultations with 71 members of staff, 60 of whom were female and 11 male. This group were not necessarily participants in the HealthWorks programme. HRUK used their standard assessment tool (see Annex 8) focusing on a number of key areas, which are considered indicators of good health and measure the risk of developing type 2 diabetes and cardiovascular compromise. Measurements included:

- Body Mass Index (BMI) and waist measurement
- blood pressure
- exercise participation
- fruit and vegetable; consumption
- snacks
- consumption of red meat
- consumption oily fish
- alcohol consumption
- perceived levels of stress

The assessment of the target group demonstrated that 50% staff were obese and 81% had a waist measurement of 35 inches or above, and where therefore at risk and needed to lose weight. 90% had healthy blood pressure, although they did not get it checked regularly. Healthy eating was identified as a problem and the issues raised related back to the RDSI findings that for staff lack of time was a factor, and that snacks were easier to source and required no preparation. HRUK identified that participants required greater education on healthy eating, especially the value of eating fruit and vegetables and oily fish. Exercise was identified as an area where participants were not achieving the levels of activity recommended to maintain health. As in the RDSI findings, time and access were identified as barriers to taking regular exercise.

Overall the findings demonstrated that the staff required further education and support in identifying the key components of adopting and maintaining a healthy lifestyle. HRUK offered support to staff, followed up individuals with phone calls and provided further information.

3.7 Enhancing the programme

The range of activities described in this section, were designed to have a broad appeal. There were several components; firstly, a series of classes that replaced or supplemented those already in place at HUHFT and secondly, enhanced focus on gym membership over and above that already in existence for NHS staff. There were also some activities for healthy eating and occupational health. These activities would be supported by CCGB for specified periods of time after which they would be evaluated and future funding would be determined by HUHFT. This section will describe those activities.

3.7.1 The exercise classes

Following the appointment of the lifestyle co-ordinator a number of new classes were introduced. The selection was based on a number of factors including the previous activities within the NHS Trust and some of the views expressed in the RDSI review and access to instructors. Instructors were sourced by the Lifestyle Co-ordinator, utilising personal contacts and contacts network of the Fitness Industry Association (FIA). The classes were planned at varied days and times (see Table 2), to try and enable greater numbers of staff to attend. The classes were sponsored by CCGB and were free for the first 7 months, after which HUHFT would need to determine how they would be funded.

Records of attendance are over the period March 2010, to the end of July 2010, with classes coming on stream at varying times during this period. Take up of the classes is illustrated in Table 2. The groupings are made on review of information supplied by HUHFT and are approximations given the descriptions of roles and departments specified. A small number did not have department or role recorded.
**Box 4 - Testimonial**

“This activity is incredibly fun and very sociable! Nordic Walking is a specific fitness technique using poles to walk by planting it behind you in a specific way that increases the use of the upper body. It can be done by anybody, anywhere. This is the activity I enjoy the most as at the end of it, I get the same benefits as working out in the gym - without the incredible pain and the ‘dying’ feeling.

Circuit Training is fun because it is a variety of exercises put together so it does not get boring doing the same thing over and over again. The instructor is a gem and changes the class every week setting us new challenges in the process. I love this class as the instructor gives us a choice of exercises for each set and we can customise it to our fitness level. I clearly overdo it sometimes!

In the running club we are shown how to run by an Olympian long distance runner and Commonwealth Bronze medallist! It is easy when you are taught right. I can now run properly and longer.

When I started with all these activities I was as unfit as they come but now I can proudly say that I much fitter and inspired to continue. Benefits of these classes for me are meeting my goals which I set before I started for example my BMI is coming down, I feel healthier, more toned and I have loads of energy! Exercising at work may seem impossible, but I have found it easier than trying to find time to exercise after work.

I would recommend any of the HealthWorks classes as they are most enjoyable and do not put a dent in your pocket, they are free.”

*HealthWorks Participant and HUHFT employee*
### Table 2 - Exercise class timetable at HUHFT

<table>
<thead>
<tr>
<th>Class Title</th>
<th>Day of Class</th>
<th>Class Time</th>
<th>Venue</th>
<th>Attendees</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nordic Walking</td>
<td>Tuesday Alt. Thursday</td>
<td>12.00-12.45 16.00-16.45</td>
<td>Local Park</td>
<td>24</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>Pilates</td>
<td>Monday</td>
<td>17.30-18.30</td>
<td>Education Centre</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Pilates</td>
<td>Thursday</td>
<td>17.30-18.30</td>
<td>Education Centre</td>
<td>29</td>
<td>0</td>
<td>29</td>
</tr>
<tr>
<td>Football</td>
<td>Wednesday for 20 weeks</td>
<td>18.00-19.00</td>
<td>Local Green</td>
<td>35</td>
<td>32</td>
<td>3</td>
</tr>
<tr>
<td>Dance</td>
<td>Monday</td>
<td>18.00-19.00</td>
<td>Hospital Gym</td>
<td>27</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Netball</td>
<td>Tuesday</td>
<td>18.00-1900</td>
<td>Leisure Centre</td>
<td>12</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Running</td>
<td>Wednesday</td>
<td>12.15-13.00</td>
<td>Local Park</td>
<td>11</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Combat</td>
<td>Wednesday</td>
<td>18.00-19.00</td>
<td>Education Centre</td>
<td>16</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Circuits</td>
<td>Tuesday</td>
<td>18.00-19.00</td>
<td>Education Centre</td>
<td>23</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>181</strong></td>
<td><strong>50</strong></td>
<td><strong>131</strong></td>
</tr>
</tbody>
</table>

Information supplied by HUHFT
Table 3 - Breakdown of class attendance by hospital department

<table>
<thead>
<tr>
<th>Department</th>
<th>Shift patterns</th>
<th>Number Attending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>24hr shift cover</td>
<td>34</td>
</tr>
<tr>
<td>Maternity</td>
<td>24hr shift cover</td>
<td>15</td>
</tr>
<tr>
<td>Administrative staff (includes IT)</td>
<td>9-5</td>
<td>19</td>
</tr>
<tr>
<td>Medical staff</td>
<td>24hr shift cover</td>
<td>7</td>
</tr>
<tr>
<td>Diagnostics (covers DI and others e.g. retinal screening)</td>
<td>9-5</td>
<td>12</td>
</tr>
<tr>
<td>Therapies</td>
<td>9–5</td>
<td>30</td>
</tr>
<tr>
<td>Supporting service (SW Pharmacy, Dietetics)</td>
<td>9–5</td>
<td>9</td>
</tr>
<tr>
<td>Charitable and patient support e.g. library nursery staff</td>
<td>9–5</td>
<td>7</td>
</tr>
<tr>
<td>Facilities</td>
<td>9–5</td>
<td>12</td>
</tr>
<tr>
<td>Management</td>
<td>9–5</td>
<td>22</td>
</tr>
<tr>
<td>Unknown</td>
<td>-</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>181</strong></td>
</tr>
</tbody>
</table>

Information supplied by HUHFT

Table 3 shows that uptake was greater in those with 9-5 roles, but a significant number of clinical staff did attend and a larger than presumed number from the Midwifery Unit department (4.3%) which is in line with the percentage attending throughout HUHFT as a whole.
A total of 181 people attended classes during this period between January and June 2010 (approximately 4.3% of the workforce) of which 75% were female and 25% male. The male population is slightly over-represented compared to the NHS Trust as a whole, which is 80% female. Classes were predominately attended by females and football by males. No record was kept of age range or ethnicity, although it is anecdotaly reported that the classes represented the workforce. A large number of attendees were from non-clinical departments or clinical departments with 9-5 hours and more regular lunch breaks. This reflects the difficulties in engaging those clinical shift workers, who work shifts that change regularly and have workloads that are unpredictable.

Changing facilities were unspecified, with staff expected to change at work, except Nordic walking where staff could wear their own clothing. Given that most activities took place after work, at least for office staff, there were no arrangements made for showering, but the NHS Trust does have a shower for staff within NHS Trust offices and a small number within the main hospital.

Equipment for all activities, except Nordic walking (in which the instructors own equipment was used), were supplied by CCGB and Capri. Costs for instructors were funded by CCGB, amounting to £345 per week.

### 3.7.2 The gym programme

A key component of the programme was the introduction of a scheme to encourage gym membership. The scheme was designed to encourage gym membership and two gyms were engaged on behalf of CCGB through Fitness Industry Association (FIA). CCGB would pay for the membership for 100 staff for the first 3 months if they met the criteria. Due to high demand at the HealthWorks launch an additional 50 places were allocated.

The main feature of the programme was to encourage membership take up through the offer of a free 6 weeks pass to all staff at two gyms within a 10 minute walk of the hospital. If attendees visited 6 times or more within the six week period, they were offered a free 3 month subscription (paid for by CCGB). On reconsideration this was reduced to 5 times in 6 weeks. A reduced subscription fee for the gyms was negotiated for all Homerton staff regardless of whether they participated in the incentive scheme offered. One gym chose to add another promotional incentive for the first 20 Staff who attended that gym and registered for reduced membership (but were not eligible for free membership as they had attended less than 5 times) would be rewarded a free spa day. Initial assessments at the gyms had to be arranged within two weeks of registering interest.

After 374 staff signed up at the launch event, approximately 150 staff registered with either gym to arrange an initial assessment. A total of 89 (2.1% of total staff) attended
either gym at least once, of these 32 went on to receive 3 months free membership. A further 73 made use of the membership at a reduced rate of £27.50 per month.

Following the launch event it was left to those registering an interest to arrange the initial assessment. Staff reported difficulties in arranging the assessments, with long delays reported and calls not returned. The two week call back and arrangement for initial assessment had to be extended as a result of this. Whilst the Lifestyle Co-ordinator had responsibility for organising the classes, gym membership was not managed by any one individual and as a consequence there was some confusion about the point of contact for interested staff. Eventually the lead at PI, who had originally set up the scheme, stepped forward and arranged the assessments along with the FIA, liaising between the gyms and the staff. This confusion delayed the start of the gym attendance and resulted in the number of gym attendances to qualify for free membership being reduced. The process is outlined in Table 4.

**Table 4 - HealthWorks participants uptake of gym membership**

<table>
<thead>
<tr>
<th>Process of offering gym membership to HUHFT staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PI/FIA arrange for two gyms to participate</td>
</tr>
<tr>
<td>2. 100 places in total initially allocated for staff</td>
</tr>
<tr>
<td>3. 3 months free gym membership</td>
</tr>
<tr>
<td>4. Conditional on attending gym 6 times in 6 weeks</td>
</tr>
<tr>
<td>5. All gym attendees required to have initial assessment at gym</td>
</tr>
<tr>
<td>6. 374 people sign up at launch event (215 and 149 for each gym respectively)</td>
</tr>
<tr>
<td>7. 50 further places allocated following demand at launch event (total 150)</td>
</tr>
<tr>
<td>8. Capacity problem of scheduling gym inductions (fitness first, GLL)</td>
</tr>
<tr>
<td>9. Communication problem contacting staff and confusion over responsibility for scheduling gym inductions</td>
</tr>
<tr>
<td>10. 2 week contact period insufficient</td>
</tr>
<tr>
<td>11. PI/FIA stepped in and called 150 HUHFT staff who signed up, about booking their initial assessment at gyms</td>
</tr>
<tr>
<td>12. 89/374 have gym induction and engage at least once (24% of those who signed up or 2.1% of total HUHFT staff)</td>
</tr>
<tr>
<td>13. Reduced to 5 times gym attendance in 6 weeks as a result of poor uptake</td>
</tr>
<tr>
<td>14. 32/150 awarded 3 month free membership having attend 5 times in 6 weeks</td>
</tr>
<tr>
<td>15. 73 uptake of reduced rate membership offer, Kings Hall only</td>
</tr>
<tr>
<td>16. 20 eligible for a free spa day</td>
</tr>
</tbody>
</table>

Information compiled by 2020health
3. The HealthWorks programme

3.7.3 The role of occupational health

During the initiation and throughout the lifetime of the programme the Occupational Health Department were unable to contribute in a meaningful way. This was due to shortage of staff and a hiatus in the team leadership which has since been rectified. The exact role that Occupational Health will provide is currently still in development by senior managers at HUHFT. There is undoubtedly a role for Occupational Health in offering confidential advice to staff on health and wellbeing. This may involve some upfront costs as additional staff may be required if the NHS Trust is to fulfil its ambition of providing staff with the opportunity for an annual health assessment or so called ‘MOT’.

3.7.4 Healthy eating

As previously discussed healthy eating was an issue raised by staff, with reference to the provision of healthy affordable food options at convenient times. Both HUHFT and CCGB engaged with the private sector provider of canteen services at HUHFT to increase the number of healthy options available and it is anticipated that further options will come on line, including a greater emphasis on steamed food and easier access to healthier options outside canteen opening hours. As part of their involvement in the project CCGB worked with their bottling partners to increase the choice of options for staff within their vending machines onsite. This has led to an increased provision of water, juice and low and no sugar varieties being stocked. However, the provision of healthy food was a real issue and it would appear there is scope to develop a greater emphasis on healthy eating as the HealthWorks programme evolves.

3.7.5 Stress and working environment

In both RDSI and HRUK interviews, working patterns, shifts and the working environment were highlighted as areas of concern for staff work load and stress. Literature supports the link between variable working patterns, high intensity, unpredictable workloads and stress. It has also been demonstrated that an unhealthy lifestyle can contribute to stress.

An objective of HealthWorks is to reduce stress through exercise and a healthy lifestyle. Since the first review, the midwifery department has moved into new upgraded accommodation and this will improve working conditions. There remains an outstanding issue with regard to shift patterns and taking proper breaks throughout the day. In June 2009, the community midwives had an average sickness rate of 3.2%, compared with the HUHFT’s rate of 3.4% and a sickness absence rate of 3.8% in the delivery suite. It is worth exploring further the underlying causes of this increased sickness rate, and what impact the HUHFT’s programme of developing a fitter work force can have.
The Nordic Walking Technique

✓ Burns 20-40% more calories
✓ Works 90% of major muscles
✓ Lessens impact on knees and joints
✓ Reduces tension in neck, back & shoulders
✓ Sociable, affordable, effective & FUN
✓ Qualified instructors across the UK
4. Outcomes

4.1 Introduction

‘We assumed that the NHS would have had health covered...’
Heart Research UK on staff MOT’s

In this section the question of whether the project achieved its overall aims is addressed. This evaluation of outcomes identifies the successes, barriers, opportunities and challenges of the HealthWorks programme. The outcomes below were compiled through staff workshops, one-to-ones, senior management interviews and HUHFT information on sickness absence etc. This noted that for all outcome measures, HealthWorks is considered the most prominent intervention, but that there might be some outside or chance factors that will influence, for example the population wide outcomes discussed in section 4.2.

Although they cannot be statistically validated within the remit of a relatively small sample, these outcomes are indicative of the potential of outreach health and wellbeing programmes. Inevitably other factors will feed into the outcomes reported for the target group and for the random population-wide sample. There is a difficulty in evaluating these outcomes because of the change in project scope from a target group to a Trust-wide initiative. The midwifery unit were the subject of the first assessments by RDSI and HRUK and the general population within the follow up assessments in July 2010. A full description of the numbers and groups involved in the assessments can be found in Section 2. It was unfortunate that the same people were not assessed both times. This might be because it was not made clear at the start the programme, or that shift patterns and work commitments made it difficult to attend the second assessments. For future programmes this should be addressed.
4.2 Population-wide outcomes

This section explores the findings from the RDSI qualitative staff survey in conjunction with Heart Research UK’s findings from one to one sessions, with further quantitative data and some reference to the interviews held by 2020health.

A continually emerging theme was that HealthWorks has been hailed a success and appears to be gathering momentum within the hospital. The launch of HealthWorks has given HUHFT staff the encouragement they needed to re-evaluate their own individual health and how this could be improved. For some, this reminder was all that was necessary, and providing this forum once had been useful in itself.

It was determined that there has been a positive impact on mental and physical aspect of those who engaged further with the programme. Participants have had feelings of a greater value of worth, care and feeling of belonging since the programmes instigation. This is reflected in one of HealthWorks biggest successes - The Launch Event - which is an example of how outward reaching and integrated health and wellbeing directed services can be.

When asked to specify the greatest benefit of HealthWorks, of those interviewed most responded that foremost it was about ease and convenience, a close third was affordability.

Part of the success of HealthWorks at Homerton as explained by staff interviewees, was due to the easy and flexible mode of communication, though this had some pitfalls. Of particular consideration was that many hospital staff did not have access to email during their shifts and though not the only form used, this was the main form of communication.

The variety of different classes, from netball to Nordic walking, was identified as a driver for success. The varied activities made it easier for a member of staff to find something appealing, or something that fitted with their routine. RDSI evaluated outcomes class by class. Generally the barriers for class attendance were predominantly time and inconvenience. The barriers to the uptake of the gym membership on offer were identified as it being in an inconvenient location in relation to their home, poor communication from the gym about membership and general dislike, as many found the gym a boring exercise prospect.

Many made reference to Vielife. The Department of Health funded programme ‘Creating a Healthier NHS’ provided by Vielife was intended to be a platform at HUHFT, providing an online gateway for all staff to access health and wellbeing services. Senior management at HUHFT thought that although successful in other pilot NHS Trusts, Vielife had not worked for Homerton staff and that there was a lack of engagement with this programme. Some participants had been suspicious of the internet based programme as an employer information gathering exercise or health screening. It also alienated many workers who did not have access to the internet on a day-to-day work basis and therefore was inequitable.

Further to this it was felt that the service was inaccessible because of poorly designed software with no contact point and time consuming because of the depth of personal information the service required before creating a personal profile. Staff that had begun to use the service felt that much of the health advice, sometimes in the form of recommended recipes, were irrelevant to their lifestyle, or far more complicated than stated. As this initiative was Department of Health led, there were further confidentiality fears to contend with, some staff had expressed concern that inputting their information would lead to punitive treatment. HealthWorks has worked because it was simple and more personal. It has also been reward based through free Spa days and focused on celebrating achievement.

Box 7 - Outcomes for Homerton staff

“Participants generally welcomed the opportunity to discuss lifestyle habits and gain an understanding of health risks and risk to heart health in particular. Tailored, practical advice and appropriate lifestyle leaflets were received in a positive way and people were encouraged by the fact that making small manageable changes could positively impact long term health and reduce the risk of developing heart disease.

Many people had actively changed lifestyle habits and experienced other health benefits such as increased confidence, better sleep quality and a willingness to try new foods and cooking methods. Most people agreed that consultations were useful and informative and felt they would enjoy long term benefits of workplace interventions and healthy heart checks.”

Heart Research UK conclusions 2010
It is also revealing what was not registered in the findings i.e. space and facilities. Although mentioned as a problem for senior management, space was not registered as a problem for staff within the remit of this research, despite HUHFT having no dedicated HealthWorks space or staff gym. This is promisingly indicative that space does not matter. Healthy learning can happen anywhere and the only need is to think creatively i.e. Nordic walking.

It was suggested that staff could further benefit from improved communication between the hospital and gyms, extra classes, recorded health assessments and annual launch events.

Quantitatively, the results showed that the staff population at Homerton had a relatively low proportion of alcohol consumption, good blood pressure and very few smokers.

Given the focus on gym attendance, and that 4.1% of the midwifery staff became engaged in the programme, the research suggests that the biggest impact that HealthWorks has had is the inclusiveness of exercise participation. This is parallel to how the programme was designed with a main focus on exercise classes and gym attendance. However, the population-wide results conflicted with this, for example in the original data taken in January 2010 as 36% of the sample exercised 3 or more times a week. This dropped in June 2010 to 19% of the sample. The reduction reflected here may be caused by HealthWorks participants not being available for interview, or the evaluation groups not being chosen by the same method.

A lesser focus on food within HealthWorks is correlated by the results. The least population-wide impact area seems to be nutrition and health eating.

### Graph 1

**Exercise Participation**

<table>
<thead>
<tr>
<th>Weekly exercise participation</th>
<th>Percent of samples (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 or more times</td>
<td>13%</td>
</tr>
<tr>
<td>3 to 4 times</td>
<td>23%</td>
</tr>
<tr>
<td>At least twice</td>
<td>11%</td>
</tr>
<tr>
<td>Once a week</td>
<td>19%</td>
</tr>
<tr>
<td>Never</td>
<td>36%</td>
</tr>
</tbody>
</table>

**Exercise participation in HealthWorks from January to June 2010**

Graph reproduced from HRUK findings July 2010
A possible reason for this is because behaviour change is harder to affect in this area or that more social support was available in exercise than healthy eating i.e. classes acted at social motivator but there was no equivalent for healthy eating.

The Trust-wide information that was thought to be indicative of HealthWorks population wide outcomes included sickness absence rates, cost of sickness absence, vacancy rates and staff turnover. The study was not strategically designed to impact on these figures, however it was thought that over time some effect might be noticeable. Box 9 shows that there is no correlating effect of HealthWorks on these major workforce indicators. All depict slight increases in sickness absence, vacancy and turnover, except cost of sickness absence the data for which is unavailable – however we do know that in the month of July 2009, the month after the comparative data was taken, sickness absence was reported at £663,524. There is a significant reduction in cost of sickness absence over this 11 month period. To reiterate, this could be because of multiple factors beyond HealthWorks’ remit, including changes in sickness absence management through improved employee health management services and procedure. Overall the increases in these percentages are a negative reflection on the business case for implementing HealthWorks, however HealthWorks as an intervention has not been operating long enough to make any verdict.

| Box 9 - Population-wide outcomes for HUHFT from June 2009 to June 2010. |
|--------------------------|--------------------------|
|                          | June 2009 | June 2010 |
| Sickness absence (%)     | 3.4       | 3.5       |
| Cost of sickness absence ( £)* | n/a (663,524) | 547,026 |
|                          | in July 2009 |
| Turnover (%)             | 11.9      | 14.7      |
| Vacancy (%)              | 10.8      | 11.5      |

*This figure incorporates employer National Insurance contributions, salary and pension payments but not agency replacement or associated predicted costs.

Informationsupplied by HUHFT

Taking information released about staff attendance of HealthWorks from January 2010 to June 2010, it is evident that 181 out of 4247 HUHFT staff engaged in exercise classes (4.3%) and a further 89 (2.1%) attending the participating gyms at least once. This means that HUHFT through the HealthWorks programme engaged a total of 6.2% of its workforce in exercise. This number accounts for limited overlap of 0.2% between those who attended both the gym and the classes. It is notable that there was restricted overlap, which suggests that individuals enjoy attending either the gym or a HealthWorks exercise class, but not both. It is unknown what percentage of people would have exercised without HealthWorks. However if this level is sustained and increases over time, there is a foreseeable health gain for staff at HUHFT. HUHFT are positive about this level of engagement.

4.3 Target group outcomes - Midwifery

There was some conflict of results in the original target group, which suggests that there are other issues to be addressed about the dynamics of the group that are external to the HealthWorks intervention. This may have impacted on the fact that the qualitative data shows a decline in engagement, but the quantifiable data suggests a real tangible health gain of those assessed consistently (36/136 people).

The department’s staff concerns remained constant throughout the evaluation period. It was noted that there might be an inability to engage with HealthWorks due to anti-social shifts and class times. Within the target group there was a notable feeling of exclusion, because of the limited ways in which this group felt they could get involved. This was emphasised as some were unable to attend the HealthWorks launch event. However there had been some usage of the HealthWorks offering including the free gym trial.

Due to the variability of the maternity unit’s roster, it was considered that a more appropriate focus for delivery ward staff could be on diet rather than exercise. This was corroborated by quantitative information that suggests that there had been some dietary changes. Although there was greater oily fish amongst this group, there were also more takeaways, the snack of choice was much less likely to be fruit and much more likely to be biscuits. However it was identified that this could be extrapolated to the whole of the population and is not specific to the target group. For this group some specific recommendations were made including short, low intensity workshops like meditation, or having an exercise machine in the staff room.

RDSI’s findings indicated that staff would like to refocus on food, including the introduction of pre-ordered lunches from the canteen to assist staff in making wiser food choices or staff sessions by the dietetics department on healthy snacking and practical tips.

During the research 2020health were given access to a range of information including that relating to sickness absence and recruitment, but it has not proved possible to provide an in depth analysis as information may not be pertinent to the individuals taking part in HealthWorks. The NHS Trust has a number of other initiatives ongoing to address sickness absence which cannot be assessed here for impact.
In June 2009 the midwifery department recorded a sickness/absence rate for community midwives of 3.2% and this had risen to 6.7% in June 2010. Likewise there was an increase for delivery suite staff from 3.8% to 5.8%. This is compared to a 0.1% increase in the Trust-wide average from 3.4% to 3.5%. These figures do not reflect trends and may represent a higher than average monthly figure or could be caused by the long term absence of a small number of staff. It is therefore difficult to make any judgment without a further understanding of factors underpinning this information.

In the quantitative phase of this research, undertaken by HRUK, the target group fared well - and had more successes than the population-wide study. It is evident from information released by HUHFT, that 4.1% of the target group attended HealthWorks’ classes. HRUK’s analysis consisted of two assessments over a 6 months period of 36 midwifery staff. Tables 5, 6 and 7 show a waist measurement drop for women and increase in exercise participation. Stress levels had decreased much more than in comparison to the HUHFT population. It is assumed that this area might have seen such improvement due to HealthWorks and other correlative factors such as a new department and staff room for employees. However there were no other significant staff changes or changes to working practices. All these measurable factors, were compiled by HRUK into a lifestyle score, which showed considerable improvement overall from the months January to June 2010. Comparisons of Tables 8 and 9 suggest the target group more than halved their high stress levels in two months (from April-June 2010) compared to the HUHFT population reduction of 1%. The HRUK Lifestyle score also is highly deceptive that those scoring a 1, the lowest risk band, had increased 53% in the target group, compared to just 3% in the HUHFT population. This suggests that targeting groups has good health outcomes.

### Table 5 - Waist Measurement comparison of target group at HUHFT from January to June 2010

<table>
<thead>
<tr>
<th>Female waist measurement (inches)</th>
<th>January</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 and above</td>
<td>81%</td>
<td>58%</td>
</tr>
<tr>
<td>32 to 35</td>
<td>13%</td>
<td>25%</td>
</tr>
<tr>
<td>below 32</td>
<td>6%</td>
<td>17%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male waist measurement (inches)</th>
<th>January</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 and above</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>37 and above</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>below 37</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Table 6 - BMI comparison of target group at HUHFT from January to June 2010

<table>
<thead>
<tr>
<th>Comparison of BMI</th>
<th>January</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 to 24</td>
<td>15%</td>
<td>19%</td>
</tr>
<tr>
<td>25 to 29</td>
<td>35%</td>
<td>37%</td>
</tr>
<tr>
<td>Above 30</td>
<td>50%</td>
<td>44%</td>
</tr>
</tbody>
</table>

### Table 7 - Exercise participation comparison of target group at HUHFT from January to June 2010

<table>
<thead>
<tr>
<th>Exercise Participation (per week)*</th>
<th>January</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>1</td>
<td>15%</td>
<td>0%</td>
</tr>
<tr>
<td>2</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>3 to 4 times</td>
<td>25%</td>
<td>19%</td>
</tr>
<tr>
<td>5 or more</td>
<td>5%</td>
<td>6%</td>
</tr>
</tbody>
</table>

*defined as 30 minutes of moderate intensity exercise.
Results reproduced from HRUK findings July 2010.
4.4 What the decision-makers said

Although the findings are not definitive, HealthWorks indicates how wellbeing initiatives in the workplace can have a positive impact on the lifestyle and engagement of its employees. Following on from the outcomes for staff, the research looked at how HealthWorks impacted on senior management thinking and wider policy adoption. Several themes were born out of this research in discussions with senior management and key stakeholders in June 2010 (full list available Annex 4), after the initial assessments but before the final HRUK and RSDI results.

When asked about the relationship between work and health, all interviewees recognised the connection pertaining to them as individuals. The role of the organisation and the responsibilities of its members with regard to health and wellbeing was less clear in people’s minds. Though this dynamic was and is understood by senior leaders within HUHFT, they have not yet fully developed their thinking on how to address this.

Most commonly expressed was the importance of the presence of a Lifestyle Co-ordinator, someone on the ground who could be both a contact point and face of the programme. Also commented was how prior to HealthWorks there were limited mechanisms in place for staff engagement.

*On conclusion of each Healthy Heart Check, participants are given a score indicating their risk of developing heart disease, based on their anthropometric measurements and lifestyle habits. The score bands range from one to five, with one being at lowest risk and five being at highest risk.

Results reproduced from HRUK findings July 2010

Table 8 a & b - HUHFT Population stress and lifestyle scores comparison at HUHFT from January to June 2010

<table>
<thead>
<tr>
<th>Stress</th>
<th>January</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>Medium (but feel negative)</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Medium (but feel positive)</td>
<td>63%</td>
<td>65%</td>
</tr>
<tr>
<td>None/low</td>
<td>14%</td>
<td>15%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lifestyle Score band*</th>
<th>January</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>41%</td>
<td>44%</td>
</tr>
<tr>
<td>2</td>
<td>50%</td>
<td>36%</td>
</tr>
<tr>
<td>3</td>
<td>9%</td>
<td>20%</td>
</tr>
<tr>
<td>4</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>5</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Table 9 a & b - Target Group at HUHFT stress and lifestyle scores comparison at HUHFT from January to June 2010

<table>
<thead>
<tr>
<th>Stress</th>
<th>January</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>20%</td>
<td>6%</td>
</tr>
<tr>
<td>Medium (but feel negative)</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Medium (but feel positive)</td>
<td>45%</td>
<td>81%</td>
</tr>
<tr>
<td>None/low</td>
<td>15%</td>
<td>13%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lifestyle Score band*</th>
<th>January</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>41%</td>
<td>44%</td>
</tr>
<tr>
<td>2</td>
<td>50%</td>
<td>36%</td>
</tr>
<tr>
<td>3</td>
<td>9%</td>
<td>20%</td>
</tr>
<tr>
<td>4</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>5</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Interviewees were given the opportunity to express any concerns about the HealthWorks programme and their personal vision for its future. For HUHFT a number of areas required further work including most commonly:

- healthy eating side of health promotion
- occupational health services
- clinical engagement
- local staff champions
- evaluation
- NHS Trust-wide integration
- some areas of project management
- admin support
- marketing and clear messages
- programme only be used by those who are already fit

These concerns are addressed in Section 5, notably there was a focus on exercise, whilst the healthy eating promotion was less prominent in the early stages of the HealthWorks programme. Similarly other parts of the HealthWorks healthy eating promotion plan which included vending machines with healthier options to address the poor provision of access to water for staff, was severely delayed because of conflicts with the contract held by the hospital’s food provider. However aspects managed internally, including marketing, were affected by mixed messages. It was known that though staff were aware of all the activities and healthy eating drive, that this was not necessarily identified as ‘HealthWorks’.

Concerns were expressed with regard to participation in exercise classes elsewhere or previous gym membership. There is the possibility that those attending were already highly motivated and exercising elsewhere. It could be construed that those attending the HealthWorks activities had simply transferred from an outside programme. If this were the case, then the 4.1% attending classes may not represent an increase in those being physically active, but there is no information available to support or refute this concern. This needs further investigation; however there is no doubt that the feel good factor of the activities taking place at HUHFT is of value. HealthWorks visibility was an encouragement to others. In reviewing the list of attendees and their departments, it is clear that teams were exercising together, it is unlikely they would be doing this outside of work.

In terms of evaluation, it was discussed whether engaging organisations like RDSI and HRUK were necessary to this model of practice. In evaluating the project from CCGB’s view, both these surveys were necessary. However HRUK’s type of risk assessments could reasonably be carried out in a confidential manner by the organisation’s occupational health department if tailor made nutritional plans or self directed learning were organised. Secondly the staff survey could form part of the NHS Trust’s annual survey of staff with the focus on health forming part of the NHS Trusts own additional questions. HUHFT is currently analysing a staff survey specifically aimed at staff who participated in HealthWorks with a view to using the results to further define and enhance the programme.

Given a clean slate, most respondents felt it would be wiser to focus more on the following items:

- nutrition
- operational processes
- determining the right objective
- better consideration to target group
- keeping up momentum
- improved organisation
- engage clinical staff
- strategic overview

In context, NHS employees have very varied working lives and some conditions are not unique to the NHS e.g. shift work, requirement to cover unexpected absence, or increases in workload. Similar problems have been found in a variety of workplaces from call centres to manufacturers. This evaluation was to test with decision makers whether HealthWorks could be considered best practice and could feasibly be implemented in other
environments. In terms of transferability to the community, and how a programme of this kind would work in other NHS Trusts and organisations, the essential requirements were identified. There were several commonly held opinions:

- a Lifestyle Co-ordinator (to act as main driver)
- leadership at senior level
- timing
- convenience
- choice of activity
- transparency
- demonstration of business case
- acceptance of trial and error
- consistent branding
- good communication
- resource
- good management
- managing expectations

It was evident that any transferral of HealthWorks to another NHS Trust would vitally depend on a Board commitment to health and wellbeing and the capacity to employ a Lifestyle Co-ordinator. Site size, size of workforce and location however were not felt to be an issue. This implies that the main quality of any wellbeing programme is in essence attitudinal, which in turns filters out in what has been termed a 'Halo effect' to eventually influence health behavioural changes of an individual and the people around them.

The original vision of HealthWorks was to provide a lasting link with London Olympics 2012 and leave a health legacy for staff at Homerton and the wider Hackney community. Although there is some indecision over how HealthWorks will be formulated in the future, it is clear that it will have a place in HUHFT. In the course of the evaluation, it was identified that its future success would be dependent on wider integration within the NHS Trust and community. HealthWorks has succeeded in helping Homerton build links with the fitness industry in Hackney. It is also anticipated to be a draw for future recruitment drives and help in investing in an already good relationship with local schools.

With respect to sustainability, there seemed to be agreement on the point that once CCGB’s funding ceased, that something would have to change. It is anticipated that HealthWorks will evolve and be reconfigured year on year but some key components will remain constant, namely the classes, the gym links and an annual HealthWorks event. Though the classes would change to employee funded, it is hoped that this will bring a degree of responsibility to attendance, and is therefore not altogether a negative development. It was evident that there was some concern about the programme having a clear and embedded vision.

Observations made from this stage of the evaluation revealed some considerations for the future. No overall responsibility for ‘HealthWorks’ was tangible before the appointment of a Lifestyle Co-ordinator. Some respondents continued to treat HealthWorks as an abstract concept rather than a fully functional programme of activity. This was evident from having no singular contact point within HUHFT, which is where the role of a Lifestyle Co-ordinator has been invaluable. This is especially true if any corporation is involved or external agencies are providing fitness services to staff.

Three elements were considered essential for ‘getting things done’ in the wellbeing programme:

- resource - time, social drive (impetus) and financial capital;
- branding - including having vision, a great brand and good communication;
- leadership - both of the programme and at board level.

Homerton will continue to fund HealthWorks once CCGB sponsorship ceases from July 2010. HUHFT have reviewed funding, community engagement with local business and communication. As a NHS Trust their next hurdle will be to keep staff health and wellbeing on the agenda in a climate of NHS efficiency saving drives. Over the next few years Homerton will merge with community providers, and it will be a challenge to ensure the vision and commitment is extended.
4. Outcomes

Key Outcomes

The key findings and outcomes can be divided into two groups. For staff at HUHFT;

- HealthWorks has had some success in encouraging staff to re-evaluate their health. It has had a positive physical and mental impact on those who have engaged with the programme.

- The greatest benefit of initiative for staff was that it made them feel valued and made exercise more accessible. On the other hand, the greatest deterrent for staff participating was time constraints due to shift patterns.

- The nominated target group of staff recorded benefits in terms of decreased stress levels and BMI, but recorded negative impact in terms of snacking and eating 5 a day. Overall the target group had more success than the general NHS Trust population. This would indicate that appointing a target group can be effective. However, only 4.1% of the target group became engaged with the programme which was determined to be a poor uptake and in need of improvement.

- Having a dedicated Lifestyle Co-ordinator helped encourage staff to stay motivated. Staff felt that the launch of HealthWorks was fun and useful.

For HUHFT as an NHS Trust;

- Minimal change in staff sickness absence, vacancy or turnover rates.

- Leadership, resource (social and financial) and branding were noted as key elements for the implementing the HealthWorks programme. Conversely, strategic overview was not seen by HUHFT initially as an essential component of making HealthWorks a success and responsibility of members for health and wellbeing was less clear.

- The introduction of a Lifestyle Co-ordinator was a key contributor to implementing this programme. The role was pivotal in ensuring strong leadership, providing motivation and communicating with employees.

- Given a clean slate HUHFT would focus more on healthy eating, operational processes and clinical engagement, especially of those staff who work outside of 9-5 hours.

- Exceptional staff attendance at the health festival that launched HealthWorks (over 600 people).
• HUHFT as an employer is now thinking more about the health and wellbeing of their staff and has a greater understanding of the links between work and health.

• Overall there was a 9% uptake of free gym membership (32 out of 374 who signed up) however 89 staff attended one of the participating gyms which represents 2.1% of all HUHFT staff. This is considered poor by the Trust. Overall 181 staff (4.3%) have taken part in a HealthWorks classes e.g. pilates. The total exercise participation of HUHFT’s workforce is 6.2%, which accounts for any overlap of participants. This number indicates a foreseeable health gain for HUHFT staff, which is seen as positive by the Trust.
5. Evaluation

5.1 Introduction

In evaluating the programme and whether it met CCGB’s original objectives, 6 key components were recognised and addressed by the following questions which we answer in this section.

- **Has HealthWorks changed the NHS Trust’s and employee’s attitude to health and wellbeing?**
- **Was the project well-managed and planned?**
- **How well does HealthWorks align with Boorman’s recommendations?**
- **Did the programme offer value for money?**
- **What was value of Coca-Cola Great Britain’s involvement?**
- **Is this a model that can be used elsewhere?**

5.2 Has it changed the NHS Trust’s and employee’s attitude to health and wellbeing?

In the course of this review it became apparent that although the HealthWorks project was not integrated with the NHS Trust’s strategic activities, it has changed both employers and employees attitudes to health and wellbeing. The Chief Executive recognised that HealthWorks should form a plank of a broader strategy integrating smoking cessation, improving access to healthy food options, stress counselling and occupational health activities. This was echoed throughout the interviews and was recognised as an area where progress was desirable. There was recognition of a need for a broader vision for improving health and wellbeing within the workplace.

Throughout the course of the interviews there was a real excitement and a high level of motivation with regard to taking the programme forward. The visibility of some of the activities was reported to have further motivated staff to develop additional activities such as an extra running session and cricket teams, the latter whilst not under the HealthWorks banner, demonstrates a renewed enthusiasm for team and group activities. It is acknowledged that these do help in team building, improving communication and gives a feel good factor about the organisation.  

As a result of the programme there is now recognition that health and wellbeing is an underpinning principle of HUHFT’s activities related to staff recruitment and management and should be a core corporate objective. A key outcome of the HealthWorks project for the NHS Trust has been the recognition that being a good employer is essential to achieving NHS Trust objectives and that ‘Homerton genuinely want a fitter more engaged workforce.’ HealthWorks has provided the focus
for shifting this change in thinking and there is now recognition at Board level of the real relationship between work and health. This will need to be driven down the organisation to line managers and incorporated into their objectives. The programme has further led senior managers to consider other programmes related to health and wellbeing such as weight-loss programme Fitbug which can be used to enhance team building.55

Although the NHS Trust has no formal staff engagement strategy, the Joint Staff Consultative Committee is well developed and was informed and actively engaged in the HealthWorks project. As a result of the HealthWorks programme HUHFT intends to incorporate consultation on the development of HealthWorks and the future of health and wellbeing within its annual staff survey.

HUHFT’s own appraisal of HealthWorks and its success has changed thinking with regard to the role that Occupational Health plays within the organisation and this is now being re-launched as Employee Health Management, with a greater integration between HealthWorks, staff counselling and smoking cessation. The Trust aims to develop a ‘wellbeing centre’ with all elements incorporated under one umbrella with clearer objectives.

HealthWorks has enabled HUHFT to become more outward focused and more clearly define its role as a leader within the community for promoting health. Another positive development is the links with the fitness industry.

The scope for their working with local business to mutual benefit was addressed. Smaller businesses find it difficult to meet their obligations with regard to staff wellbeing and could join with Homerton to participate with activities in return for sponsorship for HealthWorks. The HealthWorks model could be a joint enterprise, enabling business to meet their obligations with regard to corporate social responsibility, thereby achieving their own objectives for improving staff health and wellbeing and further integrating the NHS Trust with the local community.

For HUHFT, a merger with community provider services will provide a new emphasis on improving staff health within community services and provide more opportunities to develop new links with the broader Hackney’s community. Certainly there is an opportunity to forge closer link with the Local Authority and develop joint initiatives for staff and tackle the broader public health agenda.

**Recommendation 1**

Develop a broad vision and strategy for health and wellbeing at work that engages the wider local community and identifies opportunities for partnership.

5.3 Was the project well-managed and planned?

In reviewing the project plan the PRINCE2 (PRojects IN Controlled Environments) methodology was used as measure for best practice. PRINCE2 is the standard project tool used within the NHS to manage smaller projects is a process-based method for effective project management. PRINCE2 is a de facto standard used extensively by the UK Government and is widely recognised and used in the private sector, both in the UK and internationally. Its key features are:

- focus on business justification;
- defined organisation structure for the project management team;
- product-based planning approach;
- emphasis on dividing the project into manageable and controllable stages;
- flexibility that can be applied at a level appropriate to the project.

In reviewing the HealthWorks project plan as a whole, it is noted that no formal project tool was used. CCGB initially defined the project key objectives as:

A. delivering an effective and sustainable workplace health programme at Homerton Hospital;

B. creating a model of best practice in workplace health.

However the objectives for HUHFT were less well formulated and there were no formal written objectives. It was expressed that the project could be an instrument for resolving management issues within the target department, enhancing team building and improving leadership at local level.

There were some defined measurable benefits described for this project such as sickness absence, but there appears to have been some confusion over the benefits that both the HUHFT and CCGB were expecting to be measured. This confusion was likely given the number of organisations involved. All partners recognised that good project management was a necessity for future progress.
5. Evaluation

Part of this review has explored the leadership of the HealthWorks project. The extended timeline for the project resulted in less well defined leadership than was initially envisaged. Board level leadership was acknowledged, but leadership on the ground has largely been the remit of the Lifestyle Co-ordinator.

HUHFT and CCGB quickly recognised that the success of the project would depend on the appointment of a member of staff to lead and co-ordinate activities, as the capacity to expand pre-existing roles was limited. The appointment did not take place until 6 months after the project agreement and the Lifestyle Co-ordinator was immediately launched into the day to day management of the various activities. This has led to the Lifestyle Co-ordinator undertaking administrative duties to support the programme, and therefore less visible and less able to provide motivation and leadership on the ground.

As a result of Boorman and the White Paper’s commitment to improving NHS staff health, it is inevitable that Trusts will integrate staff wellbeing into line managers’ objectives, making leadership local as well as strategic.

Recommendation 2

Organisations should have strong Board level leadership with the resolve to support health and wellbeing, with a visible and approachable operational lead similar to HealthWorks lifestyle co-ordinator.

Recommendation 3

Ensure good project management tools e.g. PRINCE2 are adopted for any project development and roll out.

With the number of organisations from a variety of different sectors involved in a new venture such as HealthWorks, some problems within the overall project management are to be expected. Responsibility for the management of the overall project was not as well defined as it might have been and sometimes fell between CCGB, PI and HUHFT. The level of ownership at HUHFT was slow by a vacancy and the recruitment of a new Human Resources Director, highlighting the need for consistent and dedicated leadership. The project was reported on regularly to the board and discussed at executive team. One of the key changes at HUHFT has been the recognition of the need for greater Board level leadership and engagement and that this should be reflected throughout the organisation.

A key plank of project managing is the defining of benefits realisation with measureable deliverables and key milestones. Although some deliverables were defined such as improvement in sickness absence and exercise levels for the target group, little consistency in staff participation in evaluations posed problems in collecting this data. However findings outlined in section 4.3 were positive and suggest that targeting a group can make a difference. Other useful measurements that could have been usefully employed to assess the coverage of the programme include participants age range, ethnicity, salary band, or type of shift worked. The NHS Trust did not measure specifically the impact of the programme with regard to sickness absence, reduction in disciplinary procedures or grievances raised, within the target group or those actively participating in the programme. It should be noted that HUHFT collects this information and reports regularly at board meetings on performance and it should be possible to assess the coverage of the programme. There are some difficulties in assessing the impact of HealthWorks on sickness absence, turnover and other related workforce and education issues, as the NHS Trust is running a number of initiatives to enhance and improve performance in these areas.

As part of the project the NHS Trust introduced the concept of champions at departmental level to support the HealthWorks project and provide local leadership. Using champions was requested by CCGB, as it is a model that had achieved success in previous business wellbeing programmes. The lifestyle co-ordinator held regular meetings to discuss progress in individual departments, but at this stage it was felt their role had not been fulfilled. Greater clarity around the objectives of the role and an improvement in communications may have helped the champions reach their full potential. The broader concept of the work-wellbeing link and benefit realisation needs to be more clearly defined for these roles to reach the level of success they achieve in other sectors.

It is problematic to quantify changes overtime as different members of staff outside the target group were surveyed. However findings outlined in section 4.3 were positive and suggest that targeting a group can be
beneficial, but it is difficult to correlate this entirely with HealthWorks.

The original plan to improve health and wellbeing through a range of activities deviated to develop a focus on exercise with less emphasis on addressing the issues raised regarding access to healthy eating, stress and working conditions, both environmentally and with regard to shift patterns. All of these were raised as issues in the course of this assessment. The development of these strategies may have been impeded by the shortness of the timescale in which the project was finally delivered and evaluated.

**Recommendation 4**

In developing any programme there needs to be clear objectives and well-defined metrics for evaluating success.

Communication is also a vital component of any new programme or initiative. In recognising this PI and CCGB were keen to develop a visible, eye catching programme title and logo. RDSI were asked as part of the base line review to test some ideas with staff. This resulted in the adoption of the title HealthWorks and the development of the logo, both of which were used at the launch and have become the branding for the programme. They appear to be well recognised and therefore the aim has been achieved.

Some communication difficulties have been identified and these relate primarily to the use of the NHS Trusts intranet to communicate with staff. It qualitatively reported that not all staff have the time and ability to connect to the intranet, nor is availability universal.

Posters bearing the HealthWorks logo are on display within the NHS Trust, although their geographical coverage was difficult to assess. These are small and those observed were on display with large number of other posters relevant to NHS Trust activities and initiatives. Enlarging the posters and creating a separate HealthWorks notice board maybe something the NHS Trusts could give consideration to.

The Lifestyle Co-ordinator has used flyers within wards and departments as well as personal visits to the work place. These will be further increased as administrative support for this post enables greater freedom to exercise the leadership role. Redefining the role of the HealthWorks champions would further improve communication.

**Recommendation 5**

Communication and marketing should have full staff coverage, be highly visible and accessible, and supported by leaders at all levels.

5.4 How well does HealthWorks align with Boorman’s recommendations?

HealthWorks was not specifically designed by CCGB and HUHFT to align with Boorman, because the development of the programme predated the publication of the NHS report. However the health and wellbeing agenda was kept in mind. As the Government are fully committed to these recommendations, Boorman’s recommendation can be used as a tool to evaluate HealthWorks in the context of widely held national policy (for full analysis see Annex 1). With respect to implementing Boorman, NHS Trusts have been advised to pull together all existing, organisation-wide policies and initiatives in order to support the workplace health agenda. These may include occupational health services, health and safety management, risk assessment and management, counselling services, flexible working, sickness absence management, and policies for managing stress, violence, musculoskeletal problems and bullying and harassment. These could also be integrated with equality and diversity, employment and mental health, and employee engagement strategies.

HUHFT has well defined polices for Health and Safety, Equality and Diversity, Recruitment and Retention and a Work Force Strategy, but there was a recognition that these did not overtly support the concept of health and wellbeing for staff. HUHFT has no formal process of adopting the recommendations from Boorman but feel that HealthWorks provides the vehicle required to meet the recommendations made within the Boorman report. It is also noted that the NHS Trust does not use any of the tools to assess health and wellbeing including the Government’s Workplace Wellbeing Tool, HSE’s sickness absence toolkit and stress management standards.

HUHFT have stated that they are exploring the development of the interface between HealthWorks and the occupational health and counselling services, called Employee Health Management. There is recognition that HealthWorks as a brand has yet to become part of broader policies, however, senior managers at HUHFT acknowledge that this is work in progress.
The focus provided by HealthWorks has been a driver for HUHFT to reconfigure its occupational health (OH) services and align internal activities related to health and wellbeing at work. However, in some cases it might be important for services to remain separate as OH is often seen as a management tool given that most organisations’ occupational health departments’ main priority is to effectively manage sickness absence and the return to work. It is important that organisations develop an open culture that fosters trust between employer and employee.

The Boorman review recognised engagement and staff ownership as crucial to delivering successful health and wellbeing services. Communicating the goal of the programme to everyone, not just staff but patients, visitors and partner organisations is invaluable. This review has enabled HUHFT to explore some of the gaps in services available for staff and the strength of communication coverage. HUHFT will continue to evaluate HealthWorks through its annual staff survey and regular Healthy Heart checks. There needs to be a particular emphasis on hard to reach groups e.g. shift workers who have less access to health and wellbeing services.

5.5 Did the programme offer value for money?

This section reviews the costs of the programme and identifies areas where costs may be reduced. It is not possible to undertake a full cost analysis at this time for a number of reasons:

- the costs of sickness to HUHFT relate to the NHS Trusts as a whole and do not specify the target group therefore it is impossible to identify the financial impact HealthWorks might have had in reducing the cost of sickness absence;
- the HealthWorks programme is still in its infancy and any analysis can only be made with regard to short time period;
- full expenditure on the activities is not identified against allocated monies and is not broken down sufficiently;
- there is no breakdown of the charges for the gym membership by person or the level of subsidy involved.

NHS Trusts might find it difficult to justify these costs for the engagement of 6.2% of staff, however these costs could be reduced by removing the external stakeholder engagement and replacing the attitude survey with supplementary questions in the staff survey the costs would have reduced by £29,500 to £48,590 for an overall launch and assessment and programme ramp up.

Future costs to HUHFT have also been considered and the NHS Trust have undertaken their own analysis of the costs of the current classes seen based on an average weekly attendance of 91 members of staff just over 2% of the Homerton workforce. The costs are extrapolated in Table 11.

**Recommendation 6**

All organisation-wide policies should have embedded a commitment to health and wellbeing.

**Recommendation 7**

Organisations should co-ordinate activities between departments that are able to support health and wellbeing at work in an atmosphere of mutual trust and respect between employer and employee.

**Recommendation 8**

Design programmes in partnership with staff, to reflect local environments and needs, to maintain continuous evaluation and communication and to allow for adjustments.
CCGB’s overall costs for the project are reported as £83,079 against an allocated budget of £102,000. Key components of the costs are illustrated in Table 10.

<table>
<thead>
<tr>
<th>Physical activity</th>
<th>Allocated monies (£)</th>
<th>Proposed number of attendees</th>
<th>Actual costs (£)</th>
<th>Number attending</th>
<th>Costs per person (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free gym membership for 3 months</td>
<td>7,500</td>
<td>100</td>
<td>2,000</td>
<td>32</td>
<td>62.50</td>
</tr>
<tr>
<td>Reduced rate costs</td>
<td>Not attributed</td>
<td>73</td>
<td>Not quantified</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Classes and sports hall rental</td>
<td>10,100</td>
<td></td>
<td>2,366</td>
<td>181</td>
<td>13.07 for the five months to July 2010</td>
</tr>
<tr>
<td>External stakeholder engagement</td>
<td>25,000</td>
<td></td>
<td>25,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homerton staff evaluation</td>
<td>14,750</td>
<td></td>
<td>14,915</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotional activities</td>
<td>18,000</td>
<td></td>
<td>24,689</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle co-ordinator (6 months)</td>
<td>20,000</td>
<td></td>
<td>12,591</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>500</td>
<td></td>
<td>1,518</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contingency</td>
<td>5,500</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>101,350</strong></td>
<td></td>
<td><strong>83,079</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figures released by CCGB 2009-2010
Added to this is the cost of lifestyle co-ordinator and administrative support which have not been quantified.

Given that HUHFT assess that a 1% reduction in the sickness absence would save them £1 million, the programme could in the face of the gross figures, save the NHS Trust money. As there is no evidence yet that HealthWorks is contributing to a reduction in expenditure on bank and agency staff, it is not possible to prove that HealthWorks offers value for money at this stage.

There are a number of other factors to take into account:

- there has been no analysis of the improvement in efficiency that has accrued;
- no costs of the savings made due to improved quality of work and reduction in errors;
- no analysis of the impact on staff turnover or improved recruitment;
- goodwill comes at a price which is not always possible to quantify.

As previously described in Section 1.5, demonstrating the impact through writing a business case, it is hard to justify the expenditure on activities related to health and wellbeing.

Would HUHFT have achieved the same level of engagement and feel good factor through offering dietary advice and improving canteen services? It is not possible to say. Any NHS Trust would find it difficult to justify subsidised gym membership over and above that already in place through the NHS scheme and free classes may be perceived as not justifiable given the economic climate and the focus on frontline activities for patients. However the White Paper commitment to improving staff wellbeing makes it clear that employers do have a responsibility to put schemes in place. HealthWorks offers a model by which NHS Trusts can fulfil their commitment.

If it is accepted that looking after staff is a key component of improving productivity and increasing quality of care then it is reasonable for other NHS Trusts to explore the HealthWorks model.

### Table 11

<table>
<thead>
<tr>
<th>Cost per head classes</th>
<th>Costs per week at 91 people</th>
<th>HUHFT costs per 1% staff</th>
<th>Costs for 40 weeks for 1% of staff at HUHFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.45</td>
<td>£330.47</td>
<td>£78.60</td>
<td>£13,218.08</td>
</tr>
</tbody>
</table>

Figures released by HUHFT, August 2010

**Recommendation 9**

In developing a business case, identify full cost breakdowns per head of staff and identify target reductions in sickness absence against costs per head of health and wellbeing programme. These should be evaluated regularly.
5.6 What was the value of Coca-Cola’s involvement?

CCGB’s involvement was essential to the success of the HealthWorks programme. Their original proposal, resource and expertise were key components in driving HealthWorks forward at HUHFT. It was widely held that HUHFT benefitted from the ‘expertise that health doesn’t have’ and the financial resource. It is thought that CCGB’s independence, Olympic association and brand name was an additional motivator for staff involvement, as opposed to internal mechanisms e.g. occupational health department and line managers.

While CCGB provided the original impetus and initial funding for the HealthWorks programme, the initiative has empowered and enthused senior management at HUHFT to develop a greater vision with regards to the links between health and wellbeing in the work place. It is an objective to be seen a good employer attracting high quality staff to gain fulfilment in their work. Through participation in the initiative HUHFT senior management are able to think beyond Boorman. This leaves HUHFT well placed to become a leader in the delivery of best practice.

While as yet only 6.2% of the workforce is reported as being actively engaged in additional or new activities, the programme is still new and the enthusiasm and motivation may yet see increased numbers participate. It is not possible to quantify the effects this may have had on the families and friends of staff or the impact this programme may have on patients and the public at large through the spreading of good practice.

Given the changes that HUHFT are planning and the level of staff engagement, CCGB will have achieved its objective and left a legacy within HUHFT and the wider community. It should also be noted that Coca-Cola Great Britain are considering continuing their involvement at HUHFT based on the positive feedback.

5.7 Is this a model that can be used elsewhere?

To discuss whether HealthWorks could be considered good practice policy it was measured against nine best practice policy indicators, and achieves very well in seven. The HealthWorks model is forward looking, inclusive and has coped well with learning lessons (see Annex 3). This report builds on evidence that demonstrates the connection between health and wellbeing at work and improved productivity and quality of work. Furthermore the literature demonstrates that sickness absence can be reduced and employee satisfaction is enhanced. Within the NHS a number of initiatives are underway to improve the health of NHS staff, not only for their own benefit, but in recognition of their role as ambassadors for health. Various organisations that assess health care providers both within and outside the NHS will require organisations to demonstrate real improvements in creating an environment conducive to improving wellbeing at work.

For some organisations this may become tick box activity, but for those recognising the real benefits then models will need to be developed by which to make these real and tangible changes. HealthWorks has the potential to be such a model. It is developing into a multifaceted programme integrating the various strategies, policies and activities of the NHS Trust by which it can achieve its aim of a fitter workforce both physically and mentally. Its’ transferability is dependent on some key factors:

- recognition of the real gains to be made through such a programme;
- commitment and leadership at Board level;
- strong leadership and a champion at local level to drive change;
- enthusiasm and motivation throughout the organisation;
- integration with other activities;
- staff engagement;
- trust between managers and staff that any programme is not used punitively;
- sound project management.

With these elements in place it is possible to transfer HealthWorks as a model throughout the NHS. It is flexible and adaptable enough to meet the needs of various types of workplace and NHS Trust. Principles can be adapted and strategies developed locally to suit the needs of individual organisations. As discussed in section 5.5 corporate involvement at HUHFT was essential to HealthWorks success. This model shows how business, local or otherwise, can join forces with the NHS to enable mutually beneficial programmes like HealthWorks.

**Recommendation 10**

Ensure that links are maintained with partner organisations and legacy, in terms on long term impact on staff health and communities, is a key objective for any external sponsorship.
The HealthWorks programme presented an opportunity to engage in the personal health of healthcare professionals at HUHFT. This initiative, though not unique in its strategic aim of empowering and educating staff to make healthier lifestyle choices (to prevent work-related or lifestyle influenced ill health), offered a good learning opportunity in implementing wellbeing initiatives. HUHFT, through HealthWorks, reviewed their strategic approach to health and wellbeing at work. It has become a core objective integrating all related strands under one strategic plan. This approach offers value for any organisation wishing to implement a health and wellbeing programme or work with the private sector. Resource, leadership and branding were identified as key components to success.

- **Resource** - The programme requires dedicated time and a formalised approach to ensure that deliverables are achieved and where necessary, actions can be changed to achieve the desired outcomes. It is difficult to assess the overall success of HealthWorks as the criteria were not well defined. For example while 6.2% of the workforce were engaged in a workplace generated activity without knowing the target (%) it is not possible to know if goals have been reached and whether the approach needs to be altered to achieve greater participation over the next 6 months.

The financial benefits of HealthWorks to HUHFT are unclear as there was no reduction in sickness absence and turnover, and this cannot be correlated to HealthWorks. Quality targets such as reduction in errors, complaints or injuries at work were not specifically measured. If these were measured, including targeted reductions with attributed costs savings, it is possible to determine the level of investment necessary to achieve health and performance benefits for staff. To deliver this level of change an investment in time and resources are also requisite, both in getting the project off the ground and embedded throughout the organisation.

- **Leadership** - While executive leadership and managerial support is essential, at HUHFT the introduction of a Lifestyle Co-ordinator enabled the development and execution of HealthWorks. Leaders are crucial in ensuring that local managers understand the relationship between a healthy, happy workforce and the quality of care and performance within the workplace. Local objectives, that measure individual manager’s performance against key criteria relating to health and wellbeing of the staff they manage, should be developed. This will require training and support from senior managers.

- **Branding** - HealthWorks has shown that it is important to offer a range of activities to appeal to all staff, offering equality of access regardless of age, sex, ethnicity and culture. In this programme the proportion of shift workers attending the onsite activities reflected the difficulties experienced in all organisations to engage shift workers in programmes. There is further work to be done to consider how best to address the issues in engaging this group.

Good marketing is important to programme delivery, enabling staff to have access to information both generally on staying healthy and specifically on hospital initiatives is an area for development. Continuous marketing with larger set piece events such as the HealthWorks annual event and the branding of other activities will be essential for staff awareness. Local marketing and engagement will need to be carried out to keep up momentum and encourage larger numbers of the workforce to take up activities.

The HealthWorks programme encouraged HUHFT to look more widely at their place within the community. NHS Trusts should not only be a place for healthcare delivery, but a resource for those wishing to stay healthy. HealthWorks has broadened HUHFT’s role as an employer to being a role model for the local population and a potential partner for other services and local businesses.

The HealthWorks programme is more than ticking the so-called ‘Boorman box’, many of those interviewed felt that, in the course of creating HealthWorks, a feel good factor had been created at HUHFT. CCCB’s ideas, resource and expertise were central in driving HealthWorks forward at Homerton. This made HealthWorks a success story for both HUHFT and CCGB, and is a positive account of private sector involvement to which NHS Trusts and Government stakeholders can look.
**Annex 1**

**2020 health's view of HealthWorks alignment with Boorman recommendations** – Please note that No might not be negative – just not within the remit of HealthWorks. Boorman recommendations reviewed are limited to those that hold the individual trusts directly accountable for their implementation.

<table>
<thead>
<tr>
<th>Summary of Boorman recommendation 2009</th>
<th>What Homerton did</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1 Improving organisation performance</strong></td>
<td></td>
</tr>
<tr>
<td>Staff Wellbeing service centred on prevention</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| (a) all managers recognised link between staff wellbeing and organisation performance  
(b) judged in terms of their performance in this respect | (a) Yes  
(b) No |
| Strategy to improve workforce wellbeing | No |
| Implement (a) NICE and (b) national mental health and employment strategy | (a) yes / (b) no - nothing mental health specific in HealthWorks |
| Board level champion and senior management support | Yes - but no evidence in board reports |
| (a) health and wellbeing training part of management training  
(b) part of performance assessment and personal development | (a) No  
(b) No but arguably not part of HealthWorks original remit |
| **Section 2 Achieving an exemplar service** | |
| Staff wellbeing strategy assesses key health priorities and risks | Yes |
| Early access and intervention for MSD and mental health | No |
| Engaged with staff to determine provision of services | Yes - HealthWorks executed this extremely well |
| Staff engagement – goes beyond legislative obligation | Yes - goes beyond staff survey, staff assisted in design of HealthWorks from the start though this should be consistent and continued. |
| Services are properly resourced | Yes - as a result of CCGB's sponsorship, though this should be consistent and continued by NHS Homerton |
| Minimum service specification for service | - |
| Service standard for early intervention | - |
| **Section 3 Embedding staff wellbeing in NHS infrastructure** | |
| Staff wellbeing included in local governance framework to ensure board accountability for implementation | No |
| Improving support for staff health developed in partnership with (a) staff and (b) trade unions | (a) Yes / (b) Yes |
| Staff wellbeing strategy developed alongside staff, it routinely evaluated and discussed | Yes |
| Services available equally to all staff | Yes – much consideration given at Homerton, although pilot did not intent this originally |
| Delivery of staff wellbeing services monitored and reviewed | Yes, HRUK will continue to monitor, and the staff survey will be used |
## Annex 2 - Evaluation tools

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>RDSI findings</td>
<td></td>
</tr>
<tr>
<td>HRUK findings, using Healthy Heart assessment tools</td>
<td></td>
</tr>
<tr>
<td>2020 health interview findings</td>
<td></td>
</tr>
<tr>
<td>Boorman report recommendation</td>
<td></td>
</tr>
<tr>
<td>Cabinet Office Best Practice Policy</td>
<td></td>
</tr>
<tr>
<td>Prince2 methodology</td>
<td></td>
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<tr>
<td>NICE guidelines</td>
<td></td>
</tr>
<tr>
<td>Cost-benefit analysis from Coca-Cola GB accounts</td>
<td></td>
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</tbody>
</table>

## Annex 3

### Cabinet Office Best Practice Policy indicators

<table>
<thead>
<tr>
<th></th>
<th>Does HealthWorks do this?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Forward looking</strong></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Defined policy outcomes with long term view</td>
<td></td>
</tr>
<tr>
<td><strong>Outward looking</strong></td>
<td><strong>No, local but model adoption potential on national level</strong></td>
</tr>
<tr>
<td>National perspectives</td>
<td></td>
</tr>
<tr>
<td><strong>Innovative, flexible</strong></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Questioning established ways of dealing with things, encouraging new and creative ideas, identifying and managing risk</td>
<td></td>
</tr>
<tr>
<td><strong>Joined up</strong></td>
<td><strong>No, but with potential to achieve this in future</strong></td>
</tr>
<tr>
<td>Looking beyond institutional boundaries</td>
<td></td>
</tr>
<tr>
<td><strong>Inclusive</strong></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Engaging those responsible and affected by the policy</td>
<td></td>
</tr>
<tr>
<td><strong>Evidence based</strong></td>
<td><strong>No, but with potential to achieve this in future</strong></td>
</tr>
<tr>
<td>Best available evidence from a wide range of sources, and ensuring this is accessible</td>
<td></td>
</tr>
<tr>
<td><strong>Evaluated</strong></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Systematic evaluation of the effectiveness of policy</td>
<td></td>
</tr>
<tr>
<td><strong>Reviewed</strong></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Constantly reviewed to ensure it is really dealing with problems it was designed to solve</td>
<td></td>
</tr>
<tr>
<td><strong>Lessons learned</strong></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Learning from experience of what works and what does not</td>
<td></td>
</tr>
</tbody>
</table>
Annex 4

Persons interviewed by 2020health

From Homerton University Hospital NHS Foundation Trust:

Nancy Hallet, Chief Executive

Shani Anderson, Programme and Lifestyle Co-ordinator

Iain Patterson, Deputy Director of Workforce

Cheryl Clements, Director of Workforce and Education

Tonya Chalker, Fundraiser project manager, press and communication

Andrew Panniker, Director of Built Environment (former Director of Workforce)

Additional interviews:

Dr Beckie Lang, Nutrition Communication Manager, Coca-Cola Great Britain

Denise Armstrong, Assistant Director, Heart Research UK

Further spoke with though not interviewed using schedule:

Iain Weir, Politics International

Danielle Seddon, Vielife

Annex 5

2020health’s HealthWorks Evaluation Interview Schedule

These questions are a record of those asked by 2020health of senior NHS staff at Homerton and key people involved in setting up the programme.

Personal details and role in your organisation
(Brief outline of professional role and career path to date Job title, role, CV, ambitions)

1. What has been your role in the HealthWorks programme? (time commitment)

2. Has the programme changed your view of the relationship between work and health? If so, why? (personally, professionally and organisationally)

3. If you had to single out the biggest difference the programme has made to staff, what would that be? (view sickness absence differently, healthy eating at work)

4. Why do you think this programme was successful? (over other programmes i.e. vielife)

5. What part of the programme didn’t happen/didn’t work? (what stopped planned things happening i.e. vending, Canteen, no one point of contact)

6. What are the issues around transferring the programme? Why? (how? what aspects? i.e. hospital size, budget, leadership)

7. Where do you see HealthWorks in 10 years time? Why?

a. What will make this programme sustainable? How will the programme’s legacy be strengthened?

8. Given a clean slate, what would you do differently? (personally and organisationally)

9. Have you any other thoughts, ideas for the future of the programme or observations?

Closure
(re-iterate confidentiality, future progress of project, feedback from process)

Notes: Emerging themes and messages (main issues, plus any other observations (e.g. interview dynamics etc)

Gail Beer and Emma Hill, June 2010
Annex 6

Below are the questions which RDSI asked between 48-54 staff at Homerton in November 2009 and 24 people in June 2010. Please note that the sample surveyed varied.

RDSI’s November Discussion Guide

Project objectives
To ascertain (pre project) what personal health and wellbeing looks like with the target group (Midwifery unit), what would engage them in thinking about it, what opportunities would appeal and motivate them?

Phase I

• In planning for the project, we want to ensure that anything we deliver is welcomed and owned by the maternity staff. We want to understand pre project:

• Does health feature at all in the workplace for this group?

• Do they feel that their health is something they want to think about within work?

• Do they think the hospital, as their employer, should be assisting them with their own health needs

• What kind of initiatives would engage them to consider their health at work?

• Would they engage in physical activity at work? If so, what, who with, where? What would/wouldn’t work?

• What is the food/drink provision at work? Is there the choice they would want? Do they use vending/canteen/bring food in? What would they like/not like to see?

Warm up

• What are the words and phrases which spring to mind when I say health & wellbeing to you?

• What is your attitude to health & wellbeing?

• How important is health & wellbeing to you? Why?

• What are all the feelings which you associate with health & wellbeing?

  • How does it feel to be healthy?

  • How do health and wellbeing differ from one another – what’s the relationship here?

Your health & wellbeing

• Give me some examples of how you lead a healthy life?

  • Allow spontaneous examples & then probe: i.e. food and diet/exercise at home vs. at work/relaxation/distress techniques

  • Would you consider yourself to have good wellbeing? Why?

  • How easy do you find keeping healthy?

    • What makes it easy? In what areas of your life is it easiest?

    • What makes it difficult (listen for anything work related)?

  • How could we encourage further/ improved health & wellbeing for you?

Health & wellbeing at work

• What is the relationship between work and your attitude/behaviours towards being healthy?

• How much does health & wellbeing feature for you at work? In what ways?

• Does it need to feature at work? Why?

• How easy is it to be healthy at work? What makes it easy/difficult?

• What steps do you take at work to ensure good health & wellbeing?
• What steps can you take at work to ensure good health & wellbeing? Why don’t you? (i.e. eating in canteen – access to healthy food? Choice available/bringing food in/physical exercise/anything else?)

• What motivates you to make healthy choices at work?

• What puts you off/prevents you making healthy choices at work?

• How much responsibility should be placed on your employer to provide healthy initiatives at work? What kind of initiatives would interest/motivate you?

Moving forwards

• What changes would you like to see in the hospital help you live a healthier life? (i.e. food/diet and ability to take physical activity)

• How could these changes be implemented to be most motivating to you?

• How do you feel these changes would impact or you? On your working life and attitude?

• How would you see yourself utilising these changes? When? With who? How often?

• What do you think would be the overall impact on your lifestyle?

• Respondents may need some help to think of how to create a healthier work environment – we could probe some of the initiatives which are being considered to gauge interest/appeal and help stimulate conversation

• Initiatives: Pilates/Yoga/Running club/ Swimming/Gym membership/Dance class
  • What information provision do we need?
  • Want to be things alone or in a group

RDSI’s June Discussion Guide
In June Phase I questions were altered to reflect the progress in the programme. The ‘warm up’ and ‘your health and wellbeing’ sections remained the largely the same, one sections was added in place of the ‘moving forwards’ section in the November discussion titled ‘the Lifestyle programme’.

Project objectives
To look post project at success, barriers challenges and opportunities for taking forward on the issue of health and wellbeing in this environment

Phase I
Once the project has been delivered and is underway, we would like to understand how the initiative is going. We want to understand what has worked, what has been successful, what has been challenging, what have beenbarriers/opportunities, what could be developed/dropped in terms of:

• The process

• The deliverables (physical activity provision, food options etc)

• The outcomes

• Staff morale Etc.

In terms of initiatives, the following are things that are now in place:

• Launch event/Free 6 week gym trials/3 month free gym subscriptions /Classes: pilates, yoga, combat, dance, aerobics, circuits/Running club/Nordic walking

The Lifestyle Project

• Inform staff that we would like to talk about the Lifestyle Project – HealthWorks at Homerton

• Tell me about this programme…
  • What do you know about it? What is available? How did you hear about it? How did you feel about it when you heard the plans?
Annex 6 (continued)

- How involved have you been in this programme?
- Which activities/events have you attended?
  - Why these? Who did you go with? How did you find the event/activity? Do you go regularly? Why or why not? How has this event make you feel?
- Why have you not attended other activities/events?
  - What other events/activities are available that you have not made use of? Why?
  - What have been the barriers to attending these activities/events?
- How has the programme lived up to/fallen short of your hopes and expectations?
- Did you attend the launch event? Why/why not?
  - What was your experience of the launch event?
  - What did enjoy? What did you learn?
- What would you say has worked well from this programme?
  - Probe specific events, the communication of events, organisation, ease of attending
- What has worked less well from this programme?
  - Probe specific events, the communication of events, organisation, ease of attending
- How has this programme impacted on your attitude towards health and wellbeing?
  - What has changed? What is the benefit to you?
  - Probe on aspects of health & wellbeing discussed at the beginning of the interview e.g. stress, sleep, balance, diet, exercise etc.
- Would you want more regular feedback on personal progress i.e. through assessments or similar?
- What benefits has this programme brought to Homerton hospital?
  - Probe on staff morale, feeling valued, interest, motivation, excitement, engagement
- How does this programme impact on the way you feel about Homerton Hospital?
- If this programme ended and the classes etc were no longer available how would you feel?
  - What would you miss?
- What changes/improvements would you make to make this programme even more appealing?
  - Probe type of activities, timing of the activities, organisation, communication etc.
  - Any classes which you would drop?
  - Anything else which you would add in to the programme beyond physical activity to improve the health and wellbeing of staff?
  - Any gaps that are not covered by the current programme?
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CIPD. Sickness absence can be reduced but thorough review of sickness absence practice and wider public sector people management is needed. CIPD press release 25 March 2010. http://www.cipd.co.uk/pressoffice/_articles/NHSsicknessabsence250310


Websites for further information

Vielife
http://www.vielife.com/

Heart Research UK
http://www.heartresearch.org.uk/

RDSI
http://www.rdsiresearch.com/

Change4Life
http://www.nhs.uk/change4life/Pages

Business In The Community - Business Action on health
http://www.bitc.org.uk/workplace/health_and_wellbeing/

BITC’s Casestudy – The Foyle Food Group
http://www.bitc.org.uk/resources/case_studies/the_foyle_food.html

BITC’s Casestudy – The Royal Main Group
http://www.bitc.org.uk/resources/case_studies/afe_2241.html

Investors in People – Health and Wellbeing Good Practice Database
http://www.investorsinpeople.co.uk/MEDIARESEARCH/TOOLS/Pages/HealthandWellbeingGoodPracticeDatabase.aspx

Coca-Cola Great Britain’s FAQs about the Olympic Games
http://www.coca-cola.co.uk/faq/olympics.html

Homerton University Hospitals NHS Foundation NHS Trust – our objectives
http://www.homerton.nhs.uk/about-the-NHSTrust/our-objectives/

Workplace Wellbeing tool (formerly Buiseness HealthCheck Tool)

HSE’s online absence management toolkit for line-managers
http://www.hse.gov.uk/sicknessabsence/toolkit.htm

HSE’s Management standards
http://www.hse.gov.uk/stress/standards/

European Network for Workplace Health Promotion
http://www.enwhp.org/
Endnotes


6. DH. Be active, Be healthy: A plan for getting the nation moving. 2009.


10. Penaloza et al. ONS 2010


15. Kreis BT and Bodeker W. 2004


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18. See Investors in People – Health and Wellbeing Good Practice Database and BITC’s Health and Wellbeing Casestudies

19. BITC. Healthy People = Healthy Profits. 2009.


27. Pfeffer J. Human equation. 1998


29. Kreis BT and Bodeker W. 2004

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40. ibid


42. Department of Health statement response to 2020 health health enquiry 27th July 2010

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44. RDSI findings 21st July

45. RDSI findings 21st July 2010

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47. RDSI and HRUK initial findings 2009-2010

48. RDSI finding 21st July 2010

49. Ibid

50. Ibid

51. Ibid

52. Ibid

53. HRUK finding July 2010

54. 2020 health health finding July 2010

55. See www.fitbug.com

56. CCGB correspondence August 2010

57. 2020 health finding August 2010

58. RDSI finding November 2009


60. See Workplace Wellbeing tool (formerly Business HealthCheck Tool)

61. See HSE’s online absence management toolkit for line-managers and management standards

62. Bermuda Triangle, pp 23
