

# Exploring the contexts and mechanisms through which workplace health initiatives improve health and wellbeing: a realist evaluation

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## Research Article

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**Title:** Exploring the contexts and mechanisms through which workplace health initiatives improve health and wellbeing: a realist evaluation

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**Author Contributions**

CR, COM, MF, AL, FHB developed the research question and planned the evaluation protocol. CR and COM collected the initial data, and CR, COM, MF, AL, FHB analysed it. CR, COM, MF, AL, FHB collected the consolidation and theory refinement data and analysed it. Ongoing discussions and theory refinement took place with all authors. All authors provided critical feedback on drafts and approved the final manuscript for submission.

**Data Statement**

Anonymised data is available on reasonable request

**Abstract**

**Background:**

Workplace health and wellbeing initiatives are widely implemented across the UK. In the North East

of England, over 400 employers participate in the Better Health at Work Award (BHAWA), a scheme that recognises organisational efforts to foster healthier working environments.

#### **Methods:**

We conducted a realist evaluation to examine the contextual factors, mechanisms, and outcomes underpinning a workplace health and wellbeing initiative. We tested an initial programme theory, developed through prior work, using four case studies comprising interviews (n = 26) and documentary analysis of organisational portfolios. The findings informed a theory refinement process, resulting in a consolidated programme theory.

#### **Results:**

Seven interrelated programme theories were identified: cultivating an inclusive workplace culture; securing leadership commitment; ensuring equitable access to wellbeing opportunities; providing adequate resources and infrastructure; implementing adaptive communication strategies; promoting employee collaboration and co-design; and tailoring interventions to workforce characteristics.

#### **Conclusions:**

Effective workplace health and wellbeing initiatives are dependent on dynamic, context-sensitive factors, including leadership engagement, organisational culture, and relational dynamics. Understanding these interactions provides a foundation for designing sustainable, evidence-informed interventions aligned with organisational values and structures.

#### **Introduction**

The work environment is a key determinant of health and health inequalities, and workplaces play a major role in preventing ill health. International and national organisations such as the World Health

Organisation [1] and the Office for Health Improvement & Disparities (OHID, previously Public Health England) [2] encourage employers to implement workplace health initiatives (WHIs). In England, several local government-commissioned and funded schemes help employers support their workforce's health and wellbeing. One example is the Better Health at Work Award (BHAWA) [3] scheme (the Scheme), which is available to workplaces in the North East and Cumbria regions of England. Currently, over 400 employers are enrolled in BHAWA, which reaches over a quarter of a million individual workers.

#### **Box 1: The Better Health at Work Award (BHAWA) Scheme**

Workplaces that sign up to the Scheme appoint a Health Advocate(s) (HA) from within their workplace who works with the Better Health at Work Award (BHAWA) team to design and implement individual, organisational and environmental WHIs. Each year, the workplace submits a portfolio of evidence detailing the various WHIs implemented. The portfolio is assessed, and if deemed to meet pre-specified criteria, the workplace receives an Award with progression opportunities each year, starting at Bronze Award and progressing to Silver, Gold, Continuing Excellence and Maintaining Excellence.

The literature on the effectiveness of WHIs shows modest improvements in health behaviours and outcomes, such as mental wellbeing, weight management [4], and reduced absenteeism. However, other literature has shown no effect, and some WHIs have even led to a deterioration in psychosocial working conditions and employee health and wellbeing [5-7]. This inconsistency may be explained, in part, by the complexity of workplaces as sociocultural environments. Contextual factors such as the organisation's size, industry, and employee demographics likely affect WHI implementation and effectiveness. Heterogeneity across workplace contexts challenges evaluation and limits the usefulness of evidence from experimental trials. Another consideration is the broader sociopolitical context in which organisations implement these WHIs. Specifically, the COVID-19 pandemic forced significant changes to working arrangements that have persisted beyond lockdown. Many employees now have flexible working arrangements, including the option to work from home. This context may

affect the effectiveness and implementation of WHIs and, therefore, health outcomes and health inequalities.

Few studies explore why and how WHIs have succeeded or failed. [8,9]. Studies on WHIs should explore and report whether the intervention works, how it works, for whom, and under which circumstances [10]. This type of investigation lends itself to a realist evaluation, which addresses heterogeneity by examining how specific intervention mechanisms operate in each context to produce outcomes through the development and testing of Context-Mechanism-Outcome (CMO) configurations.

This realist evaluation is part of a larger study [11]. In this study, we aim to demonstrate how the realist approach helps with evaluating complex WHI.

## **Methods**

### **Research Design**

We adopted a realist evaluation methodology as the most appropriate approach for assessing complex interventions, particularly those implemented in dynamic and heterogeneous settings. [12].

Rooted in the critical realist paradigm, realist inquiry seeks to understand the interplay between context, mechanisms, and outcomes (CMO configurations) and is increasingly applied to evaluate interventions in real-world settings [13-16]. This shift reflects a growing recognition that interventions may function differently across settings and populations, and that understanding these variations is essential for improving implementation and scalability [17].

In this study, data were collected to explore:

- **Contextual factors**, including variations in workplace environments and organisational cultures.
- **Mechanisms**, such as psychological responses and engagement processes, that may not be directly observable.

- **Outcomes**, including how the health and wellbeing initiative was delivered and received by employers and employees. Outcomes included both intended and unintended effects, such as behavioural changes, which helped explain why an intervention succeeded in one context but not in another [18,19].

**Aim:** To understand the mechanisms, processes and context by which workplace health award schemes impact workplace health outcomes.

**Objectives:**

1. To determine the mechanisms, barriers, and facilitators to workplace health interventions (WHIs).
2. To develop a programme theory that will enable a deeper appreciation of how components of workplace health interventions work together

**Development of initial programme theories**

Initial programme theories were developed through a realist review of workplace health and wellbeing initiatives published elsewhere [20] and through consultations with workplace health and wellbeing practitioners and members of our Patient and Public Involvement and Engagement (PPIE) group. We then tested and refined these theories through case studies conducted with workplaces in the North East of England, UK, and with key stakeholders who participated in the health and wellbeing intervention.

**Case Study Approach**

This study used a multiple-case study [21] design, informed by realist evaluation principles [22], to explore how WHIs were implemented and what outcomes they produced. The case studies explored workplace settings in real-world contexts, helping explain why interventions succeed or fail [23].

Interventions usually depend on the involvement and engagement of several stakeholders within an

organisation [24]. The design enabled comparative analysis across diverse workplace settings and variations in programme delivery.

### **Case Study Selection**

Researchers selected six workplaces in the North East using a multi-stage sampling strategy [25]. The researchers focused on organisations participating in a WHI and holding Gold Award status (see box 1), indicating long-term engagement and successful implementation of the intervention. The team grouped workplaces by size (small, medium, large) and sector to ensure sample diversity. We randomly selected one organisation from each group to reduce bias. Two organisations withdrew before recruitment due to workload pressures. The team sought to include views from organisations that did not join the programme or had discontinued. However, staff turnover and low response rates to recruitment emails limited input. Insights from the strategic interviews helped fill this gap by explaining why WHIs did not participate or withdrew.

### **Qualitative Data**

A mixed-methods approach to data collection combined one-to-one semi-structured realist interviews and focus groups, incorporating a realist interview approach [26]. [See Supplementary material 1 interview guide] and document analysis of assessment portfolios submitted as evidence for the WHI. Additionally, informal meetings, memos, and ongoing reflection throughout the process informed data collection and iteratively guided theory development.

To complement case-level data, we conducted strategic stakeholder interviews with national and regional stakeholders, including public health officials, Local Authority representatives, and academic experts. These interviews provided insight into broader contextual influences and helped address gaps arising from non-participation or WHI withdrawal.

## **Participant Recruitment and Data Collection**

Before recruiting participants, we held pre-interview meetings with Health Advocates (HAs) in each organisation. These meetings served two purposes: gathering contextual information about the workplace and establishing rapport, which facilitated effective communication and minimised workplace disruption during interviews. This preparatory phase aligns with realist interviewing principles, ensuring researchers enter the interview setting with contextual awareness of the natural environment [27].

Document analysis of workplace portfolios, including a needs assessment, campaign materials, and outcome data, provided additional context. HAs supported recruitment by disseminating study information and invitations to all staff, with interested participants contacting the research team directly. Researchers directly approached strategic stakeholders via email. Participants could choose an interview format: face-to-face, online, or by telephone.

## **Data Collection**

### **Realist interviewing**

Interviews followed a realist approach. Participants included staff at all organisational levels and roles (e.g., senior and middle management, office-based staff, and manual workers). We iteratively developed interview guides using data collected during the study. We interviewed some participants twice to support theory testing.

### **Consent Procedures**

For case study interviews and focus group participants, we obtained informed consent in writing and verbally. With participants' permission, we audio-recorded all interviews. For document analysis, we obtained consent by email from participating workplaces that had achieved a gold-level award. We included only portfolios from the selected sample of workplaces in the analysis.

## **Programme Theory Refinement**

Following Pawson and Tilley [27], and using Rameses guidelines [28], we conducted the qualitative data collection in two stages, combining theory gleaning and theory refining in interviews with strategic and case study participants and the theory consolidation phase [26] through an online discussion group with a wider national stakeholder group and PPIE members, and an anonymous interactive online form that captured feedback. For individuals unable to attend the meeting, we also collected their perspectives via this online form. We presented and discussed this programme theory at national project dissemination meetings, which helped further refine the model. See supplementary material 2: Realist evaluation project cycle. This diagram visually explains the evaluation process and research phases used in this study, with boxes explaining the methods used for each phase adapted from DeBrun *et al.*, 2020 [29].

## **Ethics**

The Science, Technology, Engineering and Mathematics Ethical Review Committee approved the ethics application. Birmingham University [Ref: ERN\_21-0744] and approved by the Faculty of Medicine Research Ethics sub-committee. Newcastle University [Ref: 17930/2021] and Teesside University ethics committee.

## **Data Analysis**

### **Document Analysis**

The individual case study workplace portfolios were analysed using a framework approach [30] (with a CMO matrix to systematically capture data on context, mechanisms, and outcomes, such as workforce size, leadership engagement, and initiative uptake.

### **Interview and Focus Group Analysis**

We analysed data using a retroductive process that combined inductive and deductive approaches [31], and we maintained this process throughout data collection. Information ‘nuggets’ were

collected iteratively and placed within a context, mechanism, outcome (CMO) framework [32]. We transcribed data verbatim, anonymised them, and coded them using NVivo v13. We first analysed case studies and strategic interviews individually, then narratively synthesised them to refine programme theories. We developed theories by exploring context (C), mechanisms (M), and outcomes (O). We then integrated all data to develop a model explaining how, for whom, and in what context a WHI works.

## **Rigour and Triangulation**

To ensure rigour, we collected data from multiple sources and used memos throughout the research process to support analysis and the retroductive process [33, 34]. Regular research team meetings supported theory development in a valid and transparent way. In addition, to ensure consistency in coding CMO's two transcripts were blind coded by 4 researchers (CR, COM, MF, FHB). The researchers then came together to discuss their coding and develop initial codes, which the whole research team agreed to use to create a coding framework. The team then coded all transcripts and sorted coded excerpts to identify patterns or themes in the data. Two researchers (CR and COM) carried out document analysis. The researchers met regularly to discuss the data, ensure consistent coding, and develop the programme theory. The team also shared anonymised findings with the wider research team and PPIE members to further refine and test the developing programme theories.

## **Results**

### ***Participants***

Participants in the four case studies (See Table 1 for a summary of participating workplaces) comprised senior and middle management, as well as employees from different areas within the organisation (where possible) (n=19). Strategic interviews included participants who provided a strategic perspective within the region, such as OHID and Local Authority (LA) representatives (n=5).

See Table 2 for characteristics of all interview/focus group participants. Interviews lasted between 20 and 50 minutes.

**Table 1: Characteristics of case study workplaces**

| Case study | Sector             | Workplace Size (defined by number of employees) [35] |
|------------|--------------------|------------------------------------------------------|
| C          | Manufacturing      | Large                                                |
| D          | Financial Services | Small                                                |
| E          | Public Admin       | Large                                                |
| F          | Energy             | Medium                                               |

**Table 2: Characteristics of case study and strategic participants (n=26)**

|                                      |                                                                                                                     |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| Gender                               | Females n=22, Males n=4                                                                                             |
| Job Role                             | Senior managers n=2<br>Managers n=5<br>Administration role n=10<br>Non-office-based staff n=4<br>Strategic role n=5 |
| Work patterns                        | Full-time n=25, Less than full-time n=1                                                                             |
| Length of time in current employment | Ranging from 18 months to 25 years                                                                                  |
| Tenure                               | Permanent employment n=26                                                                                           |

Findings centre on seven programme theories (cultivating inclusive workplace culture; securing leadership commitment; ensuring equitable access to wellbeing opportunities; providing adequate resources and infrastructure; implementing adaptive communication strategies; promoting employee collaboration and co-design; and tailoring interventions to workforce characteristics) and link them to contexts, mechanisms, and outcome configurations in supplementary material 3.

Quotes are presented under each of the seven programme theories in the text for illustration, with the case study and unique interview/focus group identifier.

## **Programme Theory 1: Cultivating Inclusive Workplace Culture**

### **Workplace Health and Wellbeing Culture**

Workplace culture is a central contextual factor that shapes how WHIs are enabled or constrained.

Culture is not static; it's a dynamic construct shaped by leadership, communication, inclusivity, and shared values that evolve over time. WHI success depends on these cultural elements working together to meet organisational and employee expectations.

A strong health and wellbeing culture was highlighted as a central theme across all data and intersected with other themes. An organisation's values, beliefs, attitudes, and norms shape culture and strongly influence employees' experiences and WHI success. Key elements identified included genuine investment and action, feeling valued, evolution and sustainability over time and normalising health and wellbeing as part of everyday workplace life.

### **Genuine Investment and Action**

Simply having a WHI is not enough; employees need to see genuine commitment from their organisation. When organisations invest meaningfully in WHI, and it is not perceived as a 'tick-box' exercise, employees feel valued and are more likely to engage. Conversely, superficial efforts lead to disengagement and resentment, reducing participation.

*It does all seem really tailored, so I will make that point, that it does seem that we're doing it for the right reasons. We're not just doing it to tick a box and to say that we've got this award or whatever. (CS F, Int 1)*

*I think the whole thing's about culture. I think that's entirely kind of what it is. Changing kind of from a reactive to a proactive... it's kind of in the fabric of the organisation, and it's not just something people do scattergun or pay lip service... one of our workplaces used a great phrase the other day, 'built-in, not bolt-on (Strategic, Int 1)*

## 269 **Change Over Time and Sustainability**

270 Cultural and behavioural change takes time. Introducing H&W policies, charters, and campaigns  
271 helped embed wellbeing in workplace practices. Sustained efforts led to long-term improvements in  
272 workplace culture. However, some employees did not engage because of apathy or time constraints.  
273 Clear communication and reassurance eased transitions and encouraged participation.  
274 Many workplaces reported a gradual shift toward a more positive, healthy workplace culture,  
275 though this evolution was ongoing. The process required sustained effort, leadership support, and  
276 responsiveness to employee needs.

277

278 *I think the benefit is that it's cumulative, so, and often culture change isn't done in a*  
279 *fortnight; it's not done in an awareness month; it's done over years (Strategic, Int 2)*

280

281 *It's more of a challenge for those people that have worked in the organisation for a long*  
282 *time; they feel that they've had things done to them rather than they are doing things as*  
283 *part of the organisation. But that's historic culture, and I think that's mindset we need to*  
284 *change, and that's really, really hard, but that's something we've got a big focus on as well.*  
285 *(CS E, Int 4)*

286

## 287 **Normalising Health and Wellbeing**

288 Many participants noted a shift in the workplace and wider society from viewing health solely in  
289 terms of physical illness to a broader focus on mental health and prevention. As H&W is discussed  
290 more openly and embedded in daily routines, stigma decreases, and employees feel more  
291 empowered and supported. Recognising health advocate roles in job descriptions and integrating  
292 H&W into organisational norms further reinforce this shift.

293 *I think since the [organisation] values have come on board, I think the health of the*  
294 *employees, that resonates with them a little bit more. I don't know, it's just about giving the*  
295 *workforce permission to work differently, I guess, so that they're able to look after themselves*  
296 *a little bit more. (CS E, Int 4)*

297 *I think it obviously helps us, because we are empowered to do it and to continue it, and it's*  
298 *part of our- even though the health advocate role is on top of our day jobs, we don't feel like*  
299 *it is, because we feel like it's kind of ingrained now. (CS D FG)*

300

301 A friendly, open environment with approachable managers and health advocates encouraged open  
302 conversations about sensitive topics. Trust and the right interpersonal relationships were essential  
303 to effective support. Having diverse health advocates embedded across teams fostered inclusivity  
304 and broke down barriers.

305 In contrast, unsupportive environments led to breakdowns in engagement and feelings of exclusion  
306 or resentment. Some employees felt unsupported by management, particularly when they  
307 questioned access to H&W resources, which was demoralising.

308 *Yes, I think it might be different in different departments, like the main office and stuff like*  
309 *that. But I think, I didn't want to sound negative, but I think it was a tick-box exercise, dare I*  
310 *say (CS C, Int 3)*

311 Some employees reported feeling unable to step away from their work, particularly without  
312 managerial support, which led to lower engagement with WHIs. In less flexible work environments,  
313 such as those requiring timesheets or client-billed hours, participation in health and wellbeing WHIs  
314 was considered more challenging.

315 *They've [office workers] got more flexibility, but they're not getting watched all the time.*  
316 *There's no come back on them. If I was to stop on my way back and spend 15 minutes filling*

317 *the questionnaire out or doing a little quiz or whatever it is, and when I go back, I'm in*  
318 *trouble) (CS C, Int 3)*

319 *People do just want to come and get their head down, and do their job, and I think there's*  
320 *that old fashioned outlook isn't it, of being timesheet driven. You know, like chargeable*  
321 *hours. Get your chargeable hours every day. So again, that's a bit of a culture shift that we're*  
322 *currently working on, moving away from that. (CS D FG)*

323

## 324 **Programme Theory 2: Securing Leadership Commitment – (middle & senior management)**

325 Leadership commitment is critical to successfully implementing WHIs. Leadership support, whether  
326 present or absent, drives organisational culture, resource allocation, and employee engagement.  
327 Both senior and middle management play structurally significant roles in embedding H&W into the  
328 organisation's day-to-day operations.

329 Participant data suggest that when leaders demonstrate approachability, empathy, and openness to  
330 change, they create a psychologically safe environment that fosters employee recognition and  
331 inclusion, ultimately increasing engagement and participation in WHIs. This suggests a link between  
332 leadership behaviour and organisational outcomes.

333

334 Managers were reported to shape the workplace culture around H&W. For instance, enthusiastic  
335 championing of H&W created an environment in which employees felt encouraged to take care of  
336 their own H&W. This enthusiasm was perceived to filter down to health advocates delivering the  
337 programmes, who reported feeling empowered to deliver the programmes as part of their daily role.  
338 Their enthusiasm legitimises wellbeing as a shared organisational value, empowering health  
339 advocates and normalising wellbeing practices across teams.

340 *Definitely, colleagues are listened to by leaders and colleagues feel they have a voice* (CS E,  
341 Int 5)

342 *A lot of us are really, really involved in charity work. We are not punished for wanting to be*  
343 *more active in this area; it's extremely accepted. I do see it as coming like top down* (CS D,  
344 FG)

345 Conversely, when leadership is perceived as distant or indifferent, disengagement and low morale  
346 are triggered, leading to a weak H&W culture and reduced participation in WHIs. Leadership plays a  
347 key role in driving and modelling H&W behaviours, fostering a positive organisational culture, and  
348 encouraging the workforce to adopt similar practices.

349 *Morale's very low. There's no development plan in place for people to strive to get to. There is*  
350 *a reward system used in there, that's not used...So we feel like, why should we care? You*  
351 *don't care; I'm not doing it.* (CS C, Int 4)

### 352 **Programme Theory 3: Ensuring Equitable Access to Health and Wellbeing Opportunities**

353 Work context, including job type, shift patterns, and organisational structure, critically shapes the  
354 accessibility and effectiveness of WHIs. Work context may also be influenced by workplace and  
355 organisational size and type.

356 Some participants in more manual roles reported structural constraints, and work structure, hours,  
357 shift patterns, and job type strongly influenced employee participation in WHIs. Factories and large  
358 organisations with diverse roles faced greater challenges, particularly among shopfloor and shift  
359 workers who struggled to access H&W activities held during standard working hours (9am-5pm). In  
360 addition, shift work and activities outside normal hours meant management and leadership teams  
361 could not monitor or provide feedback on workplace health activities.

362 *It all depends whether we're on shift or when we're not on shift and when it's arranged for...*  
363 *it's not there for everyone, if you know what I mean.* (CS C, Int 2)

However, fatigue and limited breaks reduced motivation and engagement, particularly for those in physically demanding roles. Participants considered it unrealistic to meet the needs of the entire workforce, as some, depending on their role, were expected to remain at their workstations to meet work time frames and requirements.

*You're not going to catch everybody at once because the guys are on shift (CS F, Int 1)*

### **Introduction of flexible scheduling and managerial support**

Workplaces introduced flexible scheduling and managerial support to help overcome some of these challenges. Some employers offered designated time or financial support for participation, helping employees feel recognised and valued. However, limited flexibility reduced participation, particularly among shift workers. Some employers addressed these barriers by offering sessions during breaks or after shifts. While this improved access for some, it was not universally effective because of time constraints and post-shift fatigue. Unlike less tangible constructs such as leadership style or communication practices, the nature of work is often structurally embedded and less amenable to rapid change. As such, inclusive H&W strategies must explicitly consider this in their design and implementation. Our data highlights the importance of aligning WHIs with the structural realities of diverse workforces. However, even well-intentioned efforts to address workplace inequities may exacerbate existing disparities.

### **Programme Theory 4: Providing Adequate Resources and Infrastructure**

This programme theory highlights how resources and infrastructure enable or constrain WHI implementation. While resources are adaptable, internal (leadership) and external (systemic) factors shape their availability and perceived legitimacy.

Having the right person in the health advocate role was essential to the H&W programme's successful implementation. Leaders supported the health advocate role and the H&W programme

388 by allocating resources such as dedicated time in job descriptions, financial and practical resources  
389 (e.g., venues, printing, etc.), and staffing.

390

391 Access to appropriate information and resources to enable participation was seen to facilitate  
392 engagement. Some participants believed that investing more money in hiring professionals to deliver  
393 and support initiatives would benefit the workforce.

394 *I think just people knowing that it's there and having access. You know, good signposting.*  
395 *.....and having that knowledge that the people that can allow you the time are on board with*  
396 *it as well. They've got your best interests and your wellbeing [yeah] at the forefront of*  
397 *everything really. (CS E, Int 5)*

398 HAs commented that it was important to feel supported and valued in their workplace role,  
399 especially if they were given specific time in their job to fulfil their HA role. They also commented  
400 that their work would be sustainable and embedded in the workplace if it were a recognised role  
401 within people's jobs, as it would send an important message to everyone that management takes  
402 employees' H&W seriously.

403 *[When I took on the HA role] One of my worries was, "oh my god, I'll have to do overtime to*  
404 *take care of it, but it's actually taken into my job role, so I'm not going to have to make up*  
405 *the time later on" (CS D, FG)*

406 However, a lack of employer investment, both time and money, often meant initiatives were not  
407 accessible to all employees, particularly when workplaces were short-staffed. In smaller businesses,  
408 when an employee was off sick, other employees had to step into those roles, leaving less time and  
409 fewer opportunities to participate in workplace initiatives.

410

411           *We've had people off quite a few people off; we're not good at replacing them. We just ask*  
412           *other people to work harder, and that's tiresome, and that's very difficult, and there's no real*  
413           *structure in place for that. (CS F, Int 2)*

414  
415           *If you're a micro business, you've got nine members of staff, and actually you've managed to*  
416           *keep two of them off the sick, or you've had them checked out, and actually it's meant that*  
417           *they haven't- or they've got support around stress and mental health or whatever, then they*  
418           *feel well-supported, I'll stick working with you, whereas if you've lost that, you've lost like*  
419           *20% or 25% of your workforce, haven't you? Whereas if you've got hundreds of staff, losing*  
420           *one or two people off an a sick- the impacts less (Strategic, Int 3)*

421  
422   Participants also discussed the sustainability of initiatives and the need to ensure responsibility and  
423   drive lie collectively with the workforce. They noted that working positively with workplace  
424   infrastructure and fostering an inclusive environment enhanced workplace culture. This was seen as  
425   something that develops over time and is necessary for WHIs to become embedded within  
426   workplaces.

427           *When we first started the BHAWA workplace health award, it was literally [name of HA] by*  
428           *herself. That kick-started it and got it off the ground for our site of the [name] organisation as*  
429           *well and, but within the [name of organisation] it was very much a one-man band to begin*  
430           *with. Then a couple of others of us got involved and helped. It has grown and grown from*  
431           *there. So, I think definitely there is more support for it, and it would be able to keep going*  
432           *now without that one person driving it all the time. (CS E, Int 6)*

433   However, the availability and allocation of resources and infrastructure depend on workplace  
434   investment; for example, physical space, staff time, and information are essential contextual  
435   conditions that shape the mechanisms through which WHIs are implemented and sustained. These

436 resources are not static; leadership commitment, organisational type, size and structure, and  
437 broader socio-political and economic factors such as public health agendas, union involvement and  
438 Local Authority funding influence them.

#### 439 **Programme Theory 5: Implementing Adaptive Communication Strategies**

440 Communication within the workplace is a key aspect of WHIs. It serves as both a delivery mechanism  
441 and a relational process that shapes how employees perceive, interpret, and engage with  
442 organisational wellbeing agendas. Inclusive, context-sensitive, and feedback-responsive  
443 communication strategies can significantly enhance engagement, trust, and cultural alignment.  
444 Conversely, ineffective or exclusionary communication can undermine even well-resourced  
445 initiatives. This programme theory highlights communication's central role in enabling workplace  
446 health and wellbeing, both structurally and relationally. Therefore, communication must be  
447 inclusive, contextually tailored, and continuously adapted in response to employee feedback. When  
448 communication is perceived as authentic, accessible, and reciprocal, it builds trust, increases  
449 participation, and embeds WHIs in the culture.

450

#### 451 ***Organisational Level***

##### 452 ***Use different communication methods to engage all staff members.***

453 Workplaces used diverse methods to communicate health and wellbeing campaigns, information,  
454 new policies, or guidelines to staff, ensuring they were as inclusive as possible. HAs would send  
455 correspondence to all staff groups via email or intranets (in larger organisations). They would also  
456 put up flyers and posters in communal areas such as canteens and staff notice boards to reach  
457 employees who may not have access to email.

458

459 HAs reported, involving staff across different teams in the WHI, for example, by putting up posters in  
460 communal areas or by line managers signposting their staff to emails,

and discussing new policies or guidance during team briefings, all motivate staff and encourage more engagement. This helped increase campaign uptake and raise awareness of H&W messages.

*We have [information] where our hand wash is because if you're a factory, we have to hand wash before we go into the factory processing area. We have TV screens up there, and it'll have slides popping up on there for you to read while you're washing hands. There's a monthly newsletter comes out that you can read while you're sat in the canteen or online (CS C, Int 2)*

*Definitely the staff motivation to help bring campaigns to life and, you know, help with resources in terms of issuing email awareness linked to signposting for example or putting posters up around the office or creating an event. (CS D, FG)*

Understanding your workforce and using targeted interventions (e.g. campaigns and policies), rather than a blanket approach to communication, helped employees feel included, valued, and more engaged in WHIs. For example, employees commented that bespoke H&W messages tailored to them made the H&W campaigns more relevant, so they were more likely to engage.

*Well, we do have a few male mental health first aiders and advocates on site, so it's just trying to ask them to engage more with the men because I sometimes think if it comes from one of the women, they don't feel as engaged, or they don't feel any need for it sort of thing (CS F, Int 4)*

### ***Ineffective Communication***

Not all staff in organisations had access to a computer or time to check emails; therefore, flyers and posters in communal areas helped convey H&W messages to all employees. Some employees still

487 reported being unable to access H&W messages, even in communal areas. For example, factory and  
488 canteen workers have limited time during their workday and may be on the premises only briefly or  
489 take short breaks.

491 *There's a huge gap between office staff and shift workers. There's a huge gap between shift*  
492 *workers and their line managers. The communication is shocking. (CS C, Int 4)*

494 In workplaces with known challenges in engaging specific staff members, the HAs were aware of  
495 these challenges and, where possible, adapted their communication strategies to be more inclusive.  
496 For example, they recruited HAs within specific work areas to enable direct two-way communication  
497 and a better understanding of the needs within that area, and they engaged line managers more in  
498 how best to communicate health and wellbeing messages and interventions through team meetings  
499 and briefings, rather than relying on emails and posters, which may not be read by everyone.

501 If communication is not delivered effectively, it can undermine the H&W messages being conveyed  
502 and alienate staff, leaving them feeling frustrated and undervalued. Employees are unlikely or  
503 unable to engage with WHI and feel despondent about the workplace. All employees need to feel  
504 included and be invited to participate in interventions. Some employees (e.g., shift workers) did not  
505 feel they were always included in WHI communications or able to take part due to work  
506 commitments.

507 *Yes, they're very good at putting up notices, but then they forget to talk to the factory*  
508 *operators. (CS C, Int 2)*

#### 510 ***Communication between management and employees***

511 Senior and middle management reported communication as an important way to engage employees  
512 at all levels in health and wellbeing. When communication was effective at all levels and

513 management was visible and engaged with the H&W agenda, employees were more likely to  
514 participate and felt WHIs were more embedded in the workplace. A two-way communication  
515 strategy, in which employees' feedback is sought and acted on, was seen as an important element in  
516 building trust and a sense of being valued.

517

518 *It's about people feeling they belong, rather than it's a place to work, so a sense of*  
519 *belonging, a sense of pride in what you'd do, feeling valued, feeling listened to (CS E, Int 4)*

520

## 521 **Programme Theory 6: Promoting Employee Collaboration and Co-design**

522 Employee collaboration was identified as an active component of WHIs and may be considered the  
523 most adaptable (along with communication) in response to leadership commitment, resources and  
524 infrastructure. Creating a collaborative workplace where employees and managers work together to  
525 foster a supportive, comfortable environment that promotes a better WHI culture. This involves  
526 creating an environment that encourages trust, employee involvement, and engagement.

### 527 **Building trust**

528 Many participants said it was important to create a supportive, trusting environment where  
529 employees felt comfortable participating in H&W-related conversations and surveys. If employees  
530 feel excluded from WHIs or that they are not genuine, they are less likely to engage.

531 *We do encourage people to get involved because the future of the business is going to come*  
532 *from within the business. But I think it works really well. I think it makes people feel valued.*  
533 *Like their opinions are valued. (CS D, FG)*

534

### 535 **Providing opportunities**

536 Many participants viewed opportunities for managers to discuss and give feedback to employees,  
537 and vice versa, as an important mechanism for maintaining positive collaboration and engagement.  
538 This helped ensure that trust and understanding of workplace dynamics were communicated across  
539 all levels. It also helped employers better understand their employees' requirements, enabling them  
540 to build more effective, tailored interventions. This also helped to build and maintain a positive two-  
541 way relationship between employer and employee.

542 *Started to get the staff a lot more collaborative and getting around the table, and the staff*  
543 *helped shape our mission statement, values, and behaviour values. We then did a lot more*  
544 *staff surveys and find out what the staff wanted (CS D, FG)*

545 Workplaces used various ways to collaborate with and involve employees in WHIs: wellbeing needs  
546 assessment surveys, evaluations after specific campaigns, small groups that acted as liaisons  
547 between employees and employers, anonymous suggestion boxes, and question-and-answer  
548 sessions with senior management. These collaborative opportunities helped employees feel heard  
549 and valued, boosting motivation and helping them develop new skills. In some cases, participating in  
550 feedback discussions made employees feel confident, equipping them with new skills and a belief  
551 that they had something to contribute to the workplace.

552 *Anybody can join when people join the firm; we always say to them, this is the [name of the*  
553 *H&W organising committee], and explain to them what it is, and we do encourage people to*  
554 *get involved, because the future of the business is going to come from within the business.*  
555 *But I think it works really well. I think it makes people feel valued. Like their opinions are*  
556 *valued (CS D, FG)*

557 |  
558 *I suppose even that co-production as well of like, what do you want? And kind of I suppose*  
559 *that interaction around ideas (Strategic, Int 2)*

560 However, a small number of employees reported that, whilst they were aware of opportunities to  
561 take part in H&W activities and collaborate, these were not open to all staff, particularly non-office-  
562 based staff. Therefore, providing opportunities to help shape the H&W programme and enabling all  
563 staff to participate is vital.

564 *When they're doing different bits and pieces, it should be on more than just one occasion. So*  
565 *that it fits in with others. So, there's something that for everyone. (CS C, Int 2)*

566

### 567 **Programme Theory 7: Tailoring interventions to workforce characteristics**

568 This programme theory highlights the need to design inclusive, adaptable WHIs that respond to  
569 employees' characteristics. Engagement depends not only on the availability of H&W programmes  
570 but also on how well initiatives resonate with employees' identities, values, and lived realities.  
571 Embedding flexibility, representation, and responsiveness into intervention design and delivery is  
572 essential to achieving equitable and sustainable outcomes. Interventions aren't always at the  
573 individual level; they can also be workplace-wide, including policies that address equality, diversity,  
574 and inclusion, or new safety guidelines.

575 *You don't have to have everyone participating in a quote unquote intervention, not everyone*  
576 *participates in the training, but they benefit from it. So, for me, that's a massive thing...some*  
577 *people are going, well I'm never going to join in with whatever it is, but actually, better terms*  
578 *and conditions, flexible working policies, improved dignity at work policy, EDI groups, all of*  
579 *those things are to me- they're all interventions, rather just kind of let's stand on a scale, lose*  
580 *some weight, do some physical activity; they are all health and wellbeing interventions,*  
581 *particularly in a workplace setting. So, for me, that is the benefit: is that you can participate by*  
582 *osmosis, so to speak. (Strategic, Int 1)*

583

584 Employee characteristics, both fixed (e.g. age, gender, health status, education) and fluid (e.g.  
585 beliefs, motivation, perceived importance of health), are important contextual factors that shape  
586 how WHIs are received, interpreted, and acted upon. These characteristics influence not only  
587 intervention accessibility but also the mechanisms that facilitate or constrain engagement.

588

589 Inclusivity, therefore, is not a static design feature but a dynamic process that must be continually  
590 adapted to meet the workforce's diverse and evolving needs. Inclusivity is the extent to which all  
591 employees are considered, and the underlying principle by which WHIs should be designed and  
592 implemented to ensure that activities are inclusive, relevant, and equitable across organisations,  
593 regardless of the nature of work and employees' characteristics. WHIs need to be flexible and  
594 tailored to the workplace and employees, and this approach should also consider communication,  
595 information provision, and access to the intervention.

596

#### 597 ***Flexible, diverse approach to increase engagement***

598 Some employee groups found it more challenging to engage with the WHI than others. For example,  
599 shift workers and part-time employees are less likely to engage because of their work schedules.  
600 Male employees may also be less inclined to engage if the intervention does not appeal to them or is  
601 not specifically targeted at them. Participants reported that the interventions that have worked best  
602 targeted specific groups within the organisation, for example, gender-specific interventions such as  
603 menopause awareness.

604 A flexible approach to interventions that covers a wide range of individuals helps ensure everyone  
605 has access. A flexible approach can also help motivate and engage individuals.

606 *I think there seems to be a bit more of a challenge to engage the staff on the workshop, but I*  
607 *think it is still doable; they just need to be a bit more creative in how they do that ...*(Strategic,  
608 Int 3)

609 Consideration of inclusivity in how information and messages related to WHIs are understood to  
610 recognise and reach different employees across the workforce was viewed as important. This may be  
611 through the way information is communicated and by whom.

612 *I think it's good to have a mix of health advocates, so to have somebody when we've spoken*  
613 *about the different types of employees within one business, to have a health advocate who's*  
614 *working on the ground and then having health advocates who are maybe in, you know, the*  
615 *office admin, kind of if there's an admin team or whatever. And having, you know, from*  
616 *different parts of the workplace to engage. (Strategic, Int 2)*

## 617 618 **Supplementary material 3: Programme Theory CMO configurations**

### 619 620 **The Final workplace health and wellbeing intervention programme theory model.**

621 This model shows how the seven individual programme theories and CMO configurations link together  
622 and feed into one another, while considering external influences. It also aims to show how a workplace  
623 health and wellbeing initiative might increase employee engagement in health and wellbeing activities.

624 **(Supplementary material 4: Final Programme Theory Model to explain effective implementation of**  
625 **a workplace health and wellbeing intervention).**

## 626 **Discussion**

627 This study used a realist evaluation approach to examine how workplace H&W initiatives operate  
628 across diverse organisational settings. Drawing on Dalkin et al.'s (2015) Context-Mechanism-Outcome  
629 (CMO) framework [36], we developed seven interrelated programme theories to highlight the complex

interplay between contextual factors and mechanisms that influence the success or failure of H&W interventions.

These findings contribute to the growing literature emphasising the importance of tailoring wellbeing initiatives to an organisation's specific cultural, structural, and relational dynamics. Rather than assuming a one-size-fits-all model, the realist approach helped us identify the nuanced conditions under which H&W programmes are more likely to produce positive outcomes. These include supportive leadership, adequate resourcing, effective communication channels, collaborative practices, and inclusive organisational cultures.

#### **Workplace Culture as a Foundation**

Participants identified workplace culture as the key contextual condition shaping all other elements of H&W delivery. Participants described a positive, inclusive, and supportive culture as “built-in, not bolt-on”, which enabled the embedding of wellbeing practices in everyday organisational life. This aligns with evidence that organisational culture determines employee health behaviours and engagement [37,38].

However, participants also emphasised that cultural change is neither immediate nor automatic. It requires time, consistency, and reinforcement through everyday actions and decisions. Participants highlighted sustained leadership commitment, visible role-modelling, and open communication with the workforce as more effective levers for change than isolated or short-term initiatives. This reflects broader research on cultural transformation, which underscores that wellbeing is most impactful when it is integrated into organisational systems, values, and strategic priorities over the long term [39-41].

In this way, culture becomes both the foundation and the vehicle for meaningful, lasting change in workplace wellbeing.

### **Leadership Commitment and Support**

Leadership emerged as a critical mechanism for both activating and sustaining H&W initiatives. Participants emphasised that leaders were instrumental not only in authorising resources and legitimising practices but also in shaping wellbeing in day-to-day organisational life. When leaders modelled healthy behaviours, openly endorsed H&W activities, facilitated access to resources and visibly prioritised staff wellbeing, employees reported heightened levels of trust, recognition, and engagement. These behaviours signalled that wellbeing was a genuine organisational value rather than a rhetorical commitment, thereby fostering an environment of safety, inclusivity and collective ownership. Findings echo previous research linking transformational and authentic leadership styles to improved employee wellbeing, motivation, and perceptions of fairness [42,43].

Conversely, absent, inconsistent, or disengaged leadership undermined wellbeing efforts, often triggering mechanisms of low morale, scepticism, and disengagement. Participants described instances where leaders' inattention to wellbeing was interpreted as a lack of organisational support, reinforcing the perception that wellbeing initiatives were superficial or secondary to performance targets. This observation aligns with studies showing that perceived organisational support and leader commitment shape employee attitudes toward wellbeing interventions, particularly whether they are adopted, normalised, or resisted [44]. In this way, leadership not only drives wellbeing culture but also shapes how employees interpret the authenticity of organisational priorities.

Our results further suggested that leadership influence operates at multiple levels. At the strategic level, senior leaders can articulate wellbeing as a core organisational value, embed it in policy frameworks, and allocate resources to support its implementation. At the operational level, line

managers translate these commitments into everyday practices, serving as the primary interface through which employees experience the organisation's stance on wellbeing. This dual-level influence reflects the argument that leadership acts simultaneously as a catalyst for cultural change and as a mirror reflecting existing organisational priorities. When leaders consistently align wellbeing promotion with practice, initiatives are more likely to become embedded in organisational routines and identities. Conversely, discrepancies between formal statements and lived behaviours can erode trust and undermine the credibility of wellbeing strategies.

### **Structural Inequities and Access**

Structural conditions, such as job role, shift patterns, contractual arrangements, and organisational size, emerged as significant determinants of the accessibility and uptake of H&W initiatives. Participants highlighted that manual, frontline, and shift-based workers often faced practical barriers to engagement, including fatigue, time pressures, and inflexible schedules, which limited opportunities to participate. In contrast, office-based staff were generally perceived to have greater autonomy over their time and therefore more consistent access to wellbeing resources. This pattern of unequal access aligns with recent evidence in the occupational health literature, indicating that structural and organisational constraints disproportionately limit low-wage, shift-based, and lower-status workers' ability to participate in and benefit from workplace wellbeing programmes, relative to higher-status employees [45-47].

These inequities highlight how structural features of work both enable and constrain wellbeing efforts, with consequences for both fairness and effectiveness. For example, initiatives scheduled during standard office hours may inadvertently exclude nightshift or part-time workers, reinforcing divisions between occupational groups and limiting the reach of organisational wellbeing strategies. A recent systematic review of workplace health promotion programs for industrial workers found that interventions often failed to reach those in non-standard roles, such as shift workers, due to structural

barriers and a lack of contextual adaptation [48]. These disparities raise equity and justice concerns, suggesting that universal approaches to wellbeing risk benefiting some segments of the workforce while marginalising others. This aligns with workplace health promotion research, which cautions against “one-size-fits-all” models and emphasises tailoring initiatives to the realities of different workforce groups and roles [49].

From a structural perspective, access to workplace wellbeing is not merely a function of individual motivation or engagement; it is deeply embedded in the organisation's design and operations. Factors such as scheduling practices, workload distribution, and consistent managerial support significantly influence whether employees can realistically participate in wellbeing initiatives. Addressing these barriers may require rethinking core aspects of work organisation, including shift patterns, staffing levels, and job design, rather than relying solely on supplementary programs or ad hoc interventions.

Without such structural alignment, wellbeing efforts risk reinforcing existing inequalities by disproportionately benefiting those in more privileged or flexible roles. Recent research highlights that many workplace wellbeing programs fail to deliver meaningful outcomes because they focus on individual-level solutions while neglecting the broader organisational systems that shape employee experience [50]. Moreover, promoting health equity in the workplace requires a deliberate focus on systemic factors, such as social determinants of health, inclusive policy design, and flexible work arrangements, to ensure that all employees, regardless of role or background, have equitable access to wellbeing resources [51].

## **Resources and Infrastructure**

Adequate financial, temporal, and infrastructural resources were identified as essential facilitators of H&W initiatives and their sustainability in the workplace. Health advocates reported greater legitimacy and motivation when their roles were formally embedded in job descriptions, reflecting previous

findings that resource allocation and role clarity strengthen programme sustainability [52]. Conversely, resource scarcity, particularly in smaller organisations, led to fatigue and inequitable access, reducing participation and engagement. These findings align with broader evidence that investing in workplace wellbeing can yield long-term returns in productivity and reduced absenteeism, but only when programmes are properly resourced and supported [53,54].

### **Communication, collaboration and co-design**

Communication was a key mechanism influencing employee engagement with wellbeing initiatives. Inclusive, multi-way communication strategies that allowed for feedback enhanced employees' sense of value and belonging. These findings mirror evidence that effective communication can foster trust, social cohesion, belonging, and participation in workplace health interventions [55,56]. In contrast, one-way or generic communication alienated groups such as shift workers and factory staff, mirroring prior studies that emphasise the importance of context-sensitive messaging among diverse workforces [57]. This also highlights the importance of addressing hierarchical barriers to communication so that employees at all levels feel comfortable approaching others, sharing their experiences and voicing their opinions. Therefore, communication serves not only as a means of communication but also as a relational process that shapes employees' perceptions of organisational culture.

Employee collaboration and co-design were associated with greater ownership, pride, and cultural embedding of wellbeing initiatives. When staff actively shaped policies and campaigns, they reported a stronger sense of belonging and motivation. This aligns with participatory models of organisational health intervention, which emphasise that employee involvement enhances relevance, feasibility, and longevity [58]. Yet when collaboration opportunities were absent or inaccessible to non-office-based staff, perceptions of exclusion emerged, reinforcing inequities. Co-design therefore serves as a critical mechanism for embedding wellbeing within organisational structures and cultures at all levels.

## **Inclusivity and flexibility of WPH initiatives and interventions**

Finally, the inclusivity, flexibility and adaptability of intervention design were shown to determine perceived relevance and engagement. Employees were more likely to engage with initiatives that reflected their demographic characteristics, beliefs, and lived health experiences. These findings align with the literature on tailored health promotion programmes, which consistently shows that interventions aligned with employees' identities and needs achieve greater uptake [59,60]. By modelling desired behaviours and providing peer-to-peer encouragement, they build supportive social networks that embed health practices in organisational culture [61]. Large-scale evaluations show that wellbeing champions boost both individual engagement and perceptions of organisational commitment to employee wellbeing by tailoring initiatives to team needs and providing trusted advocacy [62]. Similarly, wellbeing champions are often described as advocates who reinforce social norms and motivate participation without relying on hierarchical authority [63]. Their effectiveness is strengthened when managers support them, highlighting how peer influence and organisational structures work together to sustain workplace health and wellbeing [64].

## **Implications for Policy and Practice**

These findings have implications for organisational leaders and policymakers regarding the design, implementation, and sustainability of workplace H&W initiatives. First, organisations should embed H&W programmes in their core values, practices, and governance structures, rather than treating them as peripheral or supplementary projects. Evidence consistently indicates that initiatives framed as "add-ons" are less likely to achieve long-term impact, as they are vulnerable to resource fluctuations and shifting priorities [65,66]. Embedding wellbeing at the structural level not only signals authenticity but also helps ensure that it becomes an enduring component of organisational identity and everyday practice.

778 Second, leadership development and training should emphasise role-modelling and psychological  
779 safety as mechanisms for cultural transformation. Leaders who embody wellbeing practices in their  
780 behaviours and interactions can build trust, credibility, and legitimacy, reinforcing a wellbeing culture  
781 in the workplace [67,68]. Furthermore, equipping leaders with the skills to foster psychological safety  
782 by encouraging open dialogue, recognising employee contributions, and responding constructively to  
783 concerns creates conditions in which wellbeing initiatives are more likely to flourish.

784

785 Third, resource allocation should ensure wellbeing does not depend solely on the enthusiasm or  
786 advocacy of individual “champions.” While such champions can be valuable catalysts, over-reliance on  
787 them risks uneven implementation and fragility if those individuals leave the organisation or lose  
788 influence. Embedding wellbeing structurally, through budgetary commitment, dedicated staffing, and  
789 integration into performance and accountability frameworks, provides a more stable foundation that  
790 emphasises collective rather than individual responsibility.

791

792 A fourth implication concerns communication strategies, which must be inclusive, context-sensitive,  
793 and reciprocal. Too often, wellbeing programmes are communicated through top-down channels that  
794 fail to resonate with employees whose roles, schedules, or contexts differ from those of office-based  
795 staff. By contrast, inclusive communication tailored to diverse occupational groups, with opportunities  
796 for feedback and dialogue, helps employees see wellbeing as relevant and responsive to their lived  
797 realities. Reciprocal communication also strengthens perceptions of fairness and trust, both key  
798 determinants of engagement with wellbeing initiatives.

799 Finally, collaboration and inclusivity should underpin wellbeing programme design to ensure equitable  
800 access across diverse employee groups. This means not only consulting widely across organisational  
801 hierarchies and roles but also addressing structural barriers, such as shift work, high workload  
802 intensity, or insecure contracts, that can limit participation and engagement. Co-design approaches

that actively involve employees in shaping wellbeing interventions have been shown to increase relevance, ownership, and sustainability [69,70]. For policymakers, this implies a responsibility to promote equity-oriented workplace wellbeing frameworks and ensure interventions do not inadvertently reinforce existing occupational inequalities.

The implications highlight the need for a holistic approach to workplace wellbeing that integrates structural, cultural, and relational dimensions. For workplace leaders, this requires sustained commitment, authentic engagement, and system-level thinking; for policymakers, it requires supportive regulatory and policy environments that encourage organisations to embed wellbeing as a central rather than peripheral concern.

#### **Strengths and Limitations of the Study**

One key strength of realist evaluation is its capacity to generate theories that explain how and why interventions work, offering transferable insights across settings, and it is increasingly applied in real-world settings [71].

Recruiting participants in workplaces was difficult. However, the interviews included participants with varying lengths of employment and job roles. Most participants were female and employed full-time. Recruiting smaller workplaces was also difficult, and two workplaces withdrew from the study. Despite efforts to replace them, we recruited no additional workplaces.

Despite concerted efforts, we could not recruit from workplaces that had shown interest in workplace H&W or had started but not progressed through the BHAWA; staff had moved on from the organisation or didn't respond to emails. However, strategic interviews helped us understand why workplaces do not participate in, or cannot continue, a WHI.

## Conclusion

This realist evaluation highlights that workplace H&W initiatives are most effective when embedded within wider organisational systems rather than delivered as standalone interventions. The seven programme theories illustrate how culture, leadership, structures, resources, communication, collaboration, and inclusivity interact to influence implementation and sustainability. The findings support a systems-oriented approach, suggesting that meaningful and equitable wellbeing outcomes require alignment between organisational values, practices, and employee needs. For policy and practice, this emphasises the importance of integrated, inclusive, and strategically led approaches to workplace wellbeing. Future research should explore the long-term impacts of system-level wellbeing strategies across diverse organisational contexts.

## Conflict of Interest

The authors declare that they conducted the research without any commercial or financial relationships that could be construed as a potential conflict of interest.

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